example, are not represented in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) criteria.[3] In evaluating the desirability of screening for depression in primary care, it is tempting, but in our view a mistake, to reify the *DSM* criteria. This line of reasoning risks losing sight of a deeper reality: the criteria for major depression are not the thing itself, but rather an imperfect index of an underlying condition.[3] A better means of assessing the desirability of depression screening is to focus on evaluating the practical clinical consequences of screening on patients who are screened.

Dr Braillon raises concerns over antidepressant use during pregnancy and calls for more research in this area. We agree that antidepressant use is common among pregnant women in the United States. Approximately 1 in 12 women within the Medicaid program, for example, receives an antidepressant at some point during her pregnancy.[4] We also agree that the risks of fetal exposure to antidepressants deserve more intensive study. The availability of large databases with information on maternal exposures linked to childhood outcomes provides opportunities to continue pursuit of this line of research.

Dr Braillon further wonders why cognitive behavioral therapy is not more widely used among women of child bearing age. We agree that evidence from randomized clinical trials[5] shows benefit for psychotherapeutic treatment of depression. Yet within the United States, increasing access to psychotherapy for depression faces several formidable obstacles. Thus, the proportion of depressed adults in the United States receiving psychotherapy remains stubbornly low, due to factors related to the economics of mental health care, low third-party reimbursement for psychotherapy, demands on patient and clinician time, the ease of prescribing antidepressants, and the geographic maldistribution of mental health professionals. We must build a larger and more broadly distributed workforce trained to use evidence-based psychotherapeutic approaches for the treatment of depression.[6]

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Disclaimer: The views and opinions expressed in this report are those of the authors and should not be construed to represent the views of any of the sponsoring organizations, agencies, or the US government.

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Incorrect Impressions Concerning Industry-Sponsored Research

To the Editor The Invited Commentary by Dr Nestle[1] in a recent issue of *JAMA Internal Medicine* leaves the impression that all industry-sponsored research is, by its nature, tainted. Among industry research triumphs were milk pasteurization (1890s), iodization of salt (1924), niacin addition to bread (1938), fluoride supplementation of toothpaste (1956), and my own industry team's original addition of fiber to bread and other products (1975),[2] as well as supplementation of foods with folic acid (1977).[3] There are many more. These products were developed, sold at lower profits, and introduced with little commotion, simply because these advances were the right things to do. These were actions of a conscientious private sector to their consumers as individuals, not as the statistical idiom, "the public." The lasting presence of these products on our supermarket shelves are testament to their value.

Understandably, large public companies suffer from a divided commitment to both consumers and to stockholders. Nevertheless, all research, public or private, that deliberately misleads can never be condoned. Aside from financial implications, however, our perception of conflict of interest must include elements of long-established intellectual attachment to safeguard an impartial presentation of evidence.

Free enterprise and the relationship between supplier and consumer has resulted in industry research providing many major health achievements. It may be useful to moderate stereotyping and recognize this fact.

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1. Nestle M. Food industry funding of nutrition research: the relevance of history for current debates. *JAMA Intern Med*. 2016;176(11):1685-1686. doi:10.1001/jamainternmed.2016.5400

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In Reply Mr Satin raises several points in response to my recent Invited Commentary[1] about how food companies fund research for marketing purposes: (1) I give the impression that all industry-funded research is inherently tainted; (2) I ignore the industry's triumph in fortifying foods with nutrients; (3) I fail to mention intellectual conflicts of interest; and (4) I should consider such issues before stereotyping.

First, my commentary was about research sponsored by food companies specifically to demonstrate the health benefits or lack of harm of a product, or to cast doubt on evidence to the contrary. It referred to a particularly egregious example—the sugar industry's attempt to manipulate research results.[2] Although some industry-funded research does produce results contrary to the sponsor's interests, such instances are rare.[3] Most ends up useful in some way to the sponsors' commercial objectives; it is marketing research, not basic science.

The point by Mr Satin about nutrient fortification has merit, but most of the basic research on nutrients used in fortification was conducted by independent scientists. Mr Satin's own Salt Institute credits independent scientists for promoting iodization and convincing the industry to cooperate with public health authorities to iodize salt.[4] Pasteurization kills pathogens; iodide and fluoride address geographical deficiencies; and niacin, folic acid, and fiber replace amounts removed from foods by processing in the first place. Once public health authorities recognized the need, they demanded milk pasteurization or the addition of nutrients to flour. When dental researchers discovered that fluoride prevents cavities, Procter & Gamble recognized its marketing potential and funded research on fluoridated toothpaste.[5]

All scientists have intellectual biases—that is how science gets done and why science works best when researchers with different views of science repeat each other's experiments. But the goals of scientists pursuing intellectual hypotheses differ markedly from those of companies seeking to sell food products.

Questioning food industry funding raises sensitive issues, not least because its influence on researchers occurs unconsciously, is usually unintentional, and is difficult for recipients to recognize.[6] Food companies are not public health agencies and should not be expected to be; their first priority is to provide profits to owners and shareholders. Funding research helps with that effort. My purpose in writing the Invited Commentary was to bring the contradictions of food industry research funding to the attention of readers.

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1. Nestle M. Food industry funding of nutrition research: the relevance of history for current debates. *JAMA Intern Med*. 2016;176(11):1685-1686.

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CORRECTION

Omitted Authorship Contribution: In the Research Letter titled "Evaluation of Potencies of Immune Globulin Products Against Hepatitis A,"[1] published online January 9, 2017, there was an omission in the authorship contributions. The following statement should have been included: "Ms Tejada-Strop and Dr Costafreda served as co–first authors, each with equal contribution to the manuscript." This article was corrected online.

1. Tejada-Strop A, Costafreda MI, Dimitrova Z, Kaplan GG, Teo C-G. Evaluation of potencies of immune globulin products against hepatitis A [published online January 9, 2017]. *JAMA Intern Med*. 10.1001/jamainternmed.2016.9057.

Additional Funding Source Added: In the article titled "Association of Patient-Physician Language Concordance and Glycemic Control for Limited–English Proficiency Latinos With Type 2 Diabetes,"[1] 2 additional grants from the National Institute of Diabetes, Digestive and Kidney Diseases—grants R01 DK065664 and K24 DK109114—were added. This article has been corrected online.

1. Parker MM, Fernandez A, Moffet HH, Grant RW, Torreblanca A, Karter AJ. Association of patient-physician language concordance and glycemic control for limited–English proficiency Latinos with type 2 diabetes [published online January 23, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2016.8648

Reporting Error in Methods Section: In the Research Letter by Moore and Mattison titled "Adult Utilization of Psychiatric Drugs and Difference by Sex, Age, and Race,"[1] there was a reporting error in the number of prescription records and patients in the Methods section. The number of prescription records was 327 557 (not 357 432), and the sample size 36 940 individuals (not 37 421). This article has been corrected online.

1. Moore TJ, Mattison DR. Adult utilization of psychiatric drugs and difference by sex, age, and race [published online December 12, 2017]. *JAMA Intern Med*. doi:10.1001/jamainternmed.2016.7507