

Controversies
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THE SHIPWRECK OF THE SINGULAR

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There has always been a pull in medicine between disorders that arise from or take root within the individual and disorders that arise from without. This pull might be expected to be strongest in psychiatry, which has to straddle a brain-mind divide. Psychiatry was the first medical specialism and has seen the most radical questioning of the medical mission. It is here that the forces acting on both doctors and patients come to their clearest focus.

The Origins of a Dialectic

While humoral theories of Dis-Ease attempted to take into account the interplay between the balance within the person and the balance between the person and their environment (the seasons, the food they ate etc.), historically the pull between seeing health problems in terms of a disorder arising within the individual or as stemming from an environmental influence has been potent. This has led to a dialectic with the field pulled between sin or physical imbalances within or the amorphous harms stemming from malign influences or physical miasmas from without.

This dialectic has been aggravated with the emergence of science and its application to healing. Starting with the work of Vesalius, the development of pathological anatomy through to the eighteenth century tied some disorders to locations within, whether these were the source or the consequence of disorder. The location of specific disturbances within, linked to the discovery of anaesthesia, grounded the healing that is modern surgery.

On the other side, a growing urbanization and industrialization in the early nineteenth century led to an association between concentrations of people and epidemics and concern about sources of disorder from an increasingly manmade environment,

especially as contagious disorders, even if they took root in slum quarters, posed risks to the wealthy.

A Sanitarian or hygienic movement emerged that attended to what could be done to reduce the risks of exposure to filth or other harmful influences or to strengthen individual constitutions to make them better able to resist ill health. Strengthening constitutions might be achieved by looking to the quality of food and this led to campaigns against the adulteration of food and in favour of temperance. This movement developed into what is mostly called Public Health Medicine but occasionally, when poverty is substituted for filth, Social Medicine.

The laboratory became the location where biomedical developments happened. Generating and mapping numbers, epidemiology, was the main tool of public health.

Where traditional medicine aimed at curing patients, public health aimed at preventing disease, something its proponents argued was more cost-effective.

Most doctors locate themselves somewhere between the Surgical and Public Health poles in medicine but most thinking defaults to one or other perspective.

Efforts to tackle the environment have been linked to a social activism, symbolized often by citing Rudolf Virchow's efforts to manage the typhus epidemic in Silesia in 1847, his aphorism that Medicine is a Social Science and his link to the European Revolutions of 1848, and their link to the writing of the Communist Manifesto.

From Virchow, through to John Snow's removal of the handle on the Broad Street Pump and on to Thomas McKeown's graphs showing the virtual elimination of tuberculosis before the advent of streptomycin, in contrast to the world of religion, this has been a domain in which those who view themselves as on the side of good have had many if not all of the Best Tunes.

The social side of medicine can legitimately claim to be progressive; there is a less legitimate implication here that the other side is not as progressive. The public health mavens have railed against biological reductionism, an idea that everybody seemingly

“gets”. They have more recently championed a biopsychosocial approach to medicine that appears to be the height of reasonableness.

Biomedicine from this perspective has been linked to a biological determinism. In the nineteenth century, this had its clearest expression in psychiatry in the concept of degeneracy, a concept with racist and supremacist overtones that for some found their ultimate expression in the gas chambers of the Final Solution.

The biomedical camp has had corresponding concerns about social medicine, but these have had less traction. Early in the nineteenth century, there was resistance to the adoption of numerical methods, from those who believed that medicine cannot be practised by numbers – that the duty of the doctor is to the patient in front of her rather than to the population.

In the 1880’s, the development of bacteriology in the hands of Louis Pasteur and Robert Koch led to a bitter dispute between the Hygienists championed by Max von Pettenkoffer and Koch. This seemed to be settled in favour of biological reductionism with the success of Emil Behring’s development of diphtheria antitoxin.

The bitterness suggests an underlying fault line. Camps built up on both sides with social scientists on the one side and biologists on the other, few of whom had a background in clinical practice.

Filth wasn’t the problem, Behring asserted. Science progressed by isolating what it was that was pathogenic about Filth. Biology could be a source of liberation. The poor may be always with us, but, where most doctors do not see themselves as agents of social change, if lead poisoning is what leads children growing up in poverty to end up poor themselves by compromising intellectual functioning, maybe bio-medicine can remedy that.

And while we can see genetic determinism on the biomedical side, it is also possible to show that the public health imperative to prevent disorder underpinned the development of a eugenic movement in the early twentieth century, compulsory vaccination programs in the nineteenth and twenty-first centuries, and in the late

twentieth century, in the name of prevention, a massive expansion in the use of medications to treat risk factors such as cholesterol levels rather than limiting their use to the treatment of diseases.

Both Biomedicine and Social Medicine had their earliest academic footholds in Germany. Where Germany had University Departments of Public Health from the 1860's, the Harvard School of Public Health was only established in 1922, and the first Chair in Social Medicine anywhere was established in Oxford in 1943. Harvard's School of Public Health embraced a Department of Social Medicine in 1980.

Outside of Germany, there was a small sprinkling of academic posts in psychiatry in Institutes such as the Institute of Psychiatry in London and Phipps Clinic in Baltimore but few Chairs of Psychiatry, biological or social, anywhere before the 1950's.

Industry

Both biomedical and public health approaches to medicine have been laid the basis for huge industrial complexes. The development of bacteriology clarified some environmental influences and how better to avoid exposure to them. It also underpinned the development of analgesics and antipyretics and later antibiotics and these medicines laid the basis for the growth of the modern pharmaceutical industry.

One of the most potent symbols of the emergence of the pharmaceutical industry was Behring's patenting of diphtheria antitoxin in the late 1890's, a move that scandalized many doctors especially in the United States, who were affronted at the idea of profiting from the cure of diseases. The problem was compounded when Behring was awarded the first Nobel Prize in Medicine in 1901.

The emergence of magic bullets as a way to solve problems pushed the locus of responsibility back on the individual. There are clear political consequences of developments that reduce the pressure to change the environment.

Public health, on the other hand, was from the very start, underpinned by an insurance industry that took shape in the eighteenth century, and the interests of this industry to manage risks laid the basis for epidemiology and an attention to numbers in health.

The hygienists, in turn, advocated strongly for pensions as a public health measure, which furthered the growth of insurance, and ultimately healthcare today is delivered through insurance schemes of one sort or the other.

In the nineteenth century, therefore, the biomedical sciences and public health movement supported the growth of the economy, and both are critical to the modern economy.

But the interplay between science and business within the health domain became more mixed in the twentieth century as it became clear that with the virtual elimination of mortality linked to bacterial infections some of the greatest hazards to health came from pollution linked to new industries such as the lead and tobacco industries. Tackling the health problems that stem from important industries cannot expect to mobilize the same degree of community or political support when that effort risks being bad for the economy and business.

Matters were complicated by the fact that while acute heavy metal poisoning gives rise to straightforward medical disorders, and there are now drug treatments that can help manage this, chronic poisoning compromises functioning rather than produces a clear cut clinical syndrome and determining whether there is an issue needs epidemiological investigations whose results are rarely conclusive. The effects of pollution can be contested in a way that the existence of infections cannot.

In addition, the links industry developed with science in the nineteenth century left it well placed, and financially more able, to mount epidemiological studies in the twentieth century. This awareness of the benefits of research, along with greater resources to sponsor studies, was deployed to great effect, for instance, in the defence of cigarette smoking where industry demonstrated it had learnt to exploit the radical doubt that drives science.

From Asylum Psychiatry to Social Psychiatry

Psychiatry came late to academia, but it had been the first medical discipline to have specialist hospitals and journals. While some have portrayed the emergence of asylums as instruments of social control, the asylum building programme was essentially a manifestation of progressive social activism, built on the same principles that underpinned the efforts of the sanitarians and Virchow – management of diet, encouragement of activity and avoidance of intoxicants.

Long before it became commonplace, Philippe Pinel was employed to give medical input to one of the earliest asylums the Salpetriere. He was the first to apply numerical methods in any kind of medicine. This exercise, in his hands, established the need for diagnosis within psychiatry. A great deal of what is now regarded as the medical apparatus within mental health came from him (Pinel 1809).

Where the hope of recovery had stimulated the opening of asylums, and while General Paralysis of the Insane and pellagra psychosis were later identified as preventable, by the late nineteenth century, the dominant theme in psychiatry was one that saw mental illness as an instance of degeneracy. The failure of asylum care to make much difference to the course of schizophrenia likely coloured such views.

By the start of the twentieth century, there was little that was social about psychiatry. Its professoriate, mainly based in Germany, was largely neuropsychiatrically oriented. Even the work of Sigmund Freud, which later contributed to an opening up of mental health to social issues, in the early twentieth century, located neurotic problems in the development of the individual rather than in exposure to the environment.

Emil Kraepelin now stands as the symbol of asylum psychiatry. After Pinel, in the period from 1891 to 1921, he became the leading champion of diagnosis. His Institute worked on the neurobiological underpinnings of disorders such as Alzheimer's and General Paresis of the Insane (GPI). But he was equally a fierce advocate of temperance and the need to study disorders in different social settings. There was a

continuity back to Virchow here - both social and biological poles of psychiatry remained in tandem at this point.

At this time, a patient powered mental hygiene movement, typified by the publication of Clifford Beers' book in 1908, took shape. The descent of this lineage can be traced through to the antipsychiatry and survivor movements of the 1970s on one side and the recovery movements of the first decade of the twenty-first century on the other.

Where the trend in the late nineteenth century had been to see mental disorder as arising primarily from inherited predispositions, the two World Wars forced a recognition that mental disorders might arise from without. While there had been a rumbling awareness that childhood trauma might lead to problems later in life, it took Global Conflicts to ground a widespread acceptance that the environment could trigger "nervous breakdowns".

The First World War to some extent but the Second World War to a greater extent catalysed the development of academic medicine outside Germany. A raft of academic psychiatry posts were established in universities rather than in asylums. In Europe, a majority of those appointed to these posts designated themselves as social psychiatrists. Psychoanalysts took up equivalent positions in the United States, and social scientists there developed an interest in mental health.

The discipline of social psychiatry came into being symbolized by the inclusion of mental disorders in the 6th Edition of the International Classification of Diseases (ICD) in 1948, and by the creation in 1952 of the first Diagnostic and Statistics Manual (DSM-I) in the United States. These developments were part of a move to develop metrics and to engage in the epidemiological surveys to map disorders and their triggers that were a necessary prelude to attempts to prevent mental illnesses.

In the early 1950's, the prospectus of social psychiatry adhered to the brief of public health medicine outlined by Kraepelin: "A psychiatry, having at its disposal statistics in their widest scope, must provide the foundations of a science of public mental health – a preventive psychological medicine for combating all those mischiefs that we group under the head of mental degeneracy".

Early epidemiological research pointed to a role of migration in causing mental disorders; both migration between countries and urban drift within a country.

A fall in suicide rates during the World Wars was taken to imply that social cohesion was an important factor in suicide. More generally, suicide and parasuicide, and evidence of variations in rates of both across cultures, between sexes and by age, also offered a basis for a traditional public health approach to the primary prevention of disorders.

There was a focus on the pace of social change as a cause of mental illness. This focus had historical antecedents from George Cheyne's linking The English Malady to development through to George Miller Beard and others blaming the pace of social development for an epidemic of neurasthenia in the late nineteenth century.

Efforts at primary prevention took standard social medicine approaches to identifying target populations and carriers. But rather than being confined to the reduction of exposures to alcohol, drug abuse and prostitution as previously, prospective mothers now became a key target population, and people who double bound others or otherwise communicated in distorted ways became key carriers. The emphasis was on social rather than physical vectors of illness.

By 1960, secondary prevention was also firmly on the map in the form of crisis intervention and community mental health programmes to shorten illness episodes.

But far from simply seeing the avoidance of admission as a way to reduce disability, there was a strand of the new thinking that looked to new settings operating on the principles underlying therapeutic communities and psychotherapy rather than on the basis of the "medical model". This new perspective linked to conceptual developments within the social sciences on the construction of identity and labelling theory in the work of Goffman and Scheff.

Finally, the 1950's brought the importance of institutionalization into the frame and this offered an opportunity for tertiary prevention and rehabilitation using standard social techniques to facilitate employment and enhance education.

Meanwhile, epidemiological studies on schizophrenia in the 1960's pointed out that outcomes were worse in the West and that there were marked differences in the likelihood of a diagnosis of schizophrenia between the USA and other countries.

Other studies in the 1970's raised the question as to whether schizophrenia had only appeared in the nineteenth century. The writings of the asylum superintendents and meetings of alienists in the late nineteenth century were dominated by questions as to whether they were seeing a real increase in insanity with some arguing they were and others claiming there was no true increase.

These issues engaged social scientists, such as Andrew Scull, and brought concepts of medicalization and considerations of service utilization into play. The debates around this theme and around Freud's work helped bring the History of Psychiatry into being as a discipline.

But a set of studies initiated by Michael Shepherd on community nervous disorders that began reporting in the mid-1960's gave a pointer to future developments. These studies made clear that psychiatrists only saw a fraction of the psychic morbidity that could be detected in primary care.

Shepherd's work mapped the prevalence of disorders rather than sought to establish social factors contributing to disorders, or attempting to distinguish disorders that arise from without from those that arise within. This work laid the basis for the Epidemiological Catchment Area studies, which began in the USA but were later extended globally. Rather than putting information in the hands of clinician or policy-makers, this body of work, Shepherd later conceded, Sorcerer's Apprentice-like, created markets for pharmaceuticals.

Social psychiatry was a vigorous field in the 1950's and 1960's. Allied to a favourable public perception of psychodynamic therapies and a culture created by the War that social factors were of importance in the generation of mental disorders, its research base made it the dominant force in psychiatry. Biological psychiatry, as it is now called, had not then been invented.

Biological Psychiatry

For a period of time, there was an assumption that social interactions, especially parenting, caught best perhaps in the notions of the refrigerator mother in the case of autism and the double-binding schizophrenogenic mother in the case of psychosis, must be responsible for significant proportion of mental health problems. But there was little evidence from epidemiology or experimental studies to back up these possibilities, and in the 1990's, the notions of refrigerator and schizophrenogenic mothers became a symbol of the failure of social approaches.

The initial impact of psychotropic drug developments on the psychiatric mix was two-fold. On the one hand, in the 1950's, the clinical use of agents such as LSD appeared to reveal prior traumas and abuse and the oppressive nature of social structures and the impact that these could have on an individual's well-being. They reinforced a therapeutic community approach.

On the other hand, antipsychotics and antidepressants, just like the antibiotics before them, buttressed a medical model that targeted the individual, rather than the environment. The clash between within and without can be seen in the licensing of selective serotonin reuptake inhibitors (SSRIs) for Post-Traumatic Stress Disorder (PTSD), where despite minimal (if any) benefits, these treatments locate problems within soldiers rather than in the theatre of combat.

The new drugs turbo-charged the neurosciences. As this was happening, it became more difficult to distinguish between the medical discipline that was social psychiatry and a full-blown anti-psychiatry, which, claiming the oppression of the mad was a symbol for the oppression of all in the industrial democracies, made a significant contribution to the Revolutions of 1968.

Against the backdrop of antipsychiatry, there was a perceived need to pull the profession back from a mission to change the world to a focus on diseases located

within individuals rather than in social settings. The rhetoric stressed a return of psychiatry to its natural home within medicine.

There are many candidates for key moments that symbolized the transition. Many point to the publication of DSM-III in 1980, not realising this was an avowedly atheoretical exercise that was primarily an effort by an epidemiological movement within American psychiatry to corral psychoanalysis. The creators of the DSM (other than the St Louis Department who were on the margins of the exercise) bridled at the slur of Neo-Kraepelinians that was thrown at them.

Part of the difficulty psychiatry had gotten itself into, the newly dominant forces in the field asserted, stemmed from its abandonment of diagnosis. The problem with this formulation is that the metrics, epidemiology and operational criteria for diagnosis and the push to use these tools primarily arose from within social rather than biological psychiatry.

The point at which biological psychiatry was created came later. The best landmark is possibly a 1989 article by Sam Guze, the head of the St Louis Department, entitled simply, "Biological psychiatry: is there any other kind?" It was not the intention of the article to get anyone to identify themselves as a biological psychiatrist but that was one of the outcomes.

Guze's article coincided with the launch of the SSRIs and in very short order, it was in practice assumed that any entities within DSM-III, even adjustment and identity disorders, were biologically underpinned.

This biological underpinning brought the triumph of a language of lowered serotonin levels and chemical imbalances that picking up on an older language of neuroses and personality disorder, located psychiatric disorders within. The language of lowered serotonin had no more basis in biology than notions of degeneracy or the Freudian libido. A biobabble replaced a psychobabble.

In contrast to the notion of a neurosis, the heuristic concepts on the social side were that of a nervous breakdown and of an identity disorder. Even if breakdowns led to

prescriptions for tranquilisers, the disorders located under this heading were seen to some extent as stemming from social situations, such as the imprisonment of women in suburbia, or men in jobs selling products they didn't believe in.

There are a number of risks in a retreat from concepts of nervous breakdown.

One is that we will import social problems into biology. We might, for instance, end up regarding African-Americans as less intelligent or more prone to criminal behaviour than Caucasians, when for instance what we are dealing with are the consequences of lead poisoning in children living in slum housing, even if the hyperactivity caused by lead poisoning shows some response to stimulants.

Another lies in a scotoma for disorders that lie on the interface of the social and the biological. Even low levels of lead produce changes in haemoglobin, increased rates of hyperactivity and loss of intelligence. These are all biological changes arising from without; the complicating factor is that they are not classic disease states.

A third is that biologizing disorders within psychiatry has conferred a certain a-historicity on them. While within mental health, changes in the prevalence of disorders (viz. neurasthenia, ADHD, Bipolar 2 Disorder) can stem from fashions, it is also the case that real diseases rise and fall in incidence and prevalence.

Historical research now makes it clear that rather like any infectious epidemic schizophrenia arose in the nineteenth century and may be disappearing. There are environmental changes that coincide with this rise and fall, such as concentrations of ambient lead and changes in obstetrical interventions that could plausibly have converted ordinarily remitting disorders, such as brief reactive psychoses, into chronic disorders.

It is even clearer that autistic spectrum disorders have emerged relatively recently and over four decades have become twenty times more prevalent than before. What are the triggers to these changes?

Supposedly biological views claim a legitimacy on the basis of a certain invariance since Greco-Roman times for disorders like Manic-Depressive Illness. The failure of social (epidemiological) psychiatry to speak to these issues and to the disappearance of disorders like catatonia or post-partum psychosis is striking.

Even more striking was a venomous assessment of Kraepelin by Shepherd in 1995 that all but blamed him for the holocaust (Shepherd 1995). The venom here was the equivalent of anything in the disputes between the bacteriologists and hygienists a century previously.

Social Psychiatry Rebadged

The term social psychiatry has vanished. But the discipline hasn't.

The Harvard Department of Social Medicine became a Department of Global Health and Social Medicine in 2008 in response to the high profile of some of its former alumni on the Global Health stage.

The Global Health initiative is a huge and powerful player with backing from the World Bank. It aims to tackle health problems linked to poverty in the wake of disasters like the Haitian earthquake.

The notion of a Global Mental Health movement was born around the same time and is identified with Harvard and the London School of Hygiene and Tropical Medicine. It has piggy-backed a ride on the Global Health movement. On the back of claims that it is important to eliminate the kinds of abuses that led to the mentally ill being confined to attics or outhouses in 1840's Britain, it has been rolling out educational programs that critics worry are more likely to educate people in how to have Western disorders. Some of its leading advocates identify lack of access to the latest Western psychotropic medicines as among the most pressing problems in world health at the moment.

A great deal of Western medicine (except surgery) has become a distribution channel for the sales of on-patent drugs most often for risk factors rather than medical disorders. There is no reason to think that Global initiatives will not be similarly captured.

A Department of Public Mental Health (PMH) was established in Kings College London in 2009. This PMH initiative has close links to the Global Mental Health movement.

The PMH concept stems from the publication of an article on Wellbeing in 1996 by Felicia Huppert. For a decade afterwards, Public Mental Health or what had been social psychiatry travelled under the banner of Wellbeing research.

Efforts to improve Wellbeing it was claimed would offer primary prevention in the case of mental disorders. In the name of public wellbeing, there have been calls to tackle factors like income inequality, marriage breakdown, and discrimination against transgender individuals as these are associated with mental disorders. Society it is said should offer opportunities for self-expression, social usefulness and the attainment of satisfactions.

Linked to this there have been efforts in the UK to roll out a much greater provision of Cognitive Behaviour Therapy (CBT) on the basis that low grade depression is compromising the functioning of workers and investing in rolling back depression would boost the economy.

According the annual report of Britain's Chief Medical Officer in 2014, however, Wellbeing researchers have been asking policy makers to take a leap of faith that pursuing a wellbeing agenda works and justifying this by claiming the medical model and biomedical reductionism doesn't fit into public mental health.

The approach, she has said, has made misleading claims for poor quality wellbeing research, while rebranding better quality psychiatric evidence as wellbeing evidence. It has sought an opt-out from research rigour by claiming that wellbeing research is too important to be held to a high evidential standard, and has justified the minimal

effects seen in much research by using the Geoffrey Rose argument from public health that even effects that are miniscule on an individual level can have large population effects.

Public Health and Public Mental Health have recently been described as Soft Healing as opposed to the Hard Healing of traditional medicine. The analogy is to Soft Power and Hard Power. Soft healing aims at prevention and populations and is delivered through economic incentives, surveillance, media and advocacy, school and worksite programs. Its research explores for instance the basis of vaccine resistance. This smacks of capture by marketing forces, particularly as in these proposals the treatment of risk factors is regarded as part of Hard Healing.

Talk of Soft Healing suggests that Public Mental Health has given up on any efforts to establish the existence of social pathogens. With the collapse of notions like the double-bind hypothesis, the only role for social psychiatry would seem to be tinkering with the conditions that might increase the risk of contracting “real” diseases or militate against recovery from them rather than dealing with biopsychosocio-pathogenic processes.

Even in this limited guise, however, Public Mental Health cannot avoid at some point facing the screening problems that will stem from the development of neuroimaging. In the service of prevention, it is highly likely that a risk management perspective will at some point endorse neuro-imaging screening programs without evidence of benefit. There is no evidence that the Public Mental Health movement has sufficient links to traditional Public Health that might enable it to temper any enthusiasm for screening of this type.

A prevention perspective will also lean toward the early identification of disorders in children. Where in the 1960’s this was aimed at improving parenting skills, it is more likely now to lead to a great increase in psychotropic drug intake in children with no one able to work out how to disable a bandwagon that will be portrayed as evidence based.

The Epidemiological Paradigm

The emergence of Wellbeing as a focus for Public Mental Health might suggest there is no role left for social medicine but to be the velvet glove around the iron fist of biomedicine. In fact, the reality is that within psychiatry, biology makes little difference, and biology makes less difference than previously in great swathes of the rest of medicine. The reason for this is that social medicine, in the form of Evidence Based Medicine, sometimes called the Epidemiological Paradigm, has taken over.

What are now called Randomized Controlled Trials (RCTs) emerged in the 1950's. Seen initially by their earliest proponent, Austin Bradford Hill, as one club in the evaluation golf-bag, over time they were increasingly portrayed as epidemiology's equivalent to laboratory demonstrations of cause and effect. The Bradford-Hill criteria - an elaboration of Koch's postulates - emerged for establishing cause and effect and these are widely deployed now with little mention of Koch or his postulates.

In the 1980's, a new movement took shape that was given a local habitation in the Cochrane Collaboration and a name - Evidence Based Medicine (EBM).

EBM is the ultimate triumph of the treatment of the average rather than the individual. Betraying its origin within Public Health, EBM has an intense hostility to all things biological.

There are two looming points of confrontation. First, it is difficult to see how the changing incidence of problems like Autistic Spectrum Disorder will be understood by epidemiology alone.

Events in 1962, when RCTs were incorporated into a set of amendments to the Food & Drugs Act, put in place in the wake of the thalidomide crisis, are of even greater importance. Most trials in the 1960's were run by bodies like the National Institutes of Health in the USA or the Medical Research Council in the UK, but the balance began to shift toward industry, and by the 1980's, a \$35 billion Clinical Research

Organization industry had come into being and ran the vast majority of trials of on-patent medicines conducted globally.

Big Pharma; Big Risk

Today, as has ever been the case, when a patient takes a problem to a doctor for help, the chances are that both the patient and the doctor locate themselves as lying somewhere between the surgical and public health poles of healthcare. Both expect the best of both traditions can be brought to bear on solving the problems the patient has.

Twenty-five years ago, doctor and patient lived in a world where medical issues were something that were found in journals, textbooks and a small number of popular medical and a somewhat larger number of popular books. A patient consulting today is likely to have a health story on the front page of their newspaper or internet media site, with an entire section devoted to health inside the paper, and an amount of health related material on the Web second only to pornography.

The political has become personal in an extraordinary fashion.

Unlike any time in medicine hitherto, today's patient has to take her place in a queue of people, many of whom have been summoned to a consultation by a clinic screening for a wide range of things, none of which bother patients, and a large proportion of those summoned will end up with diagnoses and on medication.

Today's patient has a doctor who adheres to guidelines as part of a mission to bring the best evidence to bear on her patients case, not recognizing she is being guided to see any problems in certain ways and deliver on patent treatments. Not recognizing her growing atomagnosia (inability to see the individual in front of her).

If the problem is a mental health one, both patient and doctor are likely to become aware of conversations denigrating biological reductionism claiming that it risks dehumanizing clinical encounters. In practice, however, biology contributes little or

nothing to clinical encounters about nervous problems. These encounters are being dehumanized but the problem lies with an informational reductionism linked to the use of rating scales and operational criteria.

Within the mental health domain, a great deal of public discourse claims the medical model is inappropriate, diagnosis unhelpful, and the word “patient” to be abjured along with an increasingly long string of replacement designations. But in practice, patients seek diagnoses, and the appeal of the language of chemical imbalances lay in the fact it was destigmatizing. The allure of biomedicine lies in its promise of treatments that work.

But for the first time in a century, today’s first line treatments are likely to be less effective than yesterday’s.

Within mental health, as in the rest of medicine, one of the greatest sources of morbidity and mortality now stems from the treatments patients have been put on by virtue of the risks inherent in those treatments, the multiplication of those risks by polypharmacy and the denial of the possibility of risks by corporations whose own health depends on the continuing consumption of the greatest possible number of medications by the greatest possible number of patients from the earliest possible age.

Epidemiological methods are used to deny treatment related risks. RCTs have become the gold-standard way to hide adverse events. These RCTs are taken to demonstrate cause and effect rather than the principles outlined by Koch of challenge, dechallenge and rechallenge. Were the dispute between Koch and von Pettenkoffer to be replayed today, Koch would likely lose.

Were Behring to discover a treatment worthy of a Nobel Prize today, unless the target population were sufficiently large to produce a considerable return on investment, the therapeutic lead would remain frozen in vitro rather than be planted in the womb of clinical practice – as all but happened 30 years ago with Barry Marshall’s discovery of the benefits of antibiotics for ulcers.

In the medical and lay media, Big Pharma is the whipping boy for these evils. But is it?

Economically it would seem to be in Big Risk's interests to map out the epidemiology of treatment induced morbidity but it doesn't. Big Risk's traditional methods of prevention – guidelines and RCTs – don't work for treatment-induced problems.

So uncertain has Big Risk made access to care that any suggestions that consuming fewer drugs might be healthier are drowned out for most people by concerns about access to medicines. The ACLU, for instance, will not take up the issue of whether treatment-induced violence might have led to inappropriate incarceration for fear it might complicate their efforts to ensure that prisoners have access to healthcare.

Just as a balance in drug development has tipped so that it no longer serves medical treatment, so also a balance within prevention has been perverted.

Big Risk should make it impossible for Big Pharma to take separate patents on drugs as similar as two drops of water, to ghost write over 90% of the literature for on-patent drugs and to sequester the data from clinical trials, in contravention of the fundamental norm of empirical science – but it doesn't.

Big Risk underpins a comprehensive failure to diagnose and treat in the face of morbidity and mortality on an epidemic scale.

Clinical practice is becoming degraded and there is an increasing need for clinicians to relearn the skills of listening to, seeing and touching patients. It will have to engage with a biology that recognizes the brain as a social organ rather than with biobabble. It will have to shape an epidemiology that accepts you cannot design a proper controlled trial without understanding the biology being investigated. It will have to be able to take the dynamics of industrial power into account.

Until such treatment becomes possible, individual patients will be left shipwrecked

References

Davies SC. Annual Report of the Chief Medical Officer 2013: Public Mental Health Priorities. Investing in the Evidence. (ed SC Davies): Dept of Health 2014

Durham HW. The field of social psychiatry. *American Sociological Review* 1948; 13: 183-197.

Eaton WW. *Public Mental Health*. Oxford U Press, 2012

Eisenberg L. A very British kind of social psychiatry. *Br J Psych* 1997; 171: 309-13.

Foreman DM, Psychiatry in public mental health: easy to say but harder to achieve. *British J Psychiatry* 2015; 207; 189-191

Mehta N, Davies SC. The important of psychiatry in public mental health. *British J Psychiatry* 2015; 207; 187-188

Rosen G. What is social medicine? *Bull Hist Medicine* 1947; 21: 674-733.

Rosen G. Social stress and mental disease from the 18th century to the present: some origins of social psychiatry. *Milbank Memorial Fund Quarterly* 1959; 37: 5-32.

Shepherd M, Two faces of Emil Kraepelin. *British J Psychiatry* 1995, 167, 174-183

Stewart-Brown SL. Public mental health: an interdisciplinary subject? *British J Psychiatry* 2015; 207; 192-194.

The Government Office for Science. Foresight, Mental Capital and Wellbeing Project. Gov Office for Science 2008

David Healy

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