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## Conflict of Interest Policies and Industry Relationships of Guideline Development Group Members: A Cross-Sectional Study of Clinical Practice Guidelines for Depression

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### ABSTRACT

Because of increased attention to the issue of trustworthiness of clinical practice guidelines, it may be that both transparency and management of industry associations of guideline development groups (GDGs) have improved. The purpose of the present study was to assess a) the disclosure requirements of GDGs in a cross-section of guidelines for major depression; and, b) the extent and type of conflicts of panel members. Treatment guidelines for major depression were identified and searched for conflict of interest policies and disclosure statements. Multi-modal screens for undeclared conflicts were also conducted. Fourteen guidelines with a total of 172 panel members were included in the analysis. Eleven of the 14 guidelines (78%) had a stated conflict of interest policy or disclosure statement, although the policies varied widely. Most (57%) of the guidelines were developed by panels that had members with industry financial ties to drug companies that manufacture antidepressant medication. However, only a minority of total panel members (18%) had such conflicts of interest. Drug company speakers bureau participation was the most common type of conflict. Although some progress has been made, organizations that develop guidelines should continue to work toward greater transparency and minimization of financial conflicts of interest.

### KEYWORDS

clinical practice guidelines; conflict of interest; depression; disclosure policies; public trust; research bias

## Background

The medical community relies on clinical practice guidelines (CPGs) to advance the practice of medicine, conform to standards of care, and improve patient outcomes. Over the last 10 years, not only have guidelines proliferated, but concerns have also been raised that some look more like industry “marketing

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and opinion statements” (Shaneyfelt and Centor 2009). Because CPGs have become so influential—they are the primary mechanism for “communicating ... ‘standard of care’ expectations to practicing physicians” (Genuis 2005)—their validity and trustworthiness are critical for public confidence and improving medical outcomes.

In 2009 the Institute of Medicine (IOM) recommended that guideline development groups address the issue of trustworthiness, stating, “Financial ties between medicine and industry may create conflicts of interest. Such conflicts present the risk of undue influence on professional judgments and thereby may jeopardize the integrity of scientific investigations, the objectivity of medical education, the quality of patient care, and the public’s trust in medicine” (Lo and Field 2009). Two years later, the IOM (2011) issued a report that specifically addressed the issue of transparency and management of financial conflicts of interest (FCOI), in addition to researchers who have provided recommendations for addressing the prevalence of FCOI in research (Tereskerz 2003). The IOM called for guideline development groups to develop policies regarding FCOI of panel members, specifically recommending that the chair or co-chair should not have conflicts of interest and that, ideally, all guideline panel members should be free of commercial ties (IOM 2011). Organizations with conflict of interest policies may help send the message that these conflicts can produce an unacceptable influence on CPG quality (Bastian 2016). Other groups, including the National Institute for Clinical Excellence (NICE) (NICE, 2014) and Guidelines International Network (G-I-N, Schünemann et al. 2015) have issued similar standards to control the influence of industry on the guideline development process. It is also noteworthy that the U.S. Agency for Healthcare Research and Quality (AHRQ) (AHRQ, 2015) recently required stricter standards (e.g., a systematic literature search of the evidence base must be conducted) for clinical practice guidelines to be included on the National Guideline Clearinghouse, a publicly available database produced by AHRQ. The stricter inclusion criteria provided another signal that more safeguards are needed to ensure the trustworthiness of guidelines.

The impetus behind the call for greater independence of individuals involved in guideline development arises in part from the documented “funding effect” (i.e., corporate funded research tends toward outcomes that support the funder’s financial interests) (Elliott 2008; Krinsky 2010, 2013; Resnik and Elliott 2013) and the “third person effect” (i.e., the tendency for scientists to believe that their colleagues, but not themselves, are susceptible to unconscious bias when their research is industry funded, Krinsky 2013; see Tereskerz 2003; for review of conflict of interest research). A recent report by the Cochrane organization, the leading independent source of systematic reviews, concluded that the funding effect in both drug and medical device studies is a pernicious problem and one that “cannot be explained by standard ‘risk of bias’ assessments” (Lundh et al. 2012; i.e., blinding, randomization), highlighting the fact that unconscious biases

are common and can distort the medical literature (Cosgrove et al. 2016). Thus, it is important to attend to the ways organizations that produce guidelines attempt to prohibit and/or manage conflicts of interest, and assess whether characteristics of guideline developers are associated with differences in FCOI management.

### **Current study**

The purpose of the present study is to expand on previous research in this area (Neuman et al. 2011) to include an international set of guidelines for another disease category, major depressive disorder. Specifically, we examined the extent and type of industry associations of panel members, and the relationship between type of guideline producer (i.e., government vs. non-government and U.S. versus non-U.S.) and extent of FCOI. Additionally, guidelines were assessed for their requirements for transparency and management of FCOIs. Guidelines for depression were chosen based on our previous work in which we identified inconsistencies in both treatment recommendations and disclosure requirements in a subset of guidelines on major depressive disorder (Cosgrove et al. 2013).

### **Methods**

This is a cross-sectional study of clinical practice guidelines for major depressive disorder. We examined a) the disclosure requirements for panel members and b) the extent and type of their FCOI.

### **Sample**

CPGs were identified using several databases. MEDLINE was searched using PubMed and OvidSP (see Appendix for search terms and strategy). We also searched for guidelines using the Trip search engine (Trip 2016) and the International Guideline Library of the Guidelines International Network (2015). All databases were initially searched for guidelines published between January 1, 2009 and December 31, 2014. We later updated the search in March 2016. We adopted IOM's definition of a guideline: "Clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (IOM 2009).

Guidelines were included if they were issued by national organizations; medical specialty organizations; professional associations; or government, non-profit, or commercial entities, and were intended to guide the treatment of unipolar depression (i.e., Major Depressive Disorder) in adults. Organization type was determined according to the categories of guideline producers used by

the AHRQ's National Guideline Clearinghouse. For those guidelines not listed (and thus not categorized) in the National Guideline Clearinghouse, the second author (SK) assigned producer categories (government vs. non-government) after reviewing their statements. Congruent with previous research (Neuman et al. 2011), in order to limit heterogeneity in the sample and best ensure that guidelines could be compared fairly, the following exclusion criteria were applied to the guidelines retrieved from our search: an updated version of the same guideline was also retrieved, relevant for special populations or subgroups only (e.g., pregnant women), or limited to a particular form of treatment (e.g., psychotherapy). Non-English guidelines were included if a professional translation was available.

### ***Disclosure requirements of panel members***

Fifteen disclosure categories were identified for COI policies. These categories were identified by one of the researchers (SK). They were based on previous research and current guidelines for FCOI management (e.g., IOM 2009; International Committee of Medical Journal Editors' [ICJME] conflicts of interest disclosure guidelines, ICJME 2016; and National Institutes of Health [NIH] FCOI disclosure criteria, NIH 2014). Each guideline was searched line-by-line for policies regarding disclosure and management of FCOI. For any guideline that did not include a disclosure policy, the developing organization's website was searched and if a policy could still not be located, the organization was contacted by a research team member and asked to provide its relevant COI policy if any existed. Policies were copied in their entirety and sponsorship and panel members' disclosures were de-identified. One researcher (SK) reviewed the de-identified policies and the disclosure statements and matched them against these categories.

### ***Main outcome measure***

We defined FCOI based on the International Committee of Medical Journal Editors definition (ICJME 2016). This definition includes industry financial ties such as consultancy, honoraria, speakers bureau membership, expert testimony, research funding, stock holdings, advisory board membership, unrestricted education grants, or patent holding. Industry sponsorship of the CPGs and the types of commercial associations of their panel members were identified and recorded in a template.

### ***Identification of FCOI***

Two sources of data were used for identifying FCOI: a) any disclosure statements provided in the CPGs, and b) a multi-modal search of several databases to

identify financial conflicts of interest of the panel members that were not disclosed in the guideline. We searched MEDLINE, PsycINFO, CINAHL, and Academic Search Complete; ProPublica's "Dollars for Docs" database; and the U.S. Patent and Trademark Office patent database for the 3 years on either side of the guidelines' publication dates; these searches and time frames are congruent with previous research methodology (Cosgrove et al. 2009, 2006; Neuman et al. 2011). Searches in databases for peer-reviewed journals (e.g., Medline) were terminated once a disclosure statement was found that met standards set by the International Committee for Medical Journal Editors (ICJME 2016) (e.g., "Dr. Smith reports receiving honoraria, research funding, and consulting fees from company X"). We also used Internet search engines (Google), combining each panel members' names with the name of each of the major drug manufacturers that developed antidepressants, to find other disclosures (e.g., author disclosures provided for peer-reviewed conferences).

### **Analysis**

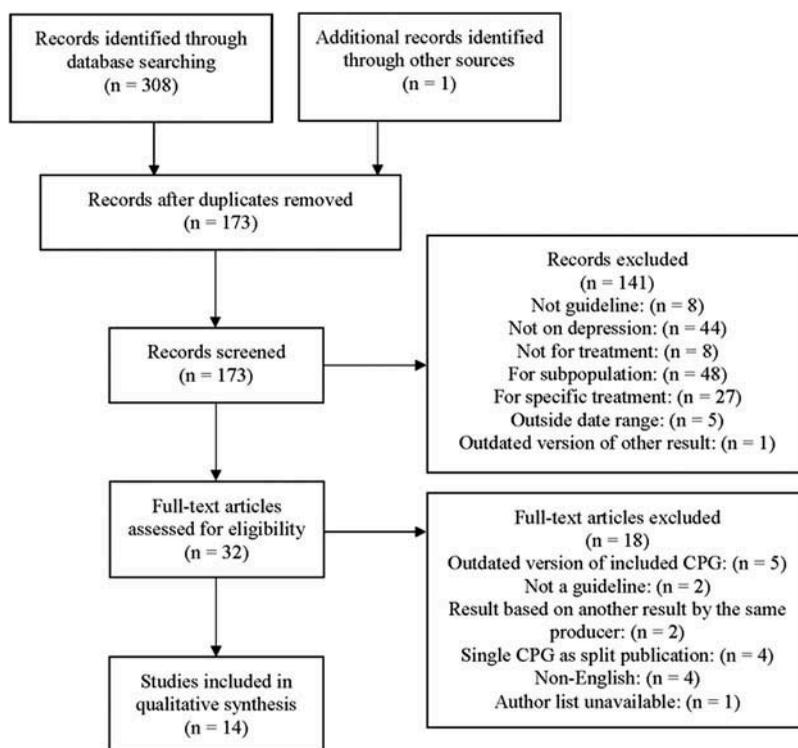
Descriptive statistics were used for most outcomes. Two-sided chi-square tests with a .05 significance level (SPSS v.22) were used to examine the proportion of guideline panelists with FCOI according to the guideline characteristics of type of sponsoring organization (government vs. non-government) and national origin of the sponsoring organization (U.S. vs. non-U.S.).

### **Results**

A total of 14 guidelines met our inclusion criteria. (See [Figure 1](#) for the results of the systematic review and [Table 1](#) for a list of the included CPGs.) Six were from the U.S., 2 from the U.K., 1 from Singapore, 1 from Germany, 1 from Brazil, 1 from Canada, 1 from Finland, and 1 from Spain. Ten of these guidelines were originally published in English; the others provided English-language translations. Statements about the funding of guidelines were found in 5 out of the 14 CPGs. Three of the five guidelines were developed by non-U.S organizations and two of the five were by government organizations. For these 5 guidelines, the statement clarified that the sponsoring organization funded the guideline and no external funding was sought or used. CPG panels ranged in size from 4 to 23 (Mean = 12.3, Median = 11). These panels were comprised of a total of 172 panel members and 171 different individuals (i.e., 1 individual participated in 2 different panels).

### **FCOI policies of the guidelines**

Six of the 14 guidelines included a FCOI policy in the guideline. The research team contacted the organizations that developed the remaining eight guidelines



**Figure 1.** Systematic review flow diagram.

and policies for 5 additional CPGs were identified, for a total of 11 policies. The policies varied in their disclosure requirements. For example, while 8 of the 11 policies required disclosure of research funding received from industry, only 2 of them specified disclosure of authorship of an industry-funded study. Among the guidelines that required any of the 15 disclosure categories, only 3 required 8 or more categories. (See [Table 2](#) for complete results of CPGs with policies.)

### **Analysis of FCOI**

Eight of the 14 guidelines (57%) had at least 1 panel member who had an industry financial tie to at least 1 company that manufactures antidepressant medication. In 7 of these guidelines, there was at least 1 member who participated on a drug company's speakers bureau. Of the 11 CPGs with identified chairs, 6 of these chairs (55%) had FCOI. (See [Table 1](#) for a summary of results.)

In the total sample of 172 panelists, 31 (18%) were found to have FCOI. Of the 70 panel members who had the opportunity to declare FCOI, 23 reported FCOI and only 1 additional member was found to have an undeclared commercial tie. Seven of the 102 members (7%) who did not have the opportunity to declare conflicts were found to have FCOI. The most commonly found conflict, among the 31 individuals with industry affiliations, was speakers bureau membership

**Table 1.** Included guidelines with FCOI results.

CPG	Title	Year published	Producer	Country	FCOI	Chair FCOI	SB/AB FCOI
1	Depression: The NICE Guideline on the Treatment and Management of Depression in Adults.	2010	National Collaborating Centre for Mental Health	UK	3/17	Yes	3/17
2	VA/DoD Clinical Practice Guideline for Management of Major Depression Disorder (MIDD)	2009	Department of Veteran Affairs; Department of Defense	USA	0/23	No	0/23
3	Practice Guideline for the Treatment of Patients with Major Depressive Disorder	2010	American Psychiatric Association	USA	6/6	Yes	5/6
4	Depression in Adults	2012	Map of Medicine	UK	3/4	N/A*	1/4
5	Depression	2011	University of Michigan Health System	USA	0/5	No	0/5
6	Major Depression in Adults in Primary Care	2013	Institute for Clinical Systems Improvement	USA	0/11	No	0/11
7	Primary Care Diagnosis and Management of Adults with Depression	2016	Michigan Quality Improvement Consortium	USA	0/17	N/A*	0/17
8	Depression	2012	Singapore Ministry of Health	Singapore	1/21	Yes	1/21
9	Adult Depression Clinical Practice Guideline	2012	Kaiser Permanente Medical Care Program	USA	0/22	No	0/22
10	Unipolar Depression: Short Version	2015	German Association for Psychiatry and Psychotherapy; German Medical Association; National Association of Statutory Health Insurance Physicians; Association of the Scientific Medical Societies	Germany	1/4	Yes	1/4
11	Review of the Guidelines of the Brazilian Medical Association for the Treatment of Depression (Full version)	2009	Brazilian Medical Association	Brazil	3/8	No	3/8
12	Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical Guidelines for the Management of Major Depression Disorder in Adults	2009	Canadian Network for Mood and Anxiety Treatments	Canada	12/14	Yes	12/14
13	Depression	2014	Finnish Medical Society Duodecim	Finland	2/11	Yes	0/11
14	Clinical Practice Guideline on the Management of Depression in Adults	2014	Galician Health Technology Assessment Agency; GuiaSalud; Ministry of Health	Spain	0/9	N/A*	0/9

Note. FCOI reported as number of panelists with reported conflicts out of total number of panelists for each guideline. AB = advisory board membership. SB = speakers bureau membership.

\*No chair was identified for the CPG.

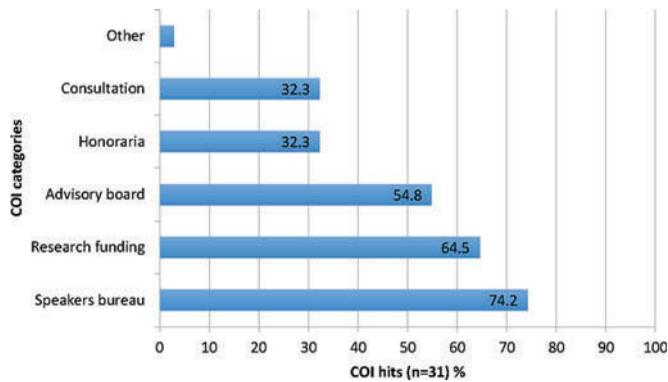
**Table 2.** Assessment of conflict of interest policies in 11 guidelines with policies.

Disclosure categories	CPG #1	CPG #2	CPG #3	CPG #4	CPG #5	CPG #6	CPG #7	CPG #10	CPG #12	CPG #13	CPG #14
1. Speakers bureau or advisory board membership	x	x	x	x	x	x	x	x	x		
2. Holds office in org or advocacy group with a direct interest in depression	x			x		x					
3. Non-financial interests, i.e., public statements made about depression	x			x							
4. Grants or fellowships from companies or foundations connected to depression	x	x	x	x		x	x	x	x		
5. Family associated with health care industry paid or unpaid	x		x			x					
6. Stock holdings in companies that manufacture or distribute antidepressants	x	x	x	x			x	x			
7. Declare interests before being appointed	x	x	x				x	x			
8. Declare interests before each development meeting or periodically as needed	x	x			x	x		x			
9. Limit panel membership of those with industry financial ties/balanced membership			x			x					
10. Reference to IOM policies on FCOI					x	x					
11. No industry employees accepted on panel			x								
12. Recusal as determined by GDG member, organization board or independent review panel		x				x					x
13. Author of industry-funded publication		x						x			
14. Stipulates time period for reporting interests				x		x				x	
15. Income from consulting or speaking related to treatments	x		x	x		x	x	x	x		

(N = 23, 74%). Frequencies of other FCOI categories are: research funding (N = 20, 64%); advisory board members (N = 17, 55%); honoraria (N = 10, 32%); consultants (N = 10, 32%); and one (3%) had another type of FCOI (reported as “salary”). (See Figure 2.)

### **Analysis of COI by CPG characteristics**

Panel members on government-produced guidelines were significantly less likely to have FCOI than panel members on non-government-produced guidelines (5.7% vs. 26.5%,  $p < .001$ ). U.S.-based organizations were



**Figure 2.** Categories of financial interest held by panel members: Members with financial interests (N = 31).

significantly less likely to have FCOI than panel members of guidelines produced by organizations from other countries (7.1% vs. 28.4%,  $p < .01$ ).

## Discussion

In this study of guidelines for the treatment of major depressive disorder, we found a significant proportion of guideline development groups with neither an explicit policy regarding FCOI nor a formal declaration of guideline development members' FCOI. Also, the wide range of disclosure requirements found in this study is consistent with Norris et al.'s (2012) concern that there are significant gaps in many disclosure policies of organizations that produce guidelines.

In terms of commercial associations, we found that 18% of individual panelists had industry financial ties, 57% of the guideline development groups had at least 1 person with an FCOI, and nearly half (43%) of the guidelines had a chair with an FCOI. Additionally, it is problematic that almost half of the guidelines had panel members who participated on industry speakers bureaus and that this type of industry relationship was the most prevalent. This kind of financial association is recognized to have a biasing effect and is typically prohibited (American Medical Students Association 2014; IOM 2011). A speakers bureau usually refers to an arrangement between a commercial entity and an individual whereby the individual is hired to give a presentation supporting the company's product (Steinbrook 2009). Concerns about these types of commercial interests of guideline panel members led the IOM to make the following recommendation: "Members of the [guideline development group] should divest themselves of financial investments they or their family members have in, and *not participate in marketing activities or advisory boards* of, entities whose interests could be affected by CPG recommendations" (IOM 2011) (emphasis added). Moreover, an increasing number of medical schools have prohibited speakers

bureau participation on the part of their faculty (American Medical Students Association 2014).

We found that panelists for guidelines produced by U.S.-based organizations were significantly less likely to have FCOI than panelists for guidelines produced by organizations from other countries. Whether or not this finding reflects increased adherence to recent recommendations (e.g., by G-I-N, the IOM) for developing trustworthy guidelines will require further testing on a larger sample of CPGs. Also, one non-US guideline (CANMAT) had 12/14 panel members with FCOI which could account for non-US guidelines appearing more conflicted than US guidelines.

Congruent with Neuman et al.'s (2011) study, we found that compared to government-sponsored panels, FCOI were far more common among panel members of non-government organizations. CPGs produced by non-government organizations, and particularly medical specialty societies, have come under scrutiny for methodological weaknesses (Shaneyfelt and Centor 2009). Other guidelines produced by specialty organizations in cardiology (Mendelson et al. 2011), in hyperlipidemia (Lenzer 2013; Neuman et al. 2011), and in schizophrenia and bipolar disorder (Cosgrove et al. 2009), have been found to have conflicted guideline development groups. These conditions affect large numbers of people and are primarily treated with pharmaceuticals, making the stakes very high in terms of the impact and cost of industry influenced recommendations. For example, 25.2 million people were taking statins from 2005 to 2010. It has been estimated that following the 2013 ACC/AHA cholesterol guidelines would more than double this number and lead to 87% of men over 60 being prescribed statins. (The chair and panel members of this CPG were found to have industry financial ties to the manufacturers of statins, Pencina et al. 2014). While these industry relationships are sometimes dismissed by leaders within medicine (Rosenbaum 2015), there is evidence that funding influences decision making (Krimsky 2010, 2013; Ornstein, Jones, and Tigas 2016; Shaneyfelt and Centor 2009).

A 2012 study of guideline development groups (Norris et al. 2012) reported a decrease in the percentage of panelists with FCOI in recent studies when compared with percentages found in older studies. Our finding that less than 20% of total panelists had FCOI is perhaps a sign of heightened awareness of the problem of undue industry influence. This finding challenges the oft-cited argument that it is not possible to find expert panel members free of commercial ties. Also congruent with recent research (Norris et al. 2012), we found that although the proportion of panel members with FCOI may be decreasing, the majority of CPGs were developed by panels with one or more members with industry financial ties. Indeed, some guidelines had panels where all or a majority of members had FCOI, and many of the chairs had industry financial ties.

The relationship between FCOI of panel members and guideline recommendations is complex, and it is not known when or under what conditions these conflicts will have a biasing effect. However, because of the far-reaching

influence of CPGs, and because of concerns about credibility and trustworthiness, AHRQ, NICE, and G-I-N have issued stricter standards regarding the prohibition, management, and disclosure of industry financial ties (see also, Guyatt et al. 2012). When there are FCOI on the part of panel members, it has been suggested that end users of guidelines should take commercial relationships into account when evaluating the trustworthiness of a guideline (IOM 2011; Lenzer 2013; Lenzer and Brownlee 2015). Attention to the presence of conflicts of interest among guideline developers may foster a more critical examination of the quality of the guideline. In the present study, both the omission of COI policies in the guidelines and the presence of commercial ties among a majority of guideline development groups and chairs stand in contrast to the recent standards developed by IOM and G-I-N and have the potential to compromise the quality and trustworthiness of those guidelines.

### **Limitations**

The included sample was limited to those available in English (including non-English CPGs whose organization provided an English translation) and accessible via the search strategy. Also, this study only included a review of guidelines for depression. Thus, the present study's findings may not be generalizable to other disease categories. However, a 2013 study of 45 CPGs produced by 14 different specialty societies found that industry financial ties were common (Bindslev et al. 2013). It should also be noted that there are still challenges to identifying FCOI, particularly the lack of public databases for non-US authors. Also, in the U.S., pharmaceutical companies are required to report all payments to physicians to Open Payments, a searchable government database of financial relationships (Centers for Medicare & Medicaid Services 2011). However, there may be some attempts to prevent the discovery of these payments; in one case, a pharmaceutical company misspelled the name of their own product 953 times in the database, which represented almost one-third of all reports for that product (Ornstein, Tigas, and Jones 2015). For those guidelines that did not have financial disclosures of panel members, our methodology for determining the FCOIs might have omitted some. Therefore, for those cases, we can only be confident that our findings are conservative. In addition, disclosures of small payments (<US\$100) for conflicts such as meals and travel were not included in this analysis. Finally, the present study focused exclusively on financial conflicts of interest and it is recognized that intellectual COIs (e.g., career advancement), adherence to a particular theoretical model, or guild interests may also be sources of bias (Godlee 2015). We share the belief that FCOI, unlike other sources of bias, are almost always unidirectional by being favorable toward commercial interests (Shaneyfelt and Centor 2009).

## Conclusions

In this cross-sectional study of guidelines for the treatment of depression, the level of specificity of policies and the extent of financial conflicts of interest of guideline development group members varied widely. Our findings suggest that disclosure of FCOI in these guidelines has not kept pace with the current standards for transparency of expert panels and medical journals. Although there may be a recent trend of increased transparency and independence from industry, producers of depression guidelines should take more aggressive steps to try to appoint panel members free of industry ties and prohibit participation on drug companies' speakers bureaus. In light of the public health burden of depression worldwide, and given the fact that the "funding effect" cannot be explained by standard risk of bias assessments (Lundh et al. 2012; Wang et al. 2010), it is critically important that end users of guidelines can be confident that recommendations are not influenced by commercial interests. The fact that only a minority of panel members had industry financial ties shows that it is possible to find independent experts. Indeed, "a guideline development panel that is free from conflicts of interest provides the best safeguard against bias" (Ransohoff, Pignone, and Sox 2013).

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## Appendix. Search strategies

PubMed:

((((((((((((((((Diet Therapy) OR Drug Therapy) OR Psychotherapy) OR Transcranial Magnetic Stimulation) OR (Acupuncture or acupuncture therapy)) OR Hypericum) OR Electroconvulsive Therapy) OR omega 3 fatty acids) OR Dietary Supplements) OR Phototherapy) OR (Exercise Therapy or Exercise)) OR Antidepressive Agents) OR Anticonvulsants) OR S-Adenosylmethionine) OR Complementary Therapies)) AND ((depressive disorder) OR depression) AND ((Consensus Development Conference[ptyp] OR Consensus Development Conference, NIH[ptyp] OR Guideline[ptyp] OR Practice Guideline[ptyp]) AND (“2009/01/01”[PDat]: “2014/12/31”[PDat]))

Medline via Ovid (including in-process and other non-indexed entries):

- 1 exp Depressive Disorder/or exp Depression/(170135)
- 2 exp Diet Therapy/(45463)
- 3 exp Drug Therapy/(1143297)
- 4 exp Psychotherapy/(166957)

5 exp Transcranial Magnetic Stimulation/(8002)  
6 exp Acupuncture Therapy/or exp Acupuncture/(19834)  
7 exp Hypericum/(1910)  
8 exp Electroconvulsive Therapy/(11902)  
9 exp Fatty Acids, Omega-3/(18939)  
10 exp Dietary Supplements/(51055)  
11 exp Phototherapy/(31271)  
12 exp Exercise Therapy/or exp Exercise/(163090)  
13 exp Antidepressive Agents/(128492) Page 2  
14 exp Anticonvulsants/(125867)  
15 exp S-Adenosylmethionine/(4901)  
16 exp Complementary Therapies/(191934)  
17 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 (1944593)  
18 1 and 17 (56486)  
19 exp Depressive Disorder/dh, dt, su, th [Diet Therapy, Drug Therapy, Surgery, Therapy]  
(36925)  
20 exp Depression/dh, dt, su, th [Diet Therapy, Drug Therapy, Surgery, Therapy] (22290)  
21 19 or 20 (57831)  
23 limit 22 to (consensus development conference or consensus development conference,  
nih or guideline or practice guideline) (204)  
24 limit 23 to yr = "2014 -Current" (12)  
25 from 24 keep 8-11 (4)  
26 24 not 25 (8)  
Trip database:  
"depression guideline," limiting to guidelines from any country  
National Guideline Clearinghouse:  
Depressive disorder, major