Special article

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Psychiatry and human rights: putting the good of the patient first

Juan José López Ibor Award Acceptance Speech*

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I am deeply honored to receive the 2008 Juan José López Ibor Award from the World Psychiatric Association. The López Ibor Foundation created this Award to «recognize... scientific contributions leading to better understanding of psychiatric diseases while being actively engaged in activities enhancing the human dignity of patients and their families». I would like to believe that that those characteristics describe my career. Accordingly, the central theme of this address is that the essence of physicianhood is putting the good of the patient first.

Just how far medicine has deviated from this principle is evident from a single distressing fact:

«Patients with serious mental illness die 25 years earlier than the general population[1].»

They die from psychiatric, medical, and social neglect. If anything, the problem is worsening[2]. Neglect leads to unrecognized and untreated cardiovascular and respiratory diseases, to diabetes and its complications, to infectious diseases including HIV, to substance abuse, and to other diseases that afflict the ill-housed, the ill-fed, and the abandoned[3-5]. Care of the severely mentally ill should have been the focus of our professional careers; advocacy for their rights should have been our role as citizens. Instead, we have engaged in solipsistic debates about brain versus mind —about psychotherapy versus drugs— about genes versus environment. Preoccupied with our theories and ourselves, we abandoned the sickest patients.

The critique of contemporary psychiatry I will present is that of the United States because that is the country I know best. The story differs in important ways from the discourse in other countries; psychoanalysis, for example, never achieved hegemony in the United Kingdom[6]; yet, in August 2008, British colleagues found it necessary to issue a joint call for action against what they consider to be «the downgrading of medical aspects» of care. They criticize mental health services «better suited to offer non-specific psychosocial support rather than thorough, broad-based diagnostic assessment leading to specific treatments»[7]. As I turn to the contemporary scene, convergence, rather than divergence, between psychiatry in the US and the other countries represented at this World Congress will become apparent.

In the first half of the 20th century, American psychiatry was virtually «brainless». Do I exaggerate? The first two editions of the American Psychiatric Association (APA), *Diagnostic and Statical Manual of Mental Disorders*[8,9] listed schizophrenia and manic-depressive disorders under the rubric: «psychogenic psychoses.» In the second half of the 20th century, psychiatry became virtually «mindless». Do I exaggerate? The most recent tally of the number of psychiatrists who provide psychotherapy during patient care declined from about half to less than a third just within the past 9 years[10]. One-sided psychiatry strips patients of their human dignity by denying them comprehensive care[11]. Now that the 21st century has arrived, an even greater threat lies ahead: the risk of becoming captive to pharmaceutical companies.

«BRAINLESS PSYCHIATRY»

When I began my training in the 1950s, psychoanalysis was the dominant ideology in academic psychiatry. How had that come about? Descriptive psychiatrists were held in little esteem; diagnosis was unreliable at best and made little difference for treatment. The nascent brain sciences were largely irrelevant to clinical practice. The psychiatric pharmacopeia was limited to hypnotics and sedatives. What we were taught was based on opinion, not evidence. Given the novelty and literary flavor of psy-

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choanalytic «explanations», the readiness with which patients accepted them and the fact that the majority of anxious and depressed outpatients improved with psychotherapy, all but the most skeptical became believers. It was what we thought we knew that obscured our vision. In Berthold Brecht's *Life of Galileo*, the astronomer cautions his student:

«One of the chief causes of poverty in science is imaginary wealth. The purpose of science is not to open the door to an infinitude of wisdom, but to set some limits on the infinitude of error[12].»

Psychiatry was by no means unique among medical specialties in its «imaginary wealth»; most therapeutic recommendations in medicine and surgery rested upon faith, not facts; randomized controlled trials (RCTs) did not enter medical research until the late 1940s[13-15].

Research on psychotherapy was scant. What little there was suggested better outcomes among treated patients than among waiting list «controls», but there were many contradictions in the «evidence». Despite differences in the techniques therapists employed, psychotherapy outcomes were remarkably similar. Even more troubling was the fact that experienced therapists seemed to produce no better results than the novices they professed to teach! Jerome Frank (1961)[16] concluded that non-specific processes common to all psychotherapies accounted for the findings: a confiding relationship with a therapist; provisional «explanations» for the patient's distress; encouragement to try new solutions to old problems; and the restoration of morale. His findings were unwelcome; his work was ignored. Young trainees continued to find long-term psychodynamic therapy intellectually fascinating, in utter disregard of the fact that the yearly cost of a psychoanalysis was more than 80% of the median income of an American worker[17]. The most seriously ill psychiatric patients were abandoned to an understaffed and underfinanced public sector.

TRYING TO COME TO GRIPS WITH EVIDENCE

Amidst this upside-down world of practice, the APA convened its second Conference on Psychiatric Education[18]. Participants agreed that the curriculum had to include much more psychopharmacology and a better understanding of anthropology, psychology, and sociology, perhaps even epidemiology. Professional staffing needs precluded lengthening the training period. At the final plenary session, I rose to call attention to an obvious oversight: the existing curriculum had to be shortened to make time for new topics and new exercises. No one having proposed elisions, I suggested the need for a sharp reduction in the hours devoted to psychoanalysis, not only because time was needed, but also because psychoanalysis stifled scientific curiosity by offering unchallengeable answers and shifted career pathways away from research and teaching to private practice. At a very great cost to their own development, trainees acquired a «therapeutic» technique that assured an intriguing day's work and a comfortable lifestyle, but that was altogether inappropriate to public need[19].

Never before (nor ever since) have I had such an electrifying effect on an audience. Before my remarks were finished, the leaders of American psychiatry lined up behind the floor microphones to denounce my contentions. Psychoanalysis, they insisted, was «the basic science of psychiatry.» They knew analysis was effective; after all, they themselves had completed one and I (obviously) had not. They claimed that their trainees were working in the public sector and were doing research (without specifying where and what). Not one participant supported my critique. When the conference volume was published, my «dissenting view» was relegated to a five-sentence footnote[18]. Yet, a decade later, when the next APA Conference on Education was convened, «de-emphasis on a psychoanalytic orientation» was listed as the most important shift in training that had occurred[20].

HOW DID «MINDLESSNESS» ARISE?

Do I credit myself for that transformation? Not for a moment! It was not that I hadn't tried. I had questioned Freudian dogma at professional meetings from the beginning of my career[21]. I introduced randomized clinical trials into child psychiatry and received the first award for a child RCT from the Psychopharmacology Service Branch of the National Institute of Mental Health (NIMH)[22]. Our research group demonstrated that two of the new «tranquilizing» drugs (meprobamate and prochlorperazine) were significantly worse than placebo for treating children with behavior disorders because of their toxicity[23]. We went on to show that dextroamphetamine[24] and methylphenidate[25] were effective for children with hyperkinetic behavior disorders, a condition few were treated for then but now is «epidemic»[26]. I editorialized about the signal importance of evaluating the outcomes of psychiatric interventions; good intentions do not assure good results. Without systematic research on the effectiveness of new programs[27]:

«We will face a succession of psychiatric "revolutions", each of which will be based on the re-discovery of moral

treatment but none of which will have advanced beyond the starting point of its predecessors.»

My critique was unavailing. Psychotherapy was driven out of the medical care marketplace by two forces: first, the effectiveness of psychotropic drugs, and second, cost controls put in place by investor-owned health maintenance organizations (HMOs) and health insurance companies.

The discovery of psychoactive drugs made an enormous difference to clinical practice. We hailed the advent of drugs as a second psychiatric revolution, equal in magnitude to the first that occurred when Pinel in France, Tuke in England, and Chiarugi in Italy introduced moral treatment of the mentally ill[28]. So bedazzled were most psychiatrists that they gave drugs full credit for emptying out overcrowded US state hospitals. In fact, the onset of deinstitutionalization preceded the introduction of drugs in communities where «open hospital» and «community psychiatry» policies[29] had been introduced in the aftermath of WWII[30]: drugs were decisive only in hospitals where patients had been warehoused[31]. «Deinstitutionalization» was driven by economic forces (shifts from the state to the federal budget), by «transinstitutionalization» of elderly patients (from state hospitals to nursing homes), and by patients discharged to hotels for transients without aftercare[32]. Psychiatric practice changed dramatically from talk therapy to drug therapy. Sales of prescription drugs in medicine rose from $664 million in 1970 to $235 billion by 2006, an almost 40-fold increase[33]. Pharmaceutical firms became major players in the medical-industrial complex[34]. Their investments in lobbying Congress have gone way up[35]. This money is nonpartisan; it goes to any politician willing to do their bidding.

THE ROLE OF PSYCHOPHARMACOLOGY

Because the new drugs seemed to be diagnosis specific, the low reliability of existing psychiatric diagnoses became a concern[36]. Studies of the puzzling discrepancy between U.S. and U.K. data on the prevalence of schizophrenia and depression revealed that differences in diagnostic practice rather than differences in disease prevalence accounted for the findings[37]. Once criteria were standardized, differences diminished. Such studies provided impetus for the development of an operationalized APA *Diagnostic and Statistical Manual and Mental Diseases* DSM-III[38]. As costs for psychiatric care increased, so did the market for the third and subsequent editions of DSM[39-40]; sales rose from 300,000 copies in 1973 to 1.5 million copies, and income for APA rose from $500,000 to $93 million[41]. DSM became indispensible in coding mental health services and legitimatizing reimbursement to institutions and practitioners. DSM matters to Big Pharma. Because diagnosis legitimates treatment, drug companies wants inclusive diagnostic criteria. False positives are profitable; false negatives are money lost! Did pharmaceutical companies play a role in the construction of DSM-IV? Cosgrove and colleagues[42] suggest that is so. A majority (56%) of the 170 panel members responsible for revising DSM-IV had ties with the industry, including **all** members of the panels for «Mood Disorder» and for «Schizophrenia and Other Psychotic Disorders». Receipt of funds from drug companies does not establish per se that panelists with industry ties voted their pocketbooks; however, it does leave the possibility open.

THE FLOWERING OF NEUROSCIENCE

Psychopharmacology wrought other changes. It helped to bring the brain back into psychiatry, and welcome it was! Neuroscience flourished. When I joined the Society of Neuroscience at its founding in 1969, I became member 91; current membership exceeds 38,000! Those numbers stand proxy for an exponential growth in neuroscience research. Our understanding of the central nervous system has been expanded enormously, but at a nontrivial cost. The very elegance of neuroscience has reinforced the «neurologizing tautology»; that is, the belief that «only those facts are scientific which can be reduced to terms of nerve cells»[43]. What pharmacologists demean by dismissing it as the «placebo effect» —better termed «the physician effect»— endows inert substances with the power to relieve cancer pain, to reverse psychotic symptoms, and even to lower recurrence rates after coronary occlusion[44].

I refer to the findings from a randomized double-blind clinical trial of clofibrate, a drug administered to reduce mortality from coronary heart disease after a prior heart attack[45]. Among the 1,100 men in the clofibrate arm of the study, those who took their pills more than 80% of the time had a significantly lower five-year mortality (15%) than those who took them less often (24.6%). At first glance, the data suggest that clofibrate is a highly effective drug when taken as directed. However, among the 2,800 men in the placebo arm of the study, those who took their placebo 80% of the time also experienced a significantly lower five-year mortality (15.1%) than did the poor compliers (28.3%). The drug, as such, had no effect on mortality, but compliance did at a P value with 16

decimal places! The researchers lamented that «these findings... show the serious difficulty... of evaluating efficacy in sub-groups determined by patient responses...». How extraordinarily blinkered that response was! Had the reduction in mortality been associated with the drug, it would have caused the company's stock to soar! Why not take the behavioral correlates of compliance seriously? Did it reflect changes in smoking, in alcohol consumption, in diet, in exercise, in other health-related behaviors, or was compliance a proxy for genetic differences? We will never know: compliance was the only behavior measured.

The most powerful of drugs is useless if it is not taken. An important determinant of whether it is taken and taken at intervals consonant with its pharmacokinetics is the patient's relationship with the doctor[46]. It is likely that the physician effect enhances (or reduces) the impact of a pharmacologically-active drug. Patients need to be listened to and heard, to be given a chance to tell their story, and to have the opportunity to review their therapeutic options. To delete the «psyche» from psychopharmacotherapy is to short-change the patient just as much as to delete the «pharma».

THE PROFIT MOTIVE ENTERS THE DELIVERY OF CARE

Health care had been a cottage industry, inefficient, poorly managed, and loosely organized. It offered a prime opportunity for profitable investments. Investors bought and created health insurance companies, HMOs, hospital chains, medical device companies, group practices, and technology-based diagnostic centers. Medicine was monetarized[47]. Psychiatric hospitals became an attractive commodity. Why? As Solomon Brothers, a Wall Street brokerage firm, explained to its clients in a 1984 advisory:

«The psychiatric hospital is an attractive subsegment of the hospital industry. Inpatient care... occurs with predictable and increasing incidence and is *complex enough to render cost control efforts difficult* (italics added)...»

The firm outlined the barriers to cost control:

«Imprecision in diagnosis...» «lack of standardized treatments» and «inability to measure the extent of recovery».

The very features of psychiatric care that troubled (or should have troubled) psychiatrists was good news for investors[48]!

As HMOs began to dominate the medical marketplace in the US, John McKinlay and John Arches[49] wrote a prophetic paper on the «proletarianization» of the American physician. As physicians lost control of the «means of production» to corporate managers of the health system, they became like Marx's «wage laborers» (though much better paid, of course!) subject to the control of and the incentives set by the owners of a commodified health system. As HMOs grew in size, organizational centralization became more and more prominent, removing decision making further and further from the sites where physicians care for patients. The physicians who became executives in the new systems and rose in the hierarchy, shifted from behaving like physicians to acting more like managers.

PHARMA'S INFLUENCE ON DOCTORS

Pharmaceutical firms wield their enormous financial resources to shape medical practice. It will not surprise you that industry-sponsored research more often favors the sponsor's drug than independently-sponsored research. Turner et al[50] found that 37 of 38 positive studies of antidepressants were published, whereas, of 36 negative studies, 33 were either not published or published with a spin to make them look positive. Merck systematically underreported mortality from its drug, rofecoxib, which it claimed slows progression in Alzheimer's disease[51]; Merck «ghost-authored» and «guest-authored» clinical papers written by company employees but published under the names of academics[52]. Warner-Lambert[53,54] paid millions of dollars to «opinion leaders» to promote off-label use of gabapentin for the treatment of bipolar disorder in direct violation of Food and Drug Administration (FDA) rules. They were fined, but the fine, lamentably, was but a pittance compared to the increased sales. Psychiatrists have been slow to consider the long-term costs of psychotropic drugs. Data from a longitudinal study will soon be published showing that patients with schizophrenia lose brain tissue at a higher rate than controls and that exposure to psychotropic drugs increases the rate of loss[55]. It is more than time to reassess the cost/benefit ratio.

When the FDA lifted its ban on direct-to-consumer (DTC) advertising in 1985, it made the United States one of only two industrialized nations that permit it (New Zealand being the other). DTC advertising has grown exponentially from $12 million in 1989 to $3.45 billion in 2004[56]. Patients come to doctors with ready-made diagnoses derived from television viewing that generates requests for specific drugs. It is easier for the doctor to go along than to take the time to explain why not! Kafka's *Country Doctor* knew that «to write prescriptions is easy, but to come to an understanding with people is hard»[57].

DTC advertising of bipolar disease treatments has become increasingly common. Drug firms circulate «patient education» booklets with symptom lists and encourage the use of «mood diaries» to make BPD «risk» palpable. Firms subsidize lay groups that lobby for more services. In 2003, the Child and Adolescent Bipolar Foundation convened a meeting to produce «treatment guidelines». The meeting was funded by «educational grants» from Abbott-AstraZeneca, Eli Lilly, Forrest, Janssen, Novartis, and Pfizer[58]. Who is using whom? At psychiatric conventions, pharmaceutical companies pay for continuing medical education (CME) accredited «satellite symposia» at which prominent academics get sizeable fees to lecture about the diagnosis and treatment. One third of the drug company-sponsored symposia at the 2003 APA meeting featured bipolar disorder![59]. Subsidization of medical specialty societies has become ubiquitous. In response to a query from US Senator Grassley, the Medical Director of the APA reported that «pharmaceutical revenue accounted for $14 million or 28% of the 2007 APA budget...»[60].

DIRECT PAYMENTS TO PHYSICIANS

But drug firms don't limit themselves to what is euphemistically called CME. They pay doctors right out and unabashedly. Manufacturers of prosthetic hip and knee joins paid 51 orthopedists more than $1 million *each* to implant their devices[61]. Most US physicians have financial relationships with industry, ranging from accepting meals, samples, and modest honoraria to very large sums for consulting or speaking[62-63]. In Minnesota, the only state that requires public reporting of all marketing payments to doctors, direct payments rose more than six-fold between 2000-2005. During that interval, prescriptions for anti-psychotics to children rose nine-fold. Cause or coincidence? Psychiatrists who received $5,000 or more from makers of «atypical anti-psychotics» wrote three times as many such prescriptions as psychiatrics who received less[64,65]. Cause or coincidence? Industry is evidence-based when it computes profitability, even if doctors are not when they prescribe. Public knowledge of the drug industry's influence on physicians' prescribing practices has lowered compliance when patients suspect that their doctors' recommendations were for the doctor's good, not theirs[66].

MOVES FOR REFORM

Forceful opposition to financial ties between doctors and industry is now being voiced by major figures in medicine, by medical journals, and by medical organizations. Marcia Angell[67], former Editor of the *New England Journal of Medicine*, points out that it is «self-evidently absurd» to look to investor-owned companies for unbiased evaluation of their own products. Susan Fletcher[68], Chair of a Macy Conference on Continuing Education, reports unanimity among conference participants that CME, if it is to be accredited, should not be commercially supported because of the risk that content will be distorted. Murad Khan[69], Professor of Psychiatry at the Aga Khan University in Karachi, notes with alarm the enormous largesse drug companies distribute to psychiatrists in under-resourced countries like Pakistan, to promote drugs that are prohibitively expensive for the vast majority of Pakistani patients. Alfredo Pisacane[70] from the University of Naples and Arnold Relman from Harvard University[71] object to subsidies from industry for CME, which should be the responsibility of the profession alone. *Nature Neuroscience* has editorialized about the credibility crisis in pediatric psychiatry arising from the large sums clinical researchers have received from pharmaceutical companies[72]. The American Association of Medical Colleges represents all accredited US medical schools and major teaching hospitals. The AAMC Council[73] unanimously adopted a Task Force proposal that industry support be channeled through a central office at each medical school rather than be provided to departments individually. Faculty should not participate in industry «speaker bureaus». Schools and hospitals should not give industry representatives access to medical students and house officers on campus. The American Medical Association's (AMA) Council on Ethical and Judicial Affairs (CEJA)[74] put forth an even stronger proposal. It recommended that neither individual physicians nor medical institutions should accept funds from drug companies for medical education. The CEJA proposals were discussed at the AMA Reference Committee; concern about the prospect of losing industry funds dominated the discussion. That Committee referred the report back to CEJA for «further review». I consider it nonetheless a quite remarkable sign of the times that so splendid a statement reached the AMA House at all.

I urge you to join this crusade to return medicine to its fundamental values. In the first book of Plato's *Republic*, Socrates avers that:

«Medicine does not consider the interests of medicine, but the interests of the patient... No physician, insofar as he is a physician, considers his own good in what he practices, but the good of his patient..»

Socrates knew, of course, that physicians needed to be compensated. The art of medicine, he said, is accompa-

nied by «the art of pay», but he added that medicine is not «the art of receiving pay simply because a man takes fees when he is engaged in healing.»

Contrast that ideal with the self-serving goal of investor-owned for-profit medical care. In the words of the Nobel Laureate in Economics, Professor Milton Friedman of the University of Chicago[75]:

«Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than *to make as money for their stockholders as possible.*»

No two goals could be more contrasting: the good of the patient; the good of the stockholder. No choice could be sharper. Some colleagues have become just as comfortable in referring to «covered lives», «customers», and «providers» as my generation was in using the quaint vocabulary of «patients» and «doctors». Words matter; words embody values.

Physicians are adepts at the art of medicine; patients must be able to trust physicians. Providers are adepts at the art of pay; customers had best beware of providers. The provision of medical care is not primarily a legal or fiscal event; it is a moral transaction.

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