



editorial

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Dancing with the Devil? A personal view of psychiatry's relationships with the pharmaceutical industry

I had just spoken to a meeting of one of our users' and carers' organisations. Mingling at coffee time, I lapped up congratulations on how approachable the College had become, when I was brought up short by a long-term patient with a scowl on his face. 'The trouble with you psychiatrists', he said, 'is that you're all pill-pushers. You're all in the pocket of the drug companies'.

As a child psychiatrist by trade, and as a President who has fought hard to tighten the College guidelines on sponsorship, I bridled at such stereotypes. But unfair though they may seem, the charges are persistent and deserve to be tackled head-on.

Reliance on medication

First, are we really 'pill-pushers' – do we rely on medication at the expense of other therapies? Well, let's get one thing said straightaway: drugs *do* help. Few will now remember how the old phenothiazines allowed staff and patients in the late 1950s to tear down the walls that separated mental illness from the rest of the world, walls that reinforced the stigma of 'them' and 'us'. The public who were appalled at what happened to Frank Bruno should appreciate that it was modern pharmacology that – by his own account – seemed to have returned him so effectively from intensive care to community. Frank's experience is repeated in ward and clinic every day, through one drug or another. Whatever their ultimate aim, the pharmaceutical companies have poured billions of pounds into alleviating patient distress.

It would be comforting to think that attitudes to medication have shifted since the 1950s, from patient 'compliance' to 'concordance' – an agreement reached between patient and doctor, as equals within the therapeutic relationship, based on informed choice between all types of treatments. The reality, of course, is very different (Shooter, 2003). Patient power is only as good as information given, and that information is often poor. Not many patients will want complicated biochemical explanations, but where theories of drug action have changed so frequently, treatment is bound to seem empirical. Patients are entitled to ask their doctor why he or she is so keen on something whose mechanism is so

little understood and whose side-effects can be so disabling, despite every effort to uncouple the therapeutic dosage from that at which side-effects occur (Tandon & Jibson, 2003).

Trust in the profession is further eroded when the suspicion grows that potentially catastrophic side-effects are being covered up. You would think that we would have learnt from the benzodiazepine story, when 16 million prescriptions were still being written every year, two decades after the first warnings had been sounded: but it seems we have not. The story is being retold with the selective serotonin reuptake inhibitors (SSRIs), through press headlines and the courts, and the price of medical protectionism will be just as high (Healy & Whitaker, 2003). If patients feel that they have been misled or kept in ignorance 'for their own benefit', how will they ever trust their doctor again?

All this is compounded when patients feel that medication is being 'over-sold', both in absolute terms and in comparison to other forms of help. Perhaps we should listen more closely to the narrative evidence of what patients feel like on their medication, rather than the randomised controlled trial that tells us what patients ought to feel because the science says so (Rose 2003). And when we do let in this element of subjectivity, it is the talking therapies that patients seem to value most, in combination with medication or in their own right. The problem is that medication is readily available (even in times of 'postcode' prescription) but the psychotherapies are not. Cognitive-behavioural therapy, of proven efficacy in an ever-widening range of illnesses, is difficult to implement in busy clinical settings. It is patchily available and therapists are poorly trained (Department of Health, 2001). Psychotherapy services are often seen as 'soft targets' by cash-strapped trust executives struggling to make ends meet. There is still too little emphasis on vocational rehabilitation – jobs and housing – so vital to the well-being of patients with severe illness (Boardman, 2003). And if all this is true of the patient population in general, it is even more so in the Black and minority ethnic communities where young African-Caribbean men are more likely to receive high doses of medication and have little access to any other therapy (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003).



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The demand for quick results

We should not imagine that this is a one-way equation, however. General practitioners, under pressure of time and numbers, will say that the public's demand for a diagnosis and quick-fit medical cure is just as great in mental disorder as it is in physical illness. Psychiatrists under equal pressure, and uncertain of their role in multidisciplinary teams, are apt to retreat into what they see as unique to them – the prescription of medication; but they are right to worry about being dragged into the medicalisation of ordinary social unhappiness. Political imperatives to meet targets based on throughput, easily identifiable outcome measures and the reduction of risk are bound to favour short-term compliance with medication over more subtle, long-term shifts in psychological outlook (Adelman *et al*, 2003), and Black and minority ethnic communities again will feel that this discriminates against them most (National Institute for Mental Health in England, 2003).

So the charge of pill-pushing, I would suggest, is not a fair one. Most psychiatrists, like their patients, would prefer to engage in face-to-face, in-depth relationships, in holistic packages of help as laid down in national guidelines (National Institute for Clinical Excellence, 2002), emphasising recovery and mental health rather than illness (Vaillant, 2003). If they are prevented from doing so, it is as much the fault of factors beyond their control as any medically dominated attitudes of their own. But what of the second charge – that psychiatry has fallen into the hands of the drug companies. Is that quite so easy to refute?

Influence of the drug industry

Of the 731 physicians directly employed by the pharmaceutical industry in the UK, 25 are psychiatrists; they tend to be regarded with a mixture of curiosity and suspicion (Aitken *et al*, 2003). But there are other ways in which the services of psychiatrists can be 'used'. Personal enticements – the mugs, pens and desk-top toys – are usually accepted unwittingly or without a second thought as the psychiatrist tours the trade stands; yet it all helps to advertise the company's products. Walking into some consultants' rooms is like entering a shrine to one firm or another, and one has to ask what message that conveys to patients about the objectivity of the advice they are about to be offered. Other enticements – free holidays, free trips to conferences and first-class travel – are more blatant both in hand-out and receipt. I cannot be the only person to be sickened by the sight of parties of psychiatrists standing at the airport desk with so many perks about them that they might as well have the name of the company tattooed across their foreheads. It simply will not do.

And what of research? We have long known about the methodological flaws that bedevil even the randomised controlled trial, or the overemphasis of results that when carefully analysed boil down to little more than the odd insignificant point on a rating score above

psychotherapy or placebo. More worrying is the deliberate bias that enters the selection of research design to achieve particular aims, or into the publication of their results. Findings in studies of both antidepressants (Baker *et al*, 2003) and antipsychotics (Moncrieff, 2003) have been shown to be clearly linked to the level of drug company sponsorship. The psychiatrist reading through them in search of advice may already be floundering in zones of clinical uncertainty (Anderson, 2003). This may turn to despair when 90% of JAMA authors are shown to have drug company links (Healy & Thase, 2003) and even Cochrane Reviews have evidence of ghost authorship among them (Mowatt *et al*, 2002).

Suggestions have been made to limit such conflict of interest or at least to expose it. Authors might be asked to describe their exact contribution to the research and its write-up; all raw data might be made accessible from industry-sponsored trials; any direct interference from the sponsor might be outlawed and the role of 'assistants' carefully delineated (Healy & Cattell, 2003). But the level of mistrust in press and public is now so deep that the jobbing clinician will have difficulty in persuading the patient that the advice being given about medication is open and honest.

Is there the same mistrust of the College too? There are clear and tightened guidelines on the relationship of individual psychiatrists with the pharmaceutical industry, on the sponsorship of local educational events and on College activities as a whole. They are posted on the College website and open to criticisms of whether they are yet tight enough. The level of industrial sponsorship of College activities has been steadily and deliberately reduced; it now forms less than 5% of the College's total income. Where a company sponsors a public education leaflet they do so with no strings attached and with the most discreet acknowledgement. Trade stands at the College Annual Meeting are not nearly as prominent as at some conferences overseas, and symposia sponsored by drug companies are kept separate from the main programme and clearly advertised as such. What little general sponsorship is still obtained for the Annual Meeting is used for entirely worthy causes – the lowering of attendance fees for trainees and support for psychiatrists from third-world countries, or users and carers, who would otherwise not be able to attend at all. In the interests of transparency, registers are kept of commercial links and public declarations demanded of any presenter about possible conflicts of interest.

In other words, the answer to the second charge, I think, is that psychiatry as a whole is not for sale, but certain psychiatrists regrettably are. The College has taken great pains to put its own house in order on this as on many other controversial subjects. To remain vigilant, we need to listen carefully to our own members, to the user and carer organisations and to patients like the one who accosted me at the meeting I started with. Yes, I did manage to persuade him that his charges were in part unfounded; but he persuaded me that a lot more needs to be done.



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