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Media pressure and patient care

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It is common practice for the media to bring public attention to causes that are forgotten, lingering or simply in oblivion. In most instances, the reaction from the concerned authorities will be directly proportional to the nature of the concern and to the degree of exposure given to the issue. Another factor which can dictate the reaction of the public or agencies is the group responsible for the problem. For instance, non-profit organizations and ecologically friendly groups will generally get out of embarrassing situations with little harm to their image or financial integrity. In this context, the pharmaceutical industry has become in recent years a villain in the public's eyes due in large part to alleged problems with various types of medications which were presumed to have been wilfully dissimulated.

In the past few years, medications have been withdrawn from the market, or their usage restricted, because journalists without medical or scientific training have reported the results of scientific publications in the media. As a result, various findings have not always been presented in their proper perspectives. Any attempt to bring the public to even consider the risk–benefit ratio of using the drug(s) in question is futile once the media have put their spin on the observations. The media are in the business to make money and a doomsday story will better catch the public's attention and sell more papers than a happy ending tale. In the process, however, they may render a disservice to current or potential patients. What is deplorable is that regulatory agencies may succumb to such media-initiated pressure. There are several examples that could be cited; here are only two related to psychopharmacology.

The selective serotonin reuptake inhibitors (SSRIs) have recently been a 'hot' topic in the media with claims of increased impulsivity, aggression and/or suicides. This issue has since been critically addressed by several authors, including our chief editor (Nutt, 2005). As clinicians, we now have to provide much more counselling to convince patients to take these medications. Some patients abruptly stopped their treatment and experienced discontinuation phenomena. There may also be patients who now will not consult fearing that they could be prescribed a 'suicide-inducing drug'. Adverse events can occur with any medication. However, as mentioned above, it is always important to consider the risk–benefit ratio with all medications. In the case of SSRIs, a review of 477 randomized controlled trials encompassing over 40 000 patients by Gunnell *et al*. (2005) did not find evidence of increased suicidal ideation, but a possible increased risk of non-fatal self-harm. The number of patients needed to treat to obtain one such negative outcome was 759. In contrast, the benefit of a fluoxetine treatment in a cohort of 1914 patients yielded a number needed to treat between four and seven for a response, defined as both self- and clinician-report, of much or very much improvement (Bech *et al*. 2000; Gunnell *et al*., 2005). Given these numbers, one may wonder how many of the 52 suicides in children below age 15 recorded in Sweden between 1992 and 2000 (without evidence of SSRI in their toxicology screen; Isacsson *et al*., 2005) could have been prevented with the use of SSRIs.

The negative events claimed to arise from SSRI use could also be due to the treatment of depression. Indeed, we have known since the advent of effective antidepressants in the late 1950s that depressed patients are at higher risk of committing a suicidal gesture in the initial phase of treatment (Jick *et al*., 2004; Wessely and Kerwin, 2004). This is one of the first things we teach medical clerks when they start a psychiatry rotation. Did it really take a media brouhaha to put emphasis on what we have known for 50 years? Using other families of antidepressants will therefore not shelter patients from this risk inherent to treatment. The bottom line is that no patient should be prescribed any antidepressant and be seen only 1, 2, or even 3 months later.

Another example of indirect effects of media pressure is the recent restrictions put on the dual reuptake inhibitor venlafaxine in England. These are: general practioners cannot prescribe it anymore, an EKG must be carried out before initiating it (and not during treatment?), blood pressure must be monitored throughout

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treatment and it is to be avoided in patients with cardiac disease, electrolyte imbalances or hypertension. It is difficult to understand how such measures were put in place for the good of patients given that the majority of depressed patients are treated by general/family physicians and that high blood pressure develops in less than 3% of the patients taking this medication at 225 mg/day or less. The first report by Buckley and McManus (2002) indicated a greater fatal toxicity index (deaths per million prescriptions) with venlafaxine than with SSRIs, but a subsequent report by Cheeta et al. (2004) showed that 39% of patients who died while on venlafaxine were also taking an antipsychotic medication. It then became obvious that the severity of these patients' illness was an important factor contributing to such a negative outcome. Therefore, it seemed that it was not the medication that produced the problem, but it was the patients who brought the problem to the medication. In support of this conclusion, a summary of the profile of 134 996 patients taking fluoxetine, 52 035 patients taking citalopram, and 27 096 patients taking venlafaxine was published based on the data set from the UK General Practice Research Database (Mines *et al*., 2005). The patients on venlafaxine were more likely to have presented previous suicidal behaviours, to have been hospitalized for depression, to have been prescribed another antidepressant and to have received an antipsychotic or a mood stabilizer than those on the other two SSRIs. The patients taking venlafaxine in England were thus, on average, more difficult to treat than patients on SSRIs. As a result, general practioners in that environment who deem that their patients could benefit from venlafaxine will have to wait for a psychiatry consultation, either leaving the patient on an ineffective medication or using tricyclic agents which we have known for 45 years, without any media fanfare, to be highly lethal in overdose.

In conclusion, while superficial and biased media coverage of some clinical issues regarding antidepressants, as a positive effect, may have brought some physicians to monitor their patients more closely when prescribing them, overall it has had a negative impact on patient care.

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