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Media care and patient pressure

Dear Sir

Dr Blier raises an issue of growing interest – the role of the media in healthcare – but the role of the media in this case seems to be in the eye of the beholder. Dr Blier blames the media for giving pharmaceutical companies a bad name, but these very same companies are probably the most assiduous users of the media, and they seem undeterred by the lack of medical or scientific training that journalists have – an issue that concerns Dr Blier. The editor of this journal, David Nutt, is one of the most media cited British psychiatrists. Among other topics, he has spoken on cognition-enhancing drugs (the future); on deep brain stimulation (exciting new treatment for depression); on anti-addiction vaccines for children (recommended); on downgrading classification of ecstasy (recommended); on the benefits of new over old hypnotics (criticising NICE guidance); on the benefits of venlafaxine for GAD (excited about it); on paroxetine for SAD (should be first choice treatment).

Against this background of media use, it is not clear that there should be undue concern about a modest amount of media reporting of the adverse effects of treatment. Given that drug hazards are all but inevitable, a lack of reporting of any hazards might reasonably lead to concerns that pharmaceutical companies have a complete stranglehold on the media. A great deal depends, as Dr Blier notes, on the quality of the science brought to bear on the issues dealt with.

In terms of the relevant science, Dr Blier's editorial offers something of a curate's egg. He cites figures of 4–7 as the number needed to treat (NNT) to obtain a benefit from antidepressant treatment versus 759 as the number needed to harm (NNH) by, in this case, leading to a suicide attempt. But there is a striking incommensurability here. These NNT figures are derived from rating scale scores and it is far from clear that such changes link to any real benefits to patients. We do not have NNT figures for endpoints such as return to work, or for suicide attempts averted, or for lives saved. Whatever the rating scale NNT figures mean, it is clear that most of the benefit can be reproduced by placebo, without incurring the risks of harm. In contrast to the above, while the data are less than perfect, the NNH number to produce sexual dysfunction seems to lie between 2 and 3 (Patterson 1993), and the number to produce growth retardation in children may also be of the order of 2 or 3 (FDA, 2003), while the data on some indication of physical dependence on some antidepressants lies between 3 and 4 (Rosenbaum *et al*., 1998).

The issue of what the data permits us to say about the relative risks and benefits of SSRIs in children is perhaps best laid out on a website run by the Alliance for Human Research Protection (AHRP, 2006). This is the kind of site that Dr Blier would presumably deplore, given that its key player does not have a medical or scientific background. But in fact the data involved in many of these issues are quite readily analysed, and it may be that not having a medical background makes it easier to pick up the problem with the NNT and NNH figures cited by Dr Blier above. If the difference really were a matter of 4–7 on the one side versus 759 on the other hand, there would have been no media or regulatory concerns about antidepressants.

Dr Blier goes on to suggest that media attention is making clinical practice more complex, with patients asking more questions, and sometimes refusing treatment. This leads him to ask how many of the 52 suicides in children below age 15 recorded in Sweden between 1992 and 2000 could have been prevented by treatment. Based on the consistent excess of suicidal acts in adult and paediatric RCTs, the answer at the moment would have to be few suicides, if any, would have been prevented and any prevented would have come at a cost. This RCT evidence appears to translate into real life outcomes. In a recently reported Danish study looking at suicides in 10–17-year olds between 1995 and 1999, there was a 19.21 times greater relative risk of a completed suicide in children treated with SSRIs compared with those not treated (Sondergard *et al*., 2006).

After adjusting for confounding in the Danish study, the risk ratio was 4.47 times greater on treatment. The 95% confidence interval for this latter risk ratio was 0.95 to 20.96. Because the over fourfold increase in risk in this study was not statistically significant, there was a widespread media dissemination of the finding as evidence that the study had shown there was no risk associated with treatment. Any temptation to suggest such media misinterpretations stem from a lack of medical or scientific training needs to be tempered by the fact that the authors make the same basic interpretative mistakes. Such mistakes have plagued the question of suicidality on antidepressants (Healy, 2006a, 2006b).

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Another thing that has plagued the question of suicidality on antidepressants has been lack of access to the raw data. It is now clear that many of the datasets put into play – primarily by pharmaceutical companies – have been quite misleading (Healy, 2006b). One has to wonder if this issue would have had much traction in the media without strong suggestions of initial and continuing cover-ups. This might be the key media lesson to learn from the antidepressant affairs. Given the legendary litigiousness of pharmaceutical companies, does anyone really believe that if a journalist's questions are reasonably answered, an editor would permit a programme or article to go ahead?

In ending Dr Blier offers the view that media input has had a negative effect on the care of depressed patients. There is no scientific evidence one way or the other on this point. But it would seem undeniable that there is growing media and consumer involvement in healthcare, and it is difficult to see how the genie can be put back in the bottle, not least because, as mentioned at the outset, pharmaceutical companies have perhaps done more than any to uncork the media bottle. In this new world, surely the best protection clinicians and their patients can have is the fullest possible access to data of the best quality and open debate about the interpretation of the findings?

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Competing interest statement

In recent years DH has had consultancies with, been a principal investigator or clinical trialist for, been a chairman or speaker at international symposia for or been in receipt of support to attend foreign meetings from: Astra-Zeneca, Boots/Knoll, Eli Lilly, Janssen-Cilag, Lorex-Synthelabo, Lundbeck, Organon, Pharmacia & Upjohn, Pierre-Fabre, Pfizer, Roche, SmithKline Beecham, Solvay-Duphar. He has also been an expert witness for the plaintiff in 10 legal actions involving SSRIs and suicide or homicide following antidepressant medication, and two legal actions involving dependence on antidepressants.

David Healy
12 July 2006