

**PSYCHIATRY AT THE CROSS-ROADS:
THE PRESCRIPTION OF MOOD ALTERING DRUGS AND
RELATED ETHICAL OBLIGATIONS**

by
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THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS
In the School
of
Criminology

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2007

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ABSTRACT

Psychiatrists work with potentially harmful mood altering drugs. Wrongful prescription and conflicts of interest remain as problems despite legal and ethical remedies. Psychiatrists also work in a context where risk management, the fiction of the “informed consumer”, and questions regarding safety and effectiveness of pharmaceutical drugs present challenges to the legitimacy and credibility of the profession. The views of seven psychiatrists are explored, using qualitative interview methods, on how prescribing impacts “doing psychiatry” and what ethical obligations are important in prescribing mood drugs. Data analyzed reveal participant views emerging around active patients, skepticism of the pharmaceutical industry, and the merits of drug treatment for mood disorders. Psychiatrists interviewed highlight the importance of an actor’s sense of ethical responsibility and efficacy. However, the willingness and potential to create dialogue within the profession around ethical prescribing, as well as challenging the entrenchment of the biomedical model, is largely uncertain.

DEDICATION

For my Grandmother Sarah and my Mother Patty-
My first feminist teachers

QUOTATION

In the year 3535
Ain't gonna need to tell the truth, tell no lie
Everything you think, do and say
Is in the pill you took today

Zager and Evans (1969), *In the Year 2525*

ACKNOWLEDGEMENTS

My supervisor Joan encouraged me to read a book titled *Addiction by Prescription. One Woman's Triumph and Fight for Change* (2000), by J. E. Gadsby. The book opened my eyes to the possibility of doing work in this area. I am thankful to Joan and to Jacqueline for their valuable criticism, insight, and support. To the members of Criminology 1000: thank-you for your kind words.

I would like to thank the physicians who participated in this study. It is my hope that I have remained true to the spirit of our discussions.

Last but not least, I have been blessed by the endless love and support of my partner Lydia, her parents, and my Mother. Thank-you is insufficient.

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CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW

First Impressions

A folded piece of card paper lies before me on the table, resting among a sea of pamphlets and assorted pens. It looks like a piece of Barbie™ furniture I made when I was a little girl. Just the right size for a makeshift dinner table. “Take one—it’s origami”, the man in the suit says as he hands me the trinket. I grab it and he gazes back, searching for approval. I look closer and when the object is flattened, there’s a photograph of a young man, smiling, positioned beside the words **Apo-Clozapine** (Clozapine). The caption asks you to consider initiating or switching your patients to Apo-Clozapine. On the other flattened side the online “risk management program and patient registry” is highlighted, complete with a screen-shot and the assurance that the company is “fully committed to providing a reliable, long-term supply of Apo-Clozapine”. I walk away from the booth of Apotex Inc. with a poker face.

This experience I had at the British Columbia Psychopharmacology Conference (2007) changed my thinking about pharmaceutical companies. I was aware that these companies provide monies for research and samples, among other perks, to physicians. I didn’t think about the other tools the companies could provide to physicians. The online risk management system is a means of monitoring patients taking Clozapine, which can cause a serious medical problem if blood cell counts move beyond the normal range. Is this an example of a pharmaceutical company making the lives of psychiatrists easier and the world of patients safer? Is this an instance of a company exerting more control over the work of physicians and providing a personal shield in case of civil court action? Can it be both?

Overview of Study

Today’s toolkit of psychiatric interventions has expanded to include powerful drug therapies. In the ever-changing social milieu, psychiatrists negotiate new challenges to the way they “do psychiatry”. The self-regulating profession of psychiatry has been scrutinized for their relations with the pharmaceutical industry and the seeming reliance on and promotion of potentially harmful and unsafe mood altering drugs. Due to this scrutiny, professional legitimacy and credibility are not guaranteed for psychiatry and for its practitioners. Risk

management, coupled with micromanaged work, increased access to information for the “informed patient”, and publicized harms caused by drugs to patient health have unleashed a critique on professional “expertise”.

The first objective of my research inquiry is to gain psychiatrist perspectives on the context in which antidepressant and anti-anxiety drugs are prescribed. This includes gathering descriptions on the use of drug-related resources and information by psychiatrists, interaction with patients as “informed, active” participants or “consumers”, and the utility of drug treatments. These reflections assist us in better understanding how psychiatric practice is shaped by the use of drug treatment and how “doing psychiatry” is intimately connected with social factors. Some of those social factors, anticipated from my background reading, are depicted in a visual map in *Appendix 6: “Doing Psychiatry”(contextualized)*.

The second objective of my study is to explore and describe the perspectives of psychiatrists on the ethical obligations that are important in the use of prescription drugs as treatments for mood disorders. Ethical obligations, in a medical context, become relevant when they are put into practice and serve to promote patient health and protect against patient harm. These obligations can be written in Codes and gleaned from law and policy. However, written requirements may lose relevance when they ignore the intricacies of a problem or are not put into practice. The daily actions of psychiatrists not only impact what treatment for mood disorders means but also what ethical treatment means.

The second objective is framed by turning attention to the problems that could be, generally, included under the banner of *wrongful prescription*.¹ The problems falling under this banner include: failure to monitor for side effects (and improvements or deterioration), failure to stop medication or change medication when evidence necessitates, choosing an inappropriate prescription (in dosage or type of medication), or prescribing a medication that is known to interact with other medications the patient is taking. The drugs are legally prescribed but the ways the drugs are prescribed, perhaps along with patient monitoring, leads to harm. Psychiatrists are not the only physicians who are capable of the wrongful prescription of mood altering drugs. As noted by Rasmussen (2006, p.291), research suggests that primary care physicians dispense the majority of all psychiatric drugs.

My second objective also involves generating discussion with psychiatrists

¹ Wrongful prescription includes inappropriate prescription, over-medication and over-prescription.

around the issue of “conflicts of interest” between the pharmaceutical industry and the psychiatric professional. Schafer (as cited in Brody, 2007, p.34) defines “conflict of interest” as follows:

A person is in a *conflict of interest* situation if she is in a relationship with another in which she has an obligation to exercise her judgment in that other’s service and, at the same time, she has an interest tending to interfere with the proper exercise of judgment in that relationship.

The pharmaceutical industry contributes monies toward medical research, drug samples, tools to use in practice,² education and conferences, as well as other perks such as meals and gifts to physicians (Kassirer, 2005). A reasonable person might conclude that the relationship between physicians and the pharmaceutical industry is too close and the influence on patient care is too great on the part of these businesses. Brody (2007, pp.37-38) suggests that some physicians react with indignation to any suggestion of impropriety, despite the subtle effects of pharmaceutical company produced advertisements and studies.

Hence, there are two main questions raised by this study. What impact do these drugs have on the daily practice of psychiatry, according to psychiatrists? What guidelines or ethical principles do psychiatrists view as important in treating patients with antidepressants and antianxiety drugs? These questions have not been sufficiently answered by the research conducted on the topic of medicating patients. In this thesis, I explore these questions by interviewing seven psychiatrists and describing my findings, using qualitative methods. This contextual approach highlights the meanings and experiences of psychiatrists who treat mood disorders.

The present chapter outlines the important considerations guiding the inquiry. The literature reviewed is engaged in an effort to provide the needed background insights, scaffolding the questions raised by the thesis. This review outlines three major areas of concern associated with psychiatrists’ treatment of mood disorders. First, an overview of mood disorders and mood altering drugs is provided. This section ends with a brief introduction to some special considerations: gender and substance abuse and their interaction with the use of mood altering drugs.

² Some of these tools can involve, for example, online monitoring systems, rating scales, diagrams and models.

Next, the context in which these drugs are prescribed is examined in light of the changing approach, one that adopts a business-friendly model. Legitimacy and credibility are essential to the maintenance of power for the psychiatric profession, a profession given the task of classifying and treating patients with mental disorders. Psychiatric practice is embedded in a complex social context, morphing in shape due to the impact of factors associated with the risk society and the influence of the pharmaceutical industry. Maintenance of power within this social context will be explored.

Third, the issue of regulating psychiatric professionals, and their prescribing practices, is canvassed, including the special role of self-regulation, medical ethics, Codes of ethics, case law, and governmental regulatory attempts. Finally, the specifics of the study at hand are introduced and unique challenges to the profession in the 21st century are explored.

Chapter Two reflexively discusses the Methodological Considerations. The place of the researcher in relation to the work (a) in-progress and (b) produced is highlighted. Reflexivity acknowledges the importance of subjectivity in creating the study and, later, the re(presentation) of participant views. It becomes integral that the audience receive sufficient information to judge the trustworthiness of the work. In Chapter Two, the approach to research, the sampling plan and interview schedule, along with explanations of the Framework method of data analysis and criteria for evaluation, are outlined. The roles to be assumed and ethical responsibilities are also noted. Next, the conversations with the seven participants are explored and described in detail in Chapter Three, the Results and Discussion section. The Results subsections are meant to provide a description of the views of participants, while the Discussion subsections provide a deeper level of interpretation and analysis.³

Finally, Chapter Four, the Implications section, brings to light some key reflections gleaned from this qualitative inquiry. In particular, reflections are presented on the varied, rich discussions around the issues of the active (informed) patient, the impact of pharmaceutical company involvement, and the potential utility of drug treatment as a means of treating mood disorders. The importance of differing ethical concerns and the relationship between social

³ This distinction reminds me of a song from the animated program *The Cat in the Hat* (Dr. Seuss, March 10, 1971: TV). Karlos K. Krinklebein, the fish, says, "Now to be certain that I have this straight, I'll re-re-capitulate". The Results section re-capitulates the views of participants. The Discussion is the re-re-capitulation.

context and ethical action is explored, along with the future directions of the profession of psychiatry.

This kind of qualitative inquiry serves a number of valuable purposes. Focusing on how psychiatrists interpret “doing psychiatry”, in relation to prescribing mood altering drugs, has the potential to open a window into the world of these professionals, society’s experts on mood disorders. Our research ought to reflect the changes to how we experience our humanity. In these years of rapid changes in neuroscience and biochemistry, we are faced with the challenges and promises of the new technologies. In the words of Lewis (2003), “it is not that medicine is simply wrong or bad, it is more that medicine is too powerful, too hegemonic, too self-serving, and too unresponsive to alternative points of view”(p.60).

The insights of psychiatrists are invaluable. For ethicists, the ideas of psychiatrists are instrumental in shaping our understanding of good prescribing choices. For the research community, the stories of psychiatrists illuminate the changing nature of the physician-patient relationship and the matter of how psychiatrists create their work. For the legal-minded, this inquiry might help explain the attitudes of psychiatrists when things go wrong.

Context of Study

Mood Disorders: Some Preliminary Number Crunching

It is useful to provide a brief numerical sketch of the problem of mood disorders in Canada. The intricacies of the statistics cannot be examined here. Depression and anxiety impact a sizeable portion of the Canadian public. The *Canadian Community Health Survey* (2002), conducted by Gravel, Connolly, and Bedard for Statistics Canada, involved a one-time collection of interview data from 36, 984 persons aged 15 years and older, who lived in private dwelling in the ten provinces.⁴ Using probability sampling, it was estimated that this group’s data can be used to represent 98% of the population of persons living in private dwellings in the ten provinces, aged 15 and older. Questions were asked about mood disorders and substance dependence problems in the twelve months prior to the interview. Out of 24, 996, 593 persons in this population, there would be 1,

⁴ www.statcan.ca/english/freepub/82-617-XIE/index.htm.

195, 955 people who meet all the *DSM-III* criteria for major depressive episode.⁵ There would be 239, 350 people who meet the criteria for manic episode⁶ and 375, 973 who meet the criteria for panic disorder.⁷ These data are simply the result of translating symptoms into the criteria, based on a single interview and therefore might not be a true indication of prevalence of depression and anxiety within the general population. Another indicator measured was life satisfaction. Of the 24, 996, 593 people in the population, there would be 1, 152, 720 persons who are dissatisfied or very dissatisfied with their lives.

The *Canadian Community Health Survey* (2002) data provides some general estimates of the overall prevalence of any mood disorder, any anxiety disorder and substance dependence (alcohol or illicit drugs) in the population described. In the twelve months prior to the interview, 4.9% of adults (3.8% of the men and 5.9% of the women) aged 15 and over in the population were living with a mood disorder. In the twelve months prior to the interview, 4.7% of adults (3.6% of the men and 5.8% of the women) aged 15 and over in the population were living with an anxiety disorder. In the twelve months prior to the interview, 3.0% of the adults (4.4% of the men and 1.6% of the women) aged 15 years and over in the population were living with substance dependence.

The *Canadian Community Health Survey* (2002) can be useful as a means of indicating potential needs within the population. Among those surveyed who reported mental disorders or substance dependencies, 21% reported feeling they needed help but were not receiving help. In total, 32% of those who reported mental disorders or substance dependencies received professional help⁸; 60% of those persons found the activity to be "a lot useful". From these numbers, one might speculate that professional help can be deemed useful to a person with a mental disorder or substance dependency, and a sizeable portion of those persons with these problems is not receiving help. Coupled with the estimation that over

⁵ Defined as at least one episode (2 weeks) with persistent depressed mood, loss of interest or pleasure in normal activities, accompanied by loss of energy, changes in sleep and appetite, impaired concentration and feelings of guilt, hopelessness or suicidal thoughts.

⁶ Defined as at least one period (1 week) with exaggerated feelings of wellbeing, energy, confidence or irritable mood during which a person can lose touch with reality. Flight of ideas, racing thoughts, inflated self-esteem, lowered need for sleep, talkativeness and irritability may be present.

⁷ Defined as repeated or unexpected attacks of intense fear and anxiety, followed by one month of persistent concern or worry about having another attack. Usually accompanied by physical manifestations (dizziness, flushing, sweating, palpitations, trembling).

⁸ Professional help included a family physician, psychiatrist, medical specialist, nurse or psychologist. Note that social workers are not included as professional helpers in this study. In my view, they play a valuable role in counseling those with mental disorders and addictions.

1, 000, 000 persons are dissatisfied or very dissatisfied with their lives, a case can be made that professional help for mental disorders and substance dependencies is a growing need. This pool of persons are likely to come into contact with antianxiety and/or antidepressant medications if they see a psychiatrist as their health professional of choice.

***Antidepressants and Antianxiety Drugs:
What Doesn't Kill You Will Make You Stronger***

In their classic text *The Perspectives of Psychiatry, 2nd ed.* (1998), McHugh and Slavney provide a unifying schema for understanding the different orientations (ways of explaining and treating mental disorder) held by psychiatrists. Four overarching perspectives (pp. 14-16, 289-90) assist in explaining "life under altered circumstances" (mental disorders):

Life can be altered by what a patient 'has' (diseases), what a patient 'is' (dimensions), what a patient 'does' (behaviours), or what a patient 'encounters' (life stories). (p.17)

The disease perspective involves the use of drug therapies to cure an abnormally functioning brain. This is but one perspective but many would argue that drug therapies have become a mainstay in the treatment of depressive and anxiety disorders. Mood altering drugs are a major focus of modern psychiatric attention.

Given the surges of new drugs on the market, one might be prompted to ask whether these drugs are making a difference.⁹ Van Praag (2003) asked this question and took "making a difference" to mean altering the suicide rate. Using World Health Organization statistics for 1980-84, 1985-89, and 1995, he concluded that "in most countries, the rates of completed suicide seem to be quite stable" (p.184). In particular, he highlights France, Spain, Italy, Germany, Poland, Portugal, England and Wales, Australia, and the United States. He notes that "[m]any studies over the past 20 years showed generally modest effect when comparing placebo and antidepressant drugs" (p.187) and we ought to ask why this might be the case. Van Praag goes on to provide some speculations (pp. 187-89). The DSM focuses on symptoms but it is impossible to tell whether an antidepressant

⁹ "Making a difference", in the context of this discussion, is focused largely around professional determinations of effectiveness. Patient perceptions of these drugs are likely to be different in some ways, and similar in others. This discussion is beyond the scope of the thesis.

is preferentially effective in treating a particular symptom. People who are distressed and worried cannot expect the same results as those with clinical depression. Furthermore, he argues that monotherapy using drugs might be an ineffective therapy for personality disorders, one component of which can be anxiety and depression, which leads to suicidal behaviour. Residual symptoms might include maintenance of suicidal thoughts. Finally, SSRIs might influence auto-aggression but this can be difficult to prove.

Van Praag (2003) encourages a questioning of the capabilities of antidepressant and anti-anxiety drugs. These remedies hold promise for the many people diagnosed with mood disorders. Research behind this treatment is as important as the treatment itself. How far can these pills go towards helping depressed and anxious persons move toward life satisfaction? What are the limitations of using these drugs as a treatment for mood disorders? These are important concerns that require closer scrutiny.

McHenry (2006) also questions the effectiveness of antidepressants by looking at the accuracy of the scientific data underlying the presentation of these drugs to the public. The newest class of antidepressants, the SSRIs, have been presented to the public as highly effective and safe for the treatment of depression (p.406). However, the long-term effects of large doses of drugs are not considered. We also have limited information about the drug trials, especially those that end in failure or are terminated due to adverse side effects. According to McHenry, the "industry is marketing the condition and then the lifelong commitment to their products" (p.407). Control of symptoms becomes the focus, not a true investigation of the causes of depression (p.406). At one time, benzodiazepines (tranquilizers) were considered non-addictive; today, that proposition is considered faulty. The author argues that full disclosure of data, at a minimum, is needed.

It is difficult to accurately describe how effective antidepressant medications have been in treating patients with depressive disorders. IMS Health Statistics, an Ottawa-based pharmaceutical tracking agency, provides some numbers as a reference point.¹⁰ IMS reports that only 6% of Canadians with depression are properly diagnosed and treated. It is not clear whether this judgment is based on a report of being free from depression post-treatment, or whether patients are judged as being misdiagnosed. Speaking about the Canadian context, IMS Health Statistics reports that antidepressant prescriptions have increased 64% between

¹⁰ www.cbc.ca/news/background/mental-health/depression-medications.html (October 17, 2006)

1996 and 2000, with psychotherapeutics being the second most dispensed drug next to heart disease drugs. Furthermore, Norman (2006, pp.394-95) argues that although antidepressant medications “remain at the forefront of treatment” there has been “no quantum leap” seen in treatment effectiveness. He suggests that it might be inherent in the nature of depressive illness that rapid response to treatment is unlikely.

As noted by Breggin (1991) and Chetley (1995), mood altering drugs come with a range of side effects. It has been the aim of psychopharmacology to create better drugs, with maximum potency for minimum side effects. Some drugs might be considered extreme experiments, including the use of ketamine. Tucker, in a *Washington Post* article (September 26, 2006), explains that ketamine is a substance used as a mild hallucinogen and pet anesthetic. Ketamine works on the electrical flow between brain cells.¹¹ Less notorious drugs also raise questions of safety, including some tranquilizers. For example, in the British Columbia Supreme Court case of *Trueman v. Ripley*, [1998] BCJ 2060 (para.20), a report provided by Dr. Rosenbloom, Physician of Pharmacy, evidenced side effects of the tranquilizer Halcion ranging from memory effects (moving information from short-term to long-term memory) to loss of control over aggressive impulses. According to Dr. Rosenbloom, there are at least 58 reported cases of increased hostility or aggression by users of these drugs. Of these cases, 50% involved physical violence in patients with no prior history of such behaviour.

Sometimes patients agree to take the prescribed drugs but later choose to abandon the treatment due to experiencing the uncomfortable effects of the drug. As Penfold and Walker (1983) note, in the physician’s office a patient often does not place her attention “on the impairment of efficiency at work, the dulling of senses and emotions, the effect on sexual performance, the lack of energy, and lethargy”(p.188) caused by these drugs. Hence, the impact of the drugs is felt later, when the patient has been taking the drugs and attempts to resume regular activities. The full impact of the drugs can come as a surprise, even if the psychiatrist has briefed the patient. Furthermore, withdrawal can produce equally difficult symptoms and requires careful monitoring by psychiatrists (Breggin, 1991). The choice of experiencing the painful physiological and psychological

¹¹ Drugs working on the glutamatergic system are described by Tucker as the wrench-toting plumbers who make house calls; drugs, such as Prozac, that target other systems such as the dopamine and serotonin centres, are more akin to workers who hunt down problems at the water plant.

changes of withdrawal and continuing to experience the effects of the drugs must be a difficult decision.

Unfortunately, psychiatrists cannot predict with one hundred percent certainty which patients will be impacted negatively by antidepressant and anti-anxiety drugs. Care in prescribing is vital to a positive outcome for the patient. Reesal and Lam (2001) comment on the "Principles of Management" and note that the ideal antidepressant does not exist. An ideal antidepressant would have rapid onset of action, be effective in short term and long term treatments, have a wide therapeutic dose range, show minimum drug-drug interactions, be safe in overdose, as well as non-addictive, cost-effective and easy to use (p.24S). Psychiatrists should consider the severity of the episode, patient's age and ability to comply, suicide risks, history of compliance, tolerance to medications, presence of comorbid disorders and the use of other medications. According to Leszcz (2001, p.123), psychiatrists should ask themselves whether prescribing the medication is (1) a magic that obviates the patient's need to take responsibility, (2) a means of avoiding the hard work of exploration, and (3) a decision made via submission and subordination rather than through collaboration. It is not an act of careful prescribing if these questions are answered in the affirmative.

The ways in which a physician shows concern for the seriousness of drug treatment can impact a patient's perceptions of the worth of that treatment. For instance, a physician who shows concern around monitoring treatment is encouraging patients to take the drugs with caution and to be aware that drug treatment is not a quick fix for problems. One study that makes this point was conducted by Barbui, Garattini, and guest Editors (2006). These researchers argue that qualitative studies suggest that general practitioners are willing to prescribe drugs without repeated follow-ups (to see if the patient's symptoms persist). The authors suggest that this behaviour may encourage patients to view pharmacological means (the "magic bullet") as the only way of getting well. Of course, this behaviour might be more prevalent among general practitioners, who are not solely focused on seeing patients with mental disorders. Mann's (2005) article describes general physician considerations involved in using drug treatments to manage depression and makes several suggestions for how physicians can best approach managing these drugs. It is advised that physicians monitor patients who start drug therapy, assessing progress through interviews and rating scales, assessing for seven states of response (p.1829). Non-response

indicates minimal, or less than 25% decrease in the baseline¹² severity of symptoms. Partial response indicates a response of between 26 and 49% baseline severity of symptoms. Partial remission indicates that there may be some residual symptoms, but the patient experiences less than or equal to 50% of initial baseline symptoms. Remission indicates a return to normal functioning and occurs when there are no symptoms. While the patient is in remission, they may return to a fully symptomatic state: relapse. Recovery is the state of extended remission. An onset of a new depressive episode in a patient who is in recovery is termed recurrence.

Mann (2005) similarly highlights the uncertainty involved in providing drugs to treat depression (p.1827). After four to six weeks, treatment is reviewed and patients with partial response should be reassessed for the diagnosis and treatment should be “optimized” (higher dosage provided). Alternatively, inadequate response could mean that a combination of drugs, augmenting the antidepressant treatment with another drug or hormone treatment, or the provision of drugs from another class of antidepressants is required. In this decision-tree, Mann notes that psychotherapy should be considered at any time and physicians must be alert for special concerns (e.g. other illnesses, pregnancy). This glimpse into physician decision-making shows the inexact science of providing antidepressants for the treatment of depression. The use of a creative approach to finding the right fit of treatments for the individual patient is needed. The biomedical concentration is also apparent, with the focus on the effects of the brain abnormality and the reduction of symptom severity.

Making sense of side effects and safety concerns can be a time-consuming venture. Given the rapid evolution of new drugs and public questioning, and sometimes government restrictions, on available drugs, it has become an important part of psychiatric practice to remain abreast of new developments in the pharmaceutical industry. Indeed, instructions can be given to psychiatrists on how to monitor patients, how best to change medications, and how to keep informed on drug options. It is more difficult to raise awareness around the larger issues of drug safety and effectiveness. McHenry (2006) offers the words of Glenmullen (2005) as a potential means of making sense of how we understand side effects: it takes 10 years to identify side effects, 20 years to accumulate data to

¹² In this case, “baseline” refers to the initial rating of severity of depression and/or anxiety by the psychiatrist, usually using the aid of standardized rating scales and interviews. The baseline determination occurs before the particular psychiatrist begins a course of treatment.

make the problem undeniable, and 30 years for agencies to address the problems caused by those side effects (pp.408-09). This statement is interesting because it raises the questions of where we are now and whose responsibility it is to become involved in bettering our drug choices and uses.

Special Considerations: Gender and Substance Abuse

As cited by Copeland (2001, p.9), "a 3:1 ratio of women to men exists at every age group in terms of depressive patients", which has been attributed to the help-seeking nature of women, the objective oppression of women, and the attitudes and behaviours of psychiatrists (p.1). His research raises the question of whether women are simply diagnosed more often than men, and then physicians use medication as the first line of treatment regardless of gender. For a number of reasons, gender is a variable under study when attempting to understand the regulation of persons labeled as mentally disordered. Dorothy Smith (1975) argues that psychiatry provides male-generated answers to women-experienced problems. Psychiatrists, not female patients, have "the privilege of defining, categorizing, interpreting and assigning value to what they have said"(p.9).¹³ Penfold and Walker (1983) have furthered that argument by noting that psychiatry, along with the rest of the medical profession, has provided "an even more comprehensive ideology to institutionalize [women's] oppression as an inevitable 'fact of life', and in developing practices that both reflect and enforce that oppression"(p.243).

How might substance abuse—a comorbid disorder—interact with the experience of a mood disorder? Mann (2005, p.1829) cautions physicians to be aware of alcoholism, substance-use disorders and the use of non-psychiatric medications when making medication changes because these issues can underlie treatment failures. The World Health Organization report titled *Neuroscience of Psychoactive Substance Use and Dependence* (2004, pp. 180-183) suggests that there is a connection between psychoactive substance use and mental illness.¹⁴ The Regier

¹³ Smith's 1975 analysis provides one means of approaching this problem. It is important to note that women psychiatrists might be just as likely to medicate. It is possible that today medication is viewed as a first response for both men and women. Further, the category of "women" is broad and needs explication: for instance, how do women of colour, queer women, poor women, role-typical women experience psychiatry? How do categories of oppression overlap?

¹⁴ Some of the drugs used to treat depression are also useful in smoking cessation and treating cocaine addiction.

et al. (1990) study is cited as finding that individuals with an affective disorder are 2.6 times more likely to use psychoactive substances than those without an affective disorder (p.180). Therefore, there might be something about mental illness—the physiological workings—that trigger substance abuse, or substances might be used as self-medication, or simultaneous and complex causal chains might be at work. Furthermore, it has been suggested that gender differences in emotional expression in Western culture can impact who is more likely to seek treatment for mental disorder (Busfield, 1996, p.94). Some people question whether men are more likely to use alcohol to self-medicate and therefore avoid seeking psychiatric help. Greenfield and O’Leary (2002, p.473) suggest that a concurrent or lifetime diagnosis of depression may be correlated with drinking outcomes (p.474).

The Psychiatric Profession

The Psychiatric Professional and Prescribing Practices

Drug treatment decisions in regard to mood disorders made in the office, within the boundaries of the physician-patient relationship, can mask a host of related concerns and objectives when viewed as discrete encounters. The experience of visiting a psychiatrist, discussing a depression and/or anxiety problem, and being provided with treatment alternatives, including drug treatment, is not an isolated set of events. This is one level of possible magnification. Move onto the next level of magnification and one begins to see an intricate web of social relations, some of which rely on the psychiatrist’s participation as a professional. A magnified view can improve our understanding of what it means to be a professional, what responsibilities and rewards are provided to professionals and the changing nature of professionalism. In relation to the changing nature of professionalism, this section explores the issues of professional legitimacy, and the emergence of risk management in a shifting professional context. This section ends with an overview of various means of regulating the prescribing practices of psychiatric professionals.

What does it mean to be a psychiatric professional? What is a “professional”? Freidson (1994) suggests that we use the folk concept to answer that question: how do we accomplish profession and what are the consequences of that accomplishment (p.25). It is difficult to agree on a set of conditions that define all professionals. Freidson explains that professional knowledge has a role in “creating and explaining the officially accepted ‘facts’ about the social and

physical world that form our consciousness" (p.44). Although professionals do not have absolute power, they have formal administrative devices, associations with links to the state, and specialized knowledge that is given privileged status, all of which help secure a certain measure of power in organizing social relations (pp.34-35).

What then is the work of psychiatric professionals? From Busfield's (1996) viewpoint, psychiatrists participate in the social construction of "mental disorder", a construction that varies across time and place. All members of society participate in the construction when they think about a "mentally disordered person" and interact with people so labeled (pp.53-60). For Castel, Castel, and Lovell (1982, p.308), psychiatric professionals treat those people they classify as being mentally disordered, using various psychiatric interventions which function as a whole but shift in essence over time and place. Their ideas about mental disorder are shaped by the world around them and the historical body of knowledge supporting psychiatry as a discipline.

How might psychiatrists describe the work they do and the people they counsel? Morant's work (2006) involved interviewing sixty mental health professionals, in London and Paris, including 11 psychiatrists.¹⁵ He notes that psychiatrists are "key players in the network of social constructive processes through which contemporary social representations of mental illness evolve" (p.819). They work to bring together the expert and lay bodies of knowledge about mental illness from policy makers, academic researchers, lay persons, and the media (p.819). Morant argues that his interviews show that "professionals view their overall aim as attempting to enhance the quality of people's lives" (pp.827-28). His participants shared the idea that mental illness is a state of exaggeration from normal conditions and the belief that the mentally ill are not dangerous or worthy of rejection (p.833). The theories brought into practice by practitioners interviewed formed an important part but not the whole part of their information base when dealing with clients. Professional commonsense was important as well.

Yet, the views of psychiatrists are by no means uniform. Psychiatrists work toward persuading other psychiatric professionals of their views, thereby bolstering confidence in the common work that is conducted. Atkinson (1994) argues that in our oral and literate culture, "medical work is constantly produced

¹⁵ Morant's work did not query how psychiatrists who have mental disorders view mental illness and their work as psychiatrists, which would provide an interesting perspective.

and reproduced through narrative and other language skills” and that work “resides in written and spoken rhetorical formats” (p.115). Conversations between colleagues, the translation of evidence into accounts, writing up cases, and producing texts including patient charts are all incidences when rhetorical impact is key (p.114).

Still, psychiatrists are afforded the power to speak as authorities on mental disorder. Besides sharing common narratives, language and rhetorics, the keeping of psychiatrists’ status has been aided by the ideology of professionalism and legitimation within the medical establishment. This ideology, Freidson (1975) argues, is supported by three main propositions asserted by physicians or medical experts: (1) medical knowledge is complex, detailed and difficult, (2) objective science underlies medical practice, and (3) physicians will place the welfare of others above their own (as summarized by Clarke, 2000, p.270). Veatch (1990) puts it this way: a core presumption in modern medicine is that “there is a medically best course of action for a given patient in a given situation” and good clinical skills assist in determining that course of action (p.25). Medical professionalism and legitimacy are also bolstered for psychiatrists when their patients trust their decisions (Misztal, 1996, pp.131-33). Misztal argues that patients trust that the physician is knowledgeable, especially if there have been prior visits, and in a way this trust serves to obviate the need for a patient to learn about medicine. Misztal suggests that the reputation of a professional is a complex social opinion and rests on a code of ethics (values), formal control (discipline), and conformity to social pressure (p.127). Childress and Siegler (1984, p.139) similarly argue that one purpose of codes of medical ethics is the fostering of trust by showing where medical professionals stand and creating a climate of trust. It is possible for “[p]atients to approach physicians with some trust and confidence in the medical profession, even though they do not know the physicians before them” (p.139).

The impressions that patients build of psychiatrists and the psychiatric profession are managed, to a degree, by the actions of psychiatrists. Professionalism—and professional authority—requires that patients trust in psychiatrist credibility. Veatch (1990) notes that physicians can persuade in subtle ways, including tone of voice, phrasing and facial expression (p.37). The rhetorical capabilities of professionals are also captured by deSwaan’s (1990, cited in Pilgrim & Rogers, 2005, p.2549) notion of “protoprofessionalization”. The professional duplicates, to a degree, her learned ideas about a problem by translating them in a persuasive fashion for a non-professional audience. In this case, psychiatrists re-

socialize the public to accept a professional conception of mental health problems. The matter of persuasion is particularly significant for psychiatrists because their knowledge resources might be too contested to maintain scientific credibility or moral authority (Pilgrim & Rogers, 2005, p.2555).

The maintenance of professional legitimacy entails the interplay of ideologies, actions and a faith in established ethics and regulations. However, scientific credibility, legitimacy, trustworthiness and professionalism are not static states but shift along with the position of the profession within a changing society. One such change involves the increasing focus on risk assessment and management.

The Psychiatric Professional in the Risk Society: The Impact of Risk Management

As argued above, when the profession is seen as being trustworthy, as providing credible information, and as serving the diverse needs of the public, then the power of the profession is more secure. When the profession's ability to deliver on these promises is questioned, so too is the place of the profession as expert guardians of knowledge and skill, and for psychiatrists as those who hold the shared monopoly on mental health care. Societal and professional change can lead to this questioning of psychiatric expertise. It is worthwhile to explore the impact of some of these changes on the workings of the psychiatric profession.

Kirk and Kutchins (1992) argue that the 1960s and 1970s saw a shift in psychiatric thinking away from theoretically rich psychoanalytic methods to ones that moved psychiatry closer to mainstream medical diagnostic methods. The structured interview helped to limit variance among different psychiatrists when making a clinical judgment (pp.47-53). The introduction of the *Diagnostic Statistics Manual III* would further increase validity and reliability by creating discrete classifications for differing mental illnesses (p.50; pp.116-119). The focus of attention is not on patient wellness, but on classification of mental disorder so that a treatment can be provided. Kirk and Kutchins conclude by noting that clinical judgment will always involve some ambiguity (pp. 229-230). For instance, the professional will always have some measure of discretion, choosing between client needs and organizational needs, and the purpose to which the discretion is used.¹⁶

Holmes and Warelow (1999) offer a different reading of the current edition

¹⁶ Some purposes include protecting the client from harm, directing the client to various systems, gaining fiscal resources, advancing political goods, and rational decision-making.

of the *DSM-IV*¹⁷. They see the *DSM* in terms of risk management. Psychiatrists provide diagnoses for “disorders”, implying a mechanistic view of the body (p.168). The manual provides “unlimited expansionism” (p.176) into the realm of classification of behaviour as mental disorder and there is no recognition of coexisting alternative interpretations of the behaviour (p.171). The manual, according to Holmes and Warelow, provides the vehicle for psychiatrists to assess the risk posed by the patient’s behaviour and ascribe “mental disorder” where that risk is unacceptable (p.175). Risk is presented as absolute and focus turns to risk management and the level of acceptable risk, again not on meeting a definition of wellness.

Scientific credibility is increasingly difficult to muster for psychiatrists due to these changes in professional thinking, characteristic of the “risk society”. For Ulrich Beck (1994), risk society is a term used to describe a society that focuses on avoiding unsafe behaviours and states of being. Because danger is a “cognitive and social construct” (p.6), there is conflict over what is safe and unsafe (p.11). In the risk society, people challenge authority because the idea of authority is questionable. The very notions of “safety” and of risk are social constructs and people are more willing to doubt authority.

How to deal with the various “bads”, including harms from mega technologies, genetic research, threats to the environment and overmilitarization (p.6), is a contentious issue. Beck (1994) suggests that cooperation among individuals, institutions and the state is necessary (p.29-30), lest institutions become “zombie institutions which have been clinically dead for a long time but are unable to die” (p.40).¹⁸ According to Beck, the state changes through the process of “withering away plus inventing” (p.38). Psychiatry runs the risk of becoming a “zombie institution”, if Beck’s ideas are plausible. Challenges to credibility in the “risk society” are part of the process of challenging values. Denney (2005) notes that professionals are facing serious challenges in a society where ideas of risk and risk assessment are commonplace. The client is more aware of the option of litigation and aware of the potential risks when consulting a professional. Information is more accessible for clients and they make demands

¹⁷ The *DSM IV* was published in 1994 and an update published in 2000 (*DSM-IV-TR*). A new version of this “gold standard” clinician’s resource is scheduled for release in 2011 (see www.dsm5.org). This manual is not without its critics, a topic too great to discuss in detail here.

¹⁸ For example, government agencies fulfilling a mandate that is already being covered by another group.

on professionals to justify and explain their actions. Clients are less trusting in the risk society. The government and managers demand that professionals justify and explain their actions. Therefore, Denney surmises that professionals are engaged in a “managed form of professionalism”(p.74). In short, it is “difficult for professionals to present themselves as the guardians of expert knowledge”(p.80) when the public is more willing to question professionals and demand justifications for action.

A Managed Form of Professionalism

Management over the work of professionals is a key change in the work of psychiatrists. As noted, clients have a greater understanding of risks, through the proliferation of knowledge and the expansion of litigation; the government provides more layers of organizational managers; the professionals are pressured to justify and explain their actions (Denney, 2005). The management of persons with mental disorders within the community has created changes to the client characteristics of persons who are treated in private practice. In other words, the independence of psychiatrist decision-making is being questioned. A brief introduction to the problems associated with professional management follows.

Medical professionals, including psychiatrists, have the power of self-regulation. Brockman (1998) comments that self-regulation involves a quasi-public body taking on government regulatory functions, including the prevention of misconduct and reduction or prevention of incompetence, thereby controlling quality of service (p.588). Four major intertwined areas of regulation are: (1) entry requirements, (2) demarcation through licensure, certification and definition of scope of practice, (3) regulation of process through dealing with competition, monitoring professionals, and providing continuing education, and (4) corrective disciplinary system (pp.588-590).

Brockman (1998) also argues that the four areas of regulation have “benefits to, and drawbacks for, the public” (p.590). Self-regulation is a source of power for professions. The rationalization is provided that some kind of monopoly over services is needed so that the organization can “operate effectively to control incompetence and misconduct”(p.593). As noted by Brockman (p.598), licensing or certification does not “guarantee[] quality of service within the restrictive system” nor does it guarantee information exchange about services outside the system. This can be of extreme importance in the medical context, where negligent actions by a physician could cost a patient her life. Furthermore, Brockman (p.595) states

that “[p]rofessional socialization, and the resulting professional culture, reinforce the expertise of the professional and the ignorance and dependency of the consumer”. The divide between lay and expert knowledge might be increasingly untenable in a world where the consumer has the potential to be more informed.

From a broader historical perspective, it can be argued that patriarchal ideologies and capitalist interests have played crucial roles in how power within the medical profession is negotiated. As noted by Witz (1992), women were more successful in using legislative means as a way to gain entrance into the medical profession, whereas men could use legislative means as well as credentialism to secure state sponsorship of male professional projects (p.196). It has been argued that this power to self-regulate severely limits society’s power to control the deviant behaviour of physicians.

Management from within, in terms of setting entry standards, education requirements, licensing, and discipline, are also taken as means of securing psychiatric control over its own work. This form of management is akin to Freidson’s(1994) analytic model for understanding the control of professionals. Under the analytic model, professionals would have full control over recruitment, training, work performance and the application of knowledge (pp.67-68): the occupational principle of organization. The gains in intellectual freedom under this model come with the complementary obligations to be trustworthy, collegial, and on guard for possible abuses of power (pp.173-75).

Regulating Prescribing Practices of Psychiatric Professionals

As a means of examining regulatory attempts on psychiatrist prescription of mood altering drugs, as well as the regulation of the drugs themselves, this section explores various legal (codes, statutes, and case-law) and extra-legal means of regulation. Ultimately, these regulatory attempts also contribute to the maintenance of professional legitimacy and credibility.

Do No Harm: Professional Medical Ethics

On a global scale, medical professionals have turned their attention to the importance of adhering to a high standard of patient care. The World Psychiatric Association's *Madrid Declaration on Ethical Standards* (1996) confirms the right of patients to be treated as partners by the psychiatrist in the therapeutic process (#3).¹⁹ Furthermore, as an additional guideline (#2) for dealing with conflicts of interest, the Association insists that psychiatrists must guard against accepting gifts that could have undue influence on work, disclose financial and contractual obligations to review boards and research subjects, and gain fully informed consent from research subjects in drug trials. This Declaration follows the United Nations adoption of Resolution 46/119 on December 17, 1991: *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.²⁰ Principle 8(2), Standards of Care, cautions that "Every patient should be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort." The problem with these sources of guidance is the lack of enforcement in psychiatric practice.

Canadian medical practitioners have multiple sources of ethical guidance. The College of Physicians and Surgeons is responsible for licensing, ensuring that standards of practice are met, and establishing those standards. Section 3 of the *Medical Practitioners Act*, RSBC 1995, Ch.285, expands on two important duties of the College:

- (d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetence, impaired or unethical practice amongst members...
- (g) to establish, monitor and enforce standards of professional ethics amongst members.

The Canadian Medical Association is a voluntary national advocacy association for physicians and medical students. They have produced a *Code of Ethics*, which is the major source of ethical guidance for Canadian physicians. Furthermore, the Canadian Psychiatric Association, another voluntary association, has produced clinical guidelines in an effort to encourage the highest standards of professional practice.

¹⁹ www.wpanet.org/home.html

²⁰ <http://www.un.org/documents/ga/res/46/a46r119.htm>

Conflicts of interest between members of the pharmaceutical industry and physicians have been the topic of regulation in Canada. The Royal College of Physicians and Surgeons of Canada has produced a Conflicts of Interest publication,²¹ which states:

The best way to manage such conflicts is to either eliminate the conflict or, alternatively, acknowledge that it exists and identify strategies for minimizing the potential effects on medical decision-making.

Physicians are directed to the CMA *Code of Ethics* and are warned to “be vigilant in discerning the difference between education and marketing.” Likewise, the College of Physicians and Surgeons of British Columbia, in their *Resource Manual*,²² cautions that such conflicts “can occur where a professional or business arrangement affords a member the opportunity to receive a personal benefit”. Physicians in British Columbia are cautioned to avoid such situations or seek College direction and/or approval. Alberta physicians are directed by their College to the relevant CMA *Code of Ethics* sections, including (1) place the wellbeing of patients first, (2) do not exploit patients but treat them with respect, (23) recommend what is beneficial, (49) conduct is open to peer review, and (50) avoid promotion of treatments for personal gain.²³

Ethical considerations around prescribing medications are also included in some guidelines and policies of the various Colleges of Physicians and Surgeons. British Columbia, Nova Scotia,²⁴ Newfoundland, New Brunswick, and Ontario have various guidelines and policies in place warning against prescribing based solely on faxed or mailed information (countersigning). Ontario provides the most clear guideline in Policy #2-05 (May/June 2005).²⁵ Physicians are cautioned to have a full understanding of the patient’s health status prior to prescribing drugs. The prescription must be done with care and within the scope of their responsibilities, acknowledging that level of care varies (episodic or well-known

²¹ See *Physicians and industry – conflicts of interest*, retrieved from <http://rcpsc.medical.org/publications/index.php>

²² See *Conflicts of interest*, retrieved from https://www.cpsbc.ca/cps/physician_resources/publications/resource_manual/conflictinterest

²³ See *Conflict of interest*, retrieved from http://www.cpsa.ab.ca/publicationsresources/attachments_policies/Conflict%20of%20Interest.pdf

²⁴ See *Policy regarding prescribing practices/countersigning prescriptions/internet prescribing and notice to non-resident physicians concerning cross-border prescribing*, retrieved from <http://www.cpsns.ns.ca/publications/policy-internet-prescribing.htm>

²⁵ See *Prescribing practices (Policy #2-05)* retrieved from http://www.cpsa.on.ca/policies/drug_prac.htm

patient, minor problem or complex issues). The *Resource Manual*²⁶ for British Columbia's physicians states that there is an obligation to arrange follow-ups and a responsibility to advise on drug effects, interactions and precautions. Ontario, in Policy #1-03 (May/June 2003),²⁷ and New Brunswick, in a commentary,²⁸ direct physicians to alert patients early and fully of any adverse effects. Once again, Ontario provides a clear statement that harms are "unexpected or normally avoidable outcome[s] that negatively affects the patient's health and/or quality of life" and it is part of the fiduciary duty and respect for patient autonomy to acknowledge such harms and arrange for follow-up care.

The psychiatric profession has the serious responsibility of monitoring the activity of members and disciplining those who act below the standards set for psychiatrists. Freidson (2001) considers the place of ethical codes and concludes that it is important that professional institutions support the professionals by undertaking "the vigorous investigation of violations and whatever corrective action is finally deemed appropriate" (p.216). Some violations cannot be easily placed into codes because they represent violations of trust (p.216). Some problems are subtle, including showing a lack of respect for the patient, providing acceptable care but not the best care (when it is possible), and being dismissive of the patient's desires are difficult to place into Codes or policies and, more importantly, to monitor.

Furthermore, Freidson (2001) notes that some problems deal with "the economic, political, social, and ideological circumstances that *create* many of the moral problems of work": the institutional ethics (p.216). Codes and policies that target the activity of individual psychiatrists are needed, but so are larger solutions that work toward setting-up a work environment that supports good decision-making and quality patient care. This is not to say that negligent behavior can be excused for psychiatrists who are struggling with the realities of modern practice. However, it does point to the fact that ethical practice cannot be divorced from the social setting in which the actors are embedded.

Psychiatrists are also held to legal standards of conduct, created through Canadian common law. Harm and causation are key issues in these negligence

²⁶ See *Prescribing practices, countersigning prescriptions and internet prescribing*, retrieved from https://www.cpsbc.ca/cps/physician_resources/publications/resource_manual/prescribingprac

²⁷ See *Disclosure of Harm (Policy #1-03)*, retrieved from <http://www.cpsbc.on.ca/policies/disclosure.htm>

²⁸ See *Selected Commentaries, Reporting of adverse events*, retrieved from <http://www.cpsnb.org/english/Selected%20Commentaries/Reporting%20of%20Adverse%20Events.html>

cases. For instance, Judge Cheverie in the PEI Supreme Court case of *Harris v. Beck Estate*, [2007] PEIJ No.11, found against the patient and stated “The question is whether by the application of those drugs there was a real risk Harris would wind up in the state which he described” (para. 45). Harris, who would accompany his wife to her appointments, was offered treatment by the psychiatrist. Harris claimed the medications were unrequested and they caused him to lose contact with reality. The judge found the evidence provided by Harris to be weak, stating that the psychiatrist met the standard of care required of psychiatrists at the time in Prince Edward Island. Further, Harris showed a willingness to take the drugs by discussing medication changes with the psychiatrist.

Psychiatrists are not expected to achieve perfection. Psychiatrists must disclose material risks and special or unique risks that a reasonable person in the patient’s situation would want to know (para.41, citing *Reibl v. Hughes* (1980) and *Hopp v. Lepp* (1980), Supreme Court of Canada). When a breach of conduct is argued by the patient, the psychiatrist has an opportunity to justify his actions. To illustrate, Justice Lang of the Ontario Superior Court of Justice, in the *Gallacher v. Jameson Estate*, [2002] OJ No. 2699 case, notes that once the court draws an inference that harm has been caused by physician negligence, it is up to the physician to lead evidence to the contrary (para. 15, citing *Snell v. Farrell* (1990), Supreme Court of Canada). The patient was unable to prove that but for the prescription of the antidepressant Anafranil, he would not have had an affair, separated from his wife, or quit his good job in favour of a risky business venture. It was likely, according to the judge, that a midlife crisis and subsequent selective memory are responsible for the account.

Amidst these sources of ethical guidance, the problems with prescribing medications and drug safety remain. The Atlantic Provinces Medical Peer Review Program²⁹ has assessed more than 1200 physicians since 1993. After the first two years, psychiatrists were added to physicians who could be randomly called for an in-office review. Some physicians are reviewed off-site. The most common deficiencies, regardless of practice type or region, are: lack of recording for repeat prescriptions, outdated drug supplies and samples, lack of allergy flagging, insufficient documentation in the patient record, and insufficient recording of prescriptions. It is easy to see how these problems are connected to poor patient outcomes and adverse drug experiences.

²⁹ www.apmpr.ca/Defic.htm

Government Actions and Regulatory Attempts

Going to the psychiatrist and starting a mood altering medication should not be a game of Russian roulette. How secure can patients, and psychiatrists, be of the safety of mood altering drugs in the Canadian setting? Another means of regulating prescribing practices comes in the form of government regulations and initiatives. In the Royal College of Physicians and Surgeons submission to the House of Commons Standing Committee on Health (November 6, 2003),³⁰ it was stated that post marketing surveillance of drugs is lacking in Canada. It is largely the responsibility of health care practitioners to record adverse effects, a poor replacement for a final stage of monitoring. The Canadian government, under the *Food and Drug Regulations*, CRC, c.870, C.01.016, requires manufacturers to report serious adverse drug reactions (including unexpected ones) and provide a concise, critical analysis of the adverse drug reactions and serious drug reactions on an annual basis. The government may request from the manufacturer case reports and a summary report of the drug reactions known to the manufacturer. The Marketed Health Products Directorate³¹ assists in the post-market surveillance of drugs and medical products, aiming to improve Health Canada's ability to identify drug safety risks and improve response time.

Not only physicians and manufacturers, but also consumers are urged to report adverse drug effects. The MedEffect online database is a place for consumers to report adverse reactions and read about warnings for various medications and medical products.³² As noted on this site, "new or 'unexpected' side effects" sometimes occur when a product is introduced into the market, exposed to "real world" conditions. These are "adverse reactions" that have not been identified in the pre-market testing. Products on the market, according to this site, have side effects ("expected" and "tolerable") that are outweighed by the benefits of the product. On October 1st, 2007, Health Canada announced that the adverse effects monitoring program, operating under MedEffect, would be renamed Canada Vigilance.³³ This technological fix for the problem of product safety, which rests on consumer "vigilance" for monitoring risk, seems to be an

³⁰ See *Prescription Drugs in Canada: Presentation to House of Commons Standing Committee on Health*, retrieved from <http://rcpsc.medical.org/publicpolicy/archives-e.php>

³¹ http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/mhpd-dpsc/index_e.html

³² http://www.hc-sc.gc.ca/dhp-mps/medeff/index_e.html

³³ http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/mhpd-dpsc/vigilance_announce-announce_e.html

“end-of-the-pipe” solution. Longer trial periods for the testing of drugs, under “real world” conditions would be another means of examining adverse side effects, without further jeopardizing the health of consumers who are depending on the medication to improve their condition.

The Health Products and Foods Branch, within Health Canada, is overseeing the implementation of a project whereby decisions about new drugs and products will be made public.³⁴ The Summary Basis of Decision for novel drug therapies (New Active Substances) and a subset of Class IV medical devices are public (for applications for products made after January 1st, 2005). The website states:

A Summary Basis of Decision is a document that outlines the scientific and benefit/risk based decisions that factor into Health Canada’s decision to grant market authorization for a drug or medical device. The document includes regulatory, safety, efficacy and quality (chemistry and manufacturing) considerations.

Therapeutic product applications and information about those products produced prior to January 1st, 2005 will not be included in this system: one must use the proper *Access to Information* protocol to gain that kind of information. There is no post-market information included, as these decisions are intended to provide additional information on risks and benefits of the products.

Researchers have also questioned what consequences government-issued warnings about antidepressants have on prescribing rates. Kurdyak, Juurlink, and Mamdani (2007) conducted a time series analysis of Ontario computerized prescription records, for the period of April 1998 through March 2005. During this time span, five high profile warnings were issued, as follows:

1. June 10, 2003: UK warns against the use of paroxetine for patients under the age of 18;
2. October 27, 2003: US FDA warns to use newer antidepressants with caution for young patients;
3. October 15, 2004: US Black Box warning, stating the threat of suicidal ideation and behaviour in children and adolescents with all antidepressants;
4. March 22, 2004: US FDA warns to closely monitor all patients after the

³⁴ www.hc-sc.gc.ca/dhp-mps/prodpharma/sbd-smd/index_e.html

- initiation of antidepressants or changes to this medication; and,
5. June 3, 2004: Health Canada issues a similar advisory as (4).

The UK warning had the effect of decreasing paroxetine prescriptions for younger patients. The North American warnings showed no impact on any age group. The researchers speculate that the specific target group and the specific instructions had an impact, as well as the fact that the UK warning was the first of its kind (p.754).

The Ontario study represents a statistical examination of trends to try to produce an explanation for prescribing behaviour. One might ask whether there is any data that asks physicians to explain their responses to such warnings. Researchers at the Mayo Clinic conducted an electronic survey (November 2005—January 2006), which included 24% of available physicians working at the Clinic at Rochester, Minnesota (Lineberry, 2007), to determine the impact of the October 2004 Black Box warning on physician behaviour. Of the 37 psychiatrists surveyed, 41% made no change in practice; 19% spent more time explaining treatment; 16% spent more time explaining rationale for treatment; and 11% would see patients more often for follow-up. The survey was sparked by a concern that over 2 years, the number of prescriptions filled for antidepressants for children and adolescents had gone down by 20% in the United States. Similar to the Ontario study, Lineberry reported a lack of changes in physician prescribing behaviour, which seems to support the idea that warnings can have little influence on psychiatrist behaviour.

Physicians, including psychiatrists, are exposed to various warnings about drug safety and have been encouraged to report any observed adverse drug effects. In terms of in-practice government supports, what is available to help psychiatrists ensure the safe prescription of mood altering drugs? In British Columbia, the Ministry of Health has offered an online database called PharmaNet, since 1995. This tool provides access to patient medication histories for pharmacists, the College of Pharmacists of British Columbia, the College of Physicians and Surgeons of British Columbia, and British Columbia physicians. If a physician wishes to have access to this tool, she must pay a license fee. Patients can also obtain access to their own medical information. Once accessed by the medical professional, the information follows the same rules of confidentiality as other medical information. The stated objectives of this program are to prevent the over consumption of prescription drugs (duplication or fraud), to prevent

inappropriate therapies (drug interactions), to improve practice standards, to promote cost effective prescribing, and to streamline claims.³⁵ The fraudulent obtainment of narcotics has been a serious problem and this database is one means of curbing this form of abuse. It is an open question whether this database is proving a useful tool for physicians as a means of assisting in prescribing medication.

Maynard and Bloor (2003) write from an international perspective about regulatory interventions aimed at practitioners. They are skeptical of the effectiveness of such actions and claim "in rare cases where the guidelines affect clinical practice, there may be a risk of increasing inefficiency by distorting overall priorities" (p.36). The best interests of the patient and society may be undermined by problems such as the proliferation of drugs, a refusal to use generic equivalents and off patent therapies. In France, Germany and the UK, governments have backed the use of best practice guidelines and three main conclusions can be drawn about such experiments, according to Maynard and Bloor (p.36). First, physicians by-and-large were not aware of the regime and found it complicated to administer. Second, newer and more costly alternatives were used when there was a list of banned drugs. Third, when it came to antidepressants, pharmacists were displeased with its impact on choice of drug. These lessons should be taken into consideration when developing policy alternatives.

Righting Wrongs: Legal and Extra-Legal Avenues of Redress for Patients

There are various possibilities open to remedy the problem of over-medication and wrongful prescription. Governmental regulation of drug companies is one possible response (Lexchin, 1990), although the problem of extra-territoriality is a major stumbling block (Kleefeld & Srivastava, 2005, pp.495-497). Internal regulation, in terms of guidelines for physicians, is another means of regulation. New Zealand has a no-fault compensation scheme, which has permitted an open dialogue with the medical profession regarding standard-setting and patient rights. However, the system offers minimal remuneration, denies compensation for the ordinary consequences of treatment and rarely opens the avenue of human rights litigation (Bismark & Patterson, 2006; Manning, 2004).

Court battles can be waged in the arenas of civil law (mainly negligence)

³⁵ <http://www.healthservices.gov.bc.ca/pharme/pharmanet/netindex.html>.

or criminal law; yet, these legal means are rarely used, and when used the plaintiff patient is rarely successful (Jones, 1999, p.121; Cebuliak, 1995; Kaiser, 2002; Liederbach, J., Cullen, F., Sundt, J., & Geis, G., 2001). In the cases of *Gadsby v. MacGillivray*, *Kroll v. Vallance*, and *Trueman v. Ripley*, the plaintiff patients were unsuccessful in their claims of negligence against their psychiatrists, for prescribing various mood altering drugs. The unsuccessful patient in *Stewart v. Barry*, was told by Judge Morin that the antidepressant was “state of the art” and acceptable to be given at the upper limit of its dosage (para. 170). In that case, the patient was switched from one tricyclic to another and claimed to undergo a period of mania, during which he stole from his client’s trust funds. The physician must be found to be wrong in his prescribing, and he was not, and the injuries must be proven, which they were not in this case.

Compensation through the judicial system appears to be difficult for patients to access, possibly due to hurdles in proving harm and causation. Non-legal responses are aimed at changing the behaviour of those diagnosed with mental disorder and/or the behaviour of the psychiatrists. The radical notion of anti-psychiatry focuses on removing the label of “mental disorder” and giving people the opportunity to resolve their problems without medical intervention (Laing, 1985; Burstow, 2005). One major problem with anti-psychiatry, as noted by Ussher (2005), is its failure to “reconcile a deconstructive critique at the macro-level with the needs of individuals at a micro-level”(p.31). In other words, how to respond to the people who feel “ill”? Another set of responses is aimed at the profession itself: building a feminist psychiatry (Ussher, 2005) or improving the work of psychiatrists. Change from within requires a sensitive approach, meaning one that is capable of generating workable solutions for psychiatrists and patients alike, in terms of practical ethics around the use of psychiatric medication.

Psychiatry in the 21st Century

In sum, psychiatric professionals are working in a changing context. The focus on risk management, coupled with a managed form of practice, forces a spotlight to shine on their performance. Among the watchful eyes are patients, who have been described as being “informed” participants in the clinical encounter. The objectivity of psychiatry as a science and the trustworthiness of psychiatric professionals also come under scrutiny, in part due to the exposure of conflicts of interest between pharmaceutical companies and psychiatrists. The pharmaceutical companies manufacture antidepressant and anti-anxiety drugs

that have potentially serious, even life-threatening, consequences for users' health. These drugs are marketed to the general public and to psychiatric professionals as positive tools for the treatment of mood disorders. The increased scrutiny over psychiatric work, coupled with its management, raises questions over the ethics of professionalism for psychiatrists. How does control over one's work impact the ability to do one's best work as a medical professional? This section aims to provide a more in-depth review of these issues facing psychiatry in the 21st century.

The Fiction of the "Informed Patient" and Psychiatric Practice

The growth of the internet and direct-to-consumer advertising has impacted our perception of patient knowledge. The passive patient can now be conceptualized as an informed consumer of medical treatment. This language has a key place in the "risk society" because the public is taken as being responsible for monitoring their risks and addressing them. Henwood, Wyatt, Hart, and Smith (2003, p.604) describe the "informed patient" by using an ideal type:

Patients take it upon themselves to become informed about their own health conditions and the treatment options available, and doctors agree to listen to patients and negotiate regarding treatments, taking patient's interests and values into account.

The fiction of the "informed patient" creates an image of a level playing field between doctor and patient (almost equal power dynamics), coupled with a hint of reverence for the final say of the physician in the health matter.

As with any ideal type, the construct has the power to expose its opposite. The division between lay and expert knowledge becomes questionable. It is possible for a patient to see her physician and gain the same information they gathered on their own time, needing the physician to simply raise the right issue and offer the right treatment to suit the patient's needs. Morant (2006) suggests that theoretical models can facilitate communication between professionals, bolster legitimacy and provide rhetorical aids, and prove useful for professional identity construction (especially for psychiatrists), but these are only "partial and provisional understandings that must be used creatively and flexibly in combination with more informal sense-making processes derived from practical experience with clients" (p.829). More attention should be paid to compromise solutions, resulting from power relationships between various social spheres when the material and status inequalities come to impact the shape of knowledge (p.834).

Would the psychiatric elite, in charge of research, administration and education, provide supports for discussion of the differences in values and information between psychiatrists and patients? One possible response to such questions is provided by Pilgrim and Rogers' (2005) examination of the Royal College of Psychiatrists (UK) campaign titled "Changing Minds: Every Family in the Land" (1998). This policy document is aimed at using psychiatric clinical categorizations of stigma and related information (p.2549) to help reduce stigma. It is stressed that mental disorders are common, education by psychiatrists is necessary to educate around stigma, psychiatry is imprecise as a science, and people should be "enabled optimally to contribute towards their own recovery" (p.2548). In this campaign, psychiatrists argue that the technical knowledge of their discipline, rather than the social sciences, gives them the mandate to deal with stigma, without considering that seeing a psychiatrist can lead to increased marginalization (p.2551). Another reading suggested by Pilgrim and Rose is to situate this campaign within the re-professionalization strategy of psychiatry: at a time when the biomedical model is being challenged, this report aligns psychiatry with a biopsychosocial approach (p.2554). Deinstitutionalization brings the ideas of stigma, social inclusion, citizenship and quality of life to the forefront. Pilgrim and Rose end by noting that if leaders of the profession express something different than that which is experienced within the clinical encounter, then psychiatry's authority will be undermined (p.2555).

The fiction of the "informed patient" has evolved alongside changes to our understanding of patient rights and responsibilities within the doctor-patient relationship. According to Veatch (1990, pp.26-29), in the late 1960s and early 1970s the medical problems of euthanasia, abortion, the treatment of serious illnesses, and genetic engineering raised moral issues for physicians and patients alike. No longer could medical opinion be considered value neutral: we are faced with "a ubiquity of values in medical choices" (p.28). This poses problems for physician authority because "professional expertise cannot determine the relation between safety and freedom" (p.32). Veatch notes the following (p.30):

Treating a broken arm or a dog bite or a hernia is necessarily contingent on the value system of the one making the choices, and there is no obvious reason why the values of the health-care professional are the appropriate ones.

He considers "medically indicated" treatment as being founded on an assumption that patient's views are similar to the physician's own views (p.32). To decide

that a certain drug is necessary is to decide that the effects are good or bad, how good or bad they are (p.31) and that the drug produces some acceptable level of reliability (p.33). Hence, when this decision becomes not simply a pharmacological choice, the right of the physician to act as drug gatekeeper can come under question (p.34).

How best to describe the balance of power within the physician-patient relationship? The negotiation model argues for adequate disclosure, voluntary actions by patients, accommodation reached by mutually accepted means, and autonomy as a constraint for action of both physician and patient (Childress and Siegler, 1984, pp.140-42). It is admitted that sometimes negotiation is not possible, or is possible in a limited form, and some matters are beyond negotiation. The negotiation model seems to accept that some limitations to patient involvement exist: "maintenance, restoration, or promotion of the patient's autonomy may be, and usually is, one important goal of medical relationships" but the importance of it is a matter for negotiation between patient and physician (p.141). The impact of values, conflicting or unclear needs and goals, and the reality of differing power potentials within the physician-patient relationship are highlighted by the fiction of the "informed patient". How adequate are such metaphors for capturing the truth of the relationship? Would it be better to re-work the metaphor to bring some consumer language into the picture: a barter? How might this look for psychiatrist-patient relationships?

Lowrey and Anderson (2006) argue that it is too early to say whether exposure to this information could increase respect for the medical profession and lead to increased compliance with treatment suggestions (p.130), or whether the overall effect will be to challenge the authority of physicians (p.126). In a telephone survey of 406 residents of Baton Rouge, Louisiana, Lowrey and Anderson found that people who use the internet for health information also tend to believe that doctors do not have exclusive control over medical knowledge, although they were more likely to dismiss an individual doctor than the entire profession (p.129). There was also some evidence to suggest that wealthier individuals and those who had a positive appreciation for alternative medicine were more likely to challenge doctors' advice and rely on their own power to obtain medical information (p.130).

Henwood et al. (2003) conducted qualitative interviews with 32 middle-aged women in Britain, who were considering taking Hormone Replacement Therapy. These researchers questioned the impact of relying on the fiction of

the “informed patient” as a means of understanding patient behavior. Sixteen of their participants had internet access and fifteen used it to access health information. The authors express that these women felt it was the doctor’s task to inform patients about their health or the women felt there would be difficulties with patients working as partners with doctors (p.598). Four women thought medical sites were more trustworthy than non-medical sites and there was little understanding of commercial interests behind the online information (pp.600-01). Fourteen of the women had actively searched for information prior to a doctor’s visit, yet they showed “[g]reat concern about appearing to over-step the boundary between ‘expert’ and patient” (p.601). These women are not the ideal “informed patients”: they display reluctance in taking on the role, although they are capable of doing so. The information gained did not seem to “empower” these women.

Henwood et al. (2003, pp. 590-94) provide interesting critiques against a strong defence of the “informed patient” position. Assuming that the responsible, informed patient will share information with doctors, leading to empowerment, is questionable. Is there a direct link between empowerment and information? Do patients want this responsibility? Furthermore, is there time within clinical encounters for this sort of back-and-forth to occur? Is the clinical encounter flexible enough to mean that information is used by doctors “for choice” and not “for compliance” (Dixon-Woods, 2001, in Henwood et al.)? Is the information framed by doctors using their rhetorical strategies to convince patients of their own approach? For Henwood et al., conflict between lay and expert opinion is part of the clinical encounter and physicians expect a certain level of compliance (p.605). In their words, “constraints exist within both practitioner and patient communities and within the space occupied by both in the medical encounter” (p. 605): the question is how to create an equitable exchange of knowledge.

There are differences between the choice of taking hormone replacement therapy to prevent cancer and taking drugs to treat a mood disorder. When the fiction of the “informed patient” is applied to psychiatry, it appears that people who consult psychiatrists are not ideal patients under this view. Viewing patients with mental disorders as being of unsound mind is part of the historical framing of mental disorders. The real physical and mental impact of mood disorders (the nature of the illness) on the patient could limit the ability to search for knowledge and retain it. It is also unclear whether there are differences in social experiences that would restrict access to resources for persons who suffer from mental disorders. For instance, if a person is on a disability pension, their limited income

might restrict easy access to quality information. The power differential within that relationship is often obscured by the fiction of the “informed patient”. Besides the question of “how knowledgeable” and “how equitable”, there is a question of “how willing”. Someone with a mood disorder might also have self-esteem issues, which may deter a patient from raising concerns and questions with the psychiatrist.

Psychiatry Meets the Pharmaceutical Industry: An Unholy Alliance?

Alongside the challenge of debunking the concept of the “informed patient”, we must be alert to the ways in which pharmaceutical industry impacts decision-making in psychiatry. Ties between the psychiatric profession and the pharmaceutical industry are not new, but have been forged over the past 50 – 100 years. This historical backdrop is a necessary part of the story of psychiatry. The ties of mutual help and interdependence—drugs to treat disorders and money to fund drug companies—are part of how psychiatry has become the creature it is today, with its plentiful tool kit of psychiatric interventions. This section expands on that history and focuses attention on current developments in the alliance between the psychiatric profession and the pharmaceutical industry. It is in light of the evolution of psychiatry and its interrelationship with Big Pharma that we are able to understand, through comparison and critical reflection, what is happening today.

Castel, Castel and Lovell (1982) recount that in the United States, between 1900 and 1930, the mental hygiene movement and the ideas of psychoanalysis (migrating from Europe) were in vogue. Psychoanalysis provides a way of reducing social issues into questions of psychology (p.261-62). According to Castel, Castel and Lovell, the idea that psychiatric professionals are necessary to deal with psychiatric clients took hold around 1944 in the United States (p.258). The problems of anxiety and psychosis created from World War II were creating government concern (p.2). Castel, Castel and Lovell (p.85) state that in May 1954 Chlorpromazine came onto the market (Thorazine) and within eight months it was provided to over two million patients.

Rasmussen (2006) argues that an alternative reading of antidepressant history is possible. In the early 1900s through to the late 1920s, drug companies approached the psychiatrists of the time (neuropsychiatrists) and marketed amphetamines for depression, drugs initially researched for their antihistamine properties and stimulating effects (pp.293-99). The company Smith Kline French

promoted Benzedrine for “mild depression”, in the late 1930s and early 1940s, thereby broadening the condition’s definition (pp.315-17). This had the effect of bolstering Myerson’s idea that depression involves apathy (adhedonia), the opposite of “pep and zeal” (p.318). Rasmussen also contends that early psychoanalysts were not solely concerned with talking therapy, but were open to using tranquilizers and electroconvulsive therapy (p.291).

The marketing of drugs to the psychiatric profession, and later to the general public, expanded the scope of psychiatric therapy beyond the confines of the prevalent form of treatment at the time—psychoanalysis. According to Kirk and Kutchins (1992), psychoanalytic methods were critiqued in the 1960s because of their limited appeal: clients were most likely to be young, attractive, verbally articulate, intelligent and successful (p.19). The 1960s and 1970s was also a time of growth of experimental talking therapeutic methods beyond drugs and psychoanalysis. As noted by Castel, Castel and Lovell (1982, p.255), “whenever psychiatrization meets with resistance, it is transformed, and what emerges in each instance is a novel and more flexible psychiatric model”. This flexibility makes the classification system vulnerable, which lead to changes in the third version of the *Diagnostic and Statistics Manual* (Kirk & Kutchins, pp.10-11). This version of the manual is a key point in the history of psychiatric theorizing because it brings psychiatry closer to mainstream medicine in terms of how disorders are diagnosed.

As we see from this brief overview of the modern rise of drug therapy, the treatment options available for psychiatrists are in flux. The tool kit of psychiatric interventions is not locked tightly but is open for new tools, while some rust from disuse. Castel, Castel and Lovell (1982, p.308) note that psychiatric interventions function as unified whole, although historically and socially different treatments and theories gain the spotlight at differing times. This spectrum of psychiatric intervention ranges from the less invasive and less restrictive forms, such as counselors and outpatient therapies, to the more invasive and restrictive forms, such as Electroconvulsive Therapy, mandatory confinement in hospital, and forced drug treatment. Today, the manufacturers of psychiatric drugs offer psychiatrists many choices.³⁶

The pharmaceutical industry—Big Pharma—has become quite friendly with the medical establishment. Drug representatives meeting in the offices

³⁶ For more detailed information on the common classes of antidepressant drugs, refer to *Appendix 1: Classes of Antidepressants*.

of physicians, company funds being given to scientists, and even the halls of medical education are not untouched by drug company dollars (Lexchin, 2001; Kassirer, 2005). On a small scale—the office—it is unclear how often patients ask specifically for mood altering drugs (Cebuliak, 1995; Penfold and Walker, 1983),³⁷ as opposed to being given the brand name drug by the physician. It is also uncertain how patients are positively impacted by the social awareness created by drug advertisements: depression and anxiety are no longer in the shadows of public thought. Speaking from a radical social control perspective, Thomas Szasz (2001) suggests that prescribing practices are fulfilling a number of needs: the public wishes to take legal drugs, pharmaceutical companies wish to make large profits, and physicians must diagnose and prescribe in order to keep their power (p.40).

When drug companies play a crucial role in dictating health care practice, patient wellbeing is impacted in a serious way. The idea of science, specifically psychiatric science, as being grounded in observation and analysis is challenged by conflicts of interests. Some thinkers have questioned the impact on democracy when health care is guided by big business ideals: sell more drugs. McKnight (1995) argues, “[i]n exchange for the power to cope and celebrate, we are offered chemically managed versions of chemical oblivion”(p.69; Rossides, 1998, p.161; Szasz, 2001, p.97). Lexchin (2001) argues that psychiatrists are prescribing “normality” when they dispense “lifestyle drugs”³⁸ and encouraging ignorance of social injustice and diversification. These “lifestyle drugs” support the notion that responsible citizens strive for perfect health. Health becomes a consumer’s choice.

One ethical question concerns conflict of interest between members of the medical establishment and the pharmaceutical industry. Brody (2007) argues for a Divestment Strategy toward the pharmaceutical industry (p.299), aided by professional repercussions for the violations of these guidelines (p.308). In his view, information provided by drug representatives is not essential because other sources (letters and downloads) are available (pp.300-01). The latest drugs might

³⁷ Mintzes et. al. (2002, pp.278-279) conducted a survey of family physicians in Vancouver and Sacramento. These researchers found that in 12% of visits, patients requested drugs (42% of which were advertised directly to consumers). Further, the physicians did not form a strong opinion on the efficacy of the drug for the particular problem in 40-50% of cases; in cases where the patient did not request the drug, physicians were ambivalent in only 12% of cases. This study lends support to the view that patients request drugs despite their potential ineffectiveness.

³⁸ “Lifestyle drugs” include hair-growth drugs and erectile dysfunction drugs. In my view, drugs that produce an upper effect when used to treat mild cases of depression (where other remedies would be equally effective) should be classed as lifestyle drugs.

not be the best drugs, and even if they were the best drugs, it is questionable whether physicians can accurately discern whether the information they obtain is unbiased. Some physicians also wish to obtain free samples (pp.302-05). Brody claims there is no data to suggest that indigent populations are benefiting from these samples. Commercial sources have been relied upon to provide gratitude to physicians and this demoralization must be addressed if physicians are to break their ties to pharmaceutical companies (pp.305-07). Brody argues for higher levels of accountability.

Steiman, Bero, Chren and Landefeld (2006) provide an example of a drug company's (Pfizer Inc., and the subsidiary Warner-Lambert or Parke-Davis) unethical promotion of their drug (gabapentin, approved in 1993 for the treatment of partial complex seizures). The authors analyzed 8000 pages of documents from the litigation, where the company answered charges that it violated federal regulations by promoting the drug for unapproved uses (spanning from 1994-1998). The draft promotion budget for the drug (1998) provided the largest single amount (percentage of total and across categories) for professional education in terms of speaker's bureaus, advisory boards and dinner meetings: \$19,110,000 (p.287). It is easy to see why one business plan stated "Medical education drives this market!!"(p.284). The single category with the largest amount of dollars devoted to its needs, surpassing the second category by twice the funds, was professional education in the area of emerging uses: \$11,039,000. By 2000, the number of prescriptions for the drug for pain and psychiatric disorders was greater than the amount prescribed for epilepsy, migraines, and other uses. This great shift was due in part to research improvements and to marketing off-label uses before getting FDA approval (p.285). In 2004, Warner-Lambert settled the litigation by paying out \$430 million dollars (p.285).

The documentary *Little Helpers* (2003) also calls for higher levels of accountability for the drug companies by examining the exposure of drug safety concerns. These matters include reported suicides while taking certain antidepressants, unusually high levels of anxiety and anger associated with taking some medications, and painful withdrawal symptoms. The situation for physicians was described as difficult because their drug information may largely be from drug manufacturers. Information about clinical drug trials is often guarded and seldom comes to light unless mandated by a court. There is a growing need for accurate information to become public before harm is caused to patient health. Although the drugs may be safe and effective for many consumers,

they have had a harmful impact on the lives of many others. The documentary makes the firm point that this harmful impact could be reduced if accurate information is released concerning the safety of these drugs. This documentary did not canvass the questions of how to measure safety and who should set these standards for antidepressants and anti-anxiety drugs.

A Changing Ethics of Psychiatric Professionalism

The degree to which professionals can assert control over their work and work products has been changing rapidly. For Freidson, this administrative control would stifle innovation and decrease trust. Therefore, it is possible that workers will rebel against this idea. The desire for administrative control "is related to the informal attempts of all workers... to do their work as they see fit on the basis of their own sense of knowing how to do it"(p.73-74).

In his updated thesis, Freidson (2001) argues that managerialism (top-down bureaucratic governance), consumerism (free market rule) and professionalism are three logics that operate in tandem and it is a policy question of how to balance them (p.181). Some measure of expert authority and professional economic privilege (credentialism and monopoly) is warranted in an effort to nurture specialized knowledge (p.208). According to Freidson, "the most important problem for the future of professionalism is neither economic nor structural but cultural and ideological" (p.213). By this he means that a strong sense of professionalism and a commitment to its highest ideals is needed if professionalism in its true sense is to survive. In addition, he argues that "the *maximization* of profit" is "antithetical" to the ethics of professionalism, and a political economy that supports it is working against this model of professionalism (p.218).

Freidson's (2001) concern about the impact of the profit motive on professionalism raises the question of what consequences result from health professionals making profits from the packaging of health as a commodity. In the growing context of the privatization of health care services, it is of concern that physicians are able to focus on making profits in the fee-for-service system and health care becomes big business (Cohen, 1985, p.64). Health care as a commodity challenges the common notion of the "good physician". In brief, "*service is to care* which is to *love* and love is the universal apolitical value"(McKnight, 1995, p.38). Why trust the professional if she is no longer above reproach?

Speaking Around Drugs, Therapy, & Ethics: Significance of The Study

How is psychiatry adapting and changing to accommodate the challenges facing the profession? The observations of working psychiatrists can provide one means of answering this question. Likewise, what do they view as being important in leading up to this particular historical moment? These views can shed light on what psychiatrists view as critical to their profession and what they are working towards, or being caught-up in (work environment). For example, Goldbloom and Garfinkel (2001, p.262) share the views of Frank and Kupfer on challenges facing psychiatry in the 21st century, based on an integrative and broad approach to psychiatry. Among those issues are the determination of how life experience alters gene expression, neurobiological effects of psychotherapy, the creation of adverse effect-free pharmacotherapies, the investigation of trauma, connecting physical illness with anxiety and mood regulation and the impact of aging on affect disorder expression and treatment.

More specially, there are few studies available highlighting the intricacies of how psychiatrists make treatment choices. In their survey of 273 psychiatric faculty members in Washington State, Sullivan, Verhulst, Russo, and Roy-Byrne (1993) report that greater than 75% “would use psychotherapy, consider its omission inappropriate, and consider it to act upon the cause of the patient’s distress in all three [personality disorder] cases [provided in the survey]”(p.419). In another study, Copeland (2001) questioned 90 licensed psychiatrists about their treatment planning in two hypothetical cases and also gauged their egalitarian attitudes towards women. His work suggests that the physicians considered medication as a first choice and did so in a systematic way, regardless of gender of the patient, gender of the practitioner, or diversity/consciousness training of the physician. According to this study, older, more experienced physicians recommended medication less regularly than the younger physicians. This is an interesting finding because the psychiatric profession is aging and there is a high attrition rate due to retirement. Numerous factors motivate psychiatrists to prescribe certain medications, ranging from expertise, training, personal beliefs, social norms, and patient satisfaction. The information gleaned from interview studies can add to our understanding of prescribing practices.

Studying other cultures for a deeper understanding of psychiatrist prescribing behaviours is another means of shedding light on North American practices. For example, Slingsby, Plotnikoff, Akabayashi, and Mizuno (2007) conducted a novel qualitative interview study of fifteen psychiatrists in Japan, four had practiced in

the United States and in Japan. Further interviews were conducted to determine cultural differences. They explored the various strategies for addressing patient adherence to psychiatric drug regimes and found that (1) the psychiatrists recognized that patients had various misconceptions regarding the drugs, such as their addictive properties, (2) side effects reinforce existing patient misconceptions and resistance to drug treatment, and (3) psychiatrists intentionally underdose patients, accept that resistance may be stronger than compliance, and employ euphemisms (p.243). These researchers state, "Effective care, thus, requires physician competence to address patients' psychiatric predispositions to the fear of the use of prescription medications" (p.241).

Slingsby et al. (2007) also reported that the psychiatrists show resignation, meaning that it is viewed as the patient's choice whether to live with the illness or take medication, and employ euphemisms, such that a psychiatrist is also called a mental internist or a neurologist depending on practice setting (p.244). It was noted that in Japan, the entrusting model predominates. In this model, patients place a high degree of trust in their physician to make choices for them. Showing resignation and employing euphemisms might be one means of showing respect for patients, who are giving psychiatrists the power to make decisions over their health. This respect might be critical in maintaining trust and ensuring compliance with treatment plans.

More studies like the Slingsby et al. (2007) study could assist us in understanding psychiatrist prescribing practices. It is more common for social science researchers to focus their attention on the opinions of those being regulated, rather than the regulators: "studying up", turning attention to those who are considered to be the experts, is less commonplace.³⁹ Based on my literature review, it appears that we have less descriptive and analytical information on how psychiatrists characterize their approach to prescribing antidepressants and anti-anxiety drugs and more information focused on treatment choices and how to prescribe drugs. Qualitative research highlighting the experiences of psychiatrists with prescribing antidepressants and anti-anxiety drugs would provide more much needed insight into how psychiatrists view their work. In short, it would be beneficial to hear from the psychiatrists themselves.

³⁹ In a comment to the article "Professions of duplexity. A prehistory of ethical codes in anthropology", by Peter Pels, Laura Nader (1999) states that "studying up" is "a term which I coined in the 1960s (Nader, 1969) precisely because I thought the channel within which anthropologists were debating ethics [to be] too narrow. It is still too narrow" (p.121).

Similarly, there is a gap in our understanding of the views of psychiatrists on the topic of their ethical commitments. Exploring the ethics around prescribing mood altering drugs has largely been the domain of philosophers and medical experts. What kinds of ethical problems, both practical and institutional (Freidson, 2001), do psychiatrists encounter when medicating patients? How do they feel about the relationship between medical professionals and medical bodies and the pharmaceutical companies (Brody, 2007)? The physician-patient relationship is impacted by other social relations, which in turn impact a psychiatrist's views of his ethical commitments. Qualitative interviews with psychiatrists are one means of questing for answers to some of these questions. The descriptive and analytical richness provided by such accounts could provide information that illuminates what it is like to "do psychiatry" in the 21st century and what attitudes and activities contribute to patient harms due to the consumption of mood altering drugs.

CHAPTER TWO: METHODOLOGICAL CONSIDERATIONS

The Birth of the Study

My topic of research is psychiatrists' views on prescribing antidepressants and anti-anxiety medications and the ethical implications. A qualitative examination of this issue, focusing on the views of psychiatrists, is useful because they are the professionals who work in the area and are trusted to provide their expertise (both on drugs and the ethical ramifications of prescribing). Readers have the opportunity to glimpse into the world of clinical psychiatrists and, hopefully, gain a richer understanding of their ideas on prescribing practices. In brief, the purposes of this study are exploratory and descriptive. The function of the research is contextual because it explores the meanings and experiences of psychiatrists who treat anxiety and depression.

Mission Questions

Chenail (1997) suggests that qualitative researchers should be guided by mission questions, which are a means of refocusing attention on the salient matters should confusion arise. Broadly speaking, the two mission questions for my study are as follows:

1. How do clinical psychiatrists view the impact of prescription drugs (to treat depression and anxiety) on their practice of psychiatry (use of drug-related resources, interaction with patients as consumers, and utility of the drugs)?
2. What ethical obligations are important or need work in the use of prescription drugs in psychiatric practice (to treat mood disorders)?

Data Collection Methods

(a) How to best approach the problem

In the words of Ritchie (2003), the qualitative approach "offers the opportunity to 'unpack' issues, to see what they are about or what lies inside, and to explore how they are understood by those connected with them"(p.27). Psychiatrists working with depressed and anxious patients are in a good position to discuss the issues surrounding prescribing antidepressants and anti-anxiety drugs, as well as the ethical implications. To borrow a metaphor from Rubin and Rubin

(2005, p.11), qualitative researchers work “more like a skilled painter than a photographer, selecting details and creating an image from them”. This painting should be rich in detail. I would add that this painting includes more colours in part because of the work of feminist social scientists. Atkinson, Coffey and Delamont (2003, p.83) note, “we [researchers] now have to ask ourselves who ‘we’ are, who ‘they’ are, how we represent ourselves and others, and even what methods we employ”.

The preferred method of gathering data is via face-to-face interviews with psychiatrists. In the words of Arksey and Knight (1999, p.32), “Interviewing is a powerful way of helping people to make explicit things that have hitherto been implicit—to articulate their tacit perceptions, feelings and understanding”. The advantages of face-to-face interviewing over questionnaire/survey methods are many, including the ability to clarify of meanings generated by the subject (Arksey & Knight, 1999; Palys, 2003, p.160). Furthermore, specialists might provide “fairly idiosyncratic” perspectives and the subject matter is complex, making the project suited to interview inquiry (Ritchie, 2003, p.33).

Individual, face-to-face, interviews are ideal because the subject matter is private (in the sense that it involves individual practices and ethical views) and detailed accounts are sought (Lewis, 2003, p.56-60). The personal experiences and views of psychiatrists, which are intermediated by and partially created by the social factors, are the units of study. I attempt to make sense of their words by looking at prior literature on the matter and by looking at my own understanding of what might be impacting their views. I also tried to probe for clarification of some of these social factors. These ideas speak to the critical realist assumption that there is a reality and it is tangible/knowable through our views of it (Lewis, 2003, pp.56-60). This study is guided by my belief that “knowledge in the social sciences is provisional, uneven, complex and contexted”(Arksey & Knight, 1999, pp.18-19).

(b) Sampling plan, setting, and interviewing

I purposefully chose twenty-four psychiatrists to approach, first via a letter from my supervisor (*Appendix 2: Letter of Introduction*) and then following-up with a phone call or email. I searched the British Columbia College of Physicians and Surgeons online database and used the search engine Google.ca to determine whom to contact. When searching with the College database, I selected the listing of psychiatrists, chose a number to mark an interval, and wrote down the names

of psychiatrists whose names were in the database at this interval. The chosen psychiatrists are clinical psychiatrists, licensed to practice in British Columbia, and have different affiliations. A few psychiatrists were excluded because of repeat affiliations (i.e. working at the same hospital); when this occurred, I moved to the next name in the database. One psychiatrist was removed because he practiced forensic psychiatry, which is outside of my research focus. Seven psychiatrists agreed to participate. Seventeen psychiatrists said "no" or did not answer my follow-up call or email.

The seven psychiatrists "have had the appropriate experience, are knowledgeable and are able to explain to [me] what they know" (Rubin & Rubin, 2005, p.70). Three out of seven participants serve in administrative capacities, two of whom have served in teaching roles. One psychiatrist is retired from practice. The average number of years in psychiatric practice is 30.5. Four psychiatrists have been practicing between 20 to 30 years. Together, the psychiatrists are from the geographic areas of New Westminster, Richmond, Vancouver and Victoria British Columbia. Psychiatrists from Surrey and Burnaby did not agree to participate.

In addition to accessing the 24 contact names from the British Columbia College of Physicians and Surgeons website, I used chain referral sampling, or snowball sampling. According to Palys (2003), "snowball sampling involves starting with one or two people and then using their connections, and their connections' connections, to generate a large sample"(p.145). According to Palys, the technique is less costly and time consuming than attempting to generate a representative sample from a large geographic area (Palys, 2003, p.140). Atkinson and Flint (2001, p.2) note that this method is useful when the population is hard to access (trust is needed to gain access) and can be effective when the aims of the study are exploratory and descriptive.

However, of the six psychiatrists who were asked to provide referrals, five provided one name each. When the five referrals were contacted (total number of psychiatrists contacted increased to 29), none of the five referrals agreed to participate in the study. I did not provide the name of the referring psychiatrist in an effort to protect confidentiality and anonymity. It is my guess that chain referral sampling works well when an informant can contact participants and the personal connection is used to encourage participation. Another tactic, in retrospect, would be to take the time and network within the psychiatric community and build personal connections.

Another potential obstacle to accessing participants is the time commitment involved. One psychiatrist in particular described his reasons for refusing to participate in a way that stressed the complexity of the issues and the inability to offer one hour of time. Perhaps an online survey method would work well with this group, securing higher participation rates. Yet, the benefits of a face-to-face interview would be lost in an effort to gain a higher response rate.

It is my belief that these issues can be explored initially through the analysis of the seven case studies presented here. In order to protect their identities, I assigned the participants the following code names: Peter, Kitta, Dolan, Pearl, Nelson and Marty.⁴⁰ Dr. Hoffer insisted that his real name be used in this thesis. Each face-to-face interview was approximately one hour in length. Peter, Dolan and Marty's interviews were taped. Kitta, Pearl and Nelson's were not taped. Notes were taken in all cases. I transcribed the interviews verbatim shortly after each interview. Each line of text on the printed page was given a number to aid organization.

The interviews took place at the participants' respective offices. Peter and Kitta work in hospital settings. Dolan, Pearl and Nelson work at private offices. Marty works in an office building and does not see clients. Dr. Hoffer works as a consultant for his orthomolecular medicine business, seeing clients. The feelings I had as I waited for each interview varied greatly because I dislike hospital settings. Their smell and sterile feel make me feel sick to my stomach. Dolan's private office, on the other hand, had a warm and inviting waiting room with friendly receptionists. Refreshments were also available on the table for those waiting in Dolan's office. In Marty's office, I did not encounter patients waiting for their appointment. I did not notice any ways that atmosphere impacted the interview, in terms of length or quality of responses, or nervousness of interviewer.

The flexible and emergent nature of qualitative research provided the opportunity to revise questions. Each interviewee's responses evoked new images and ideas in my mind, which influenced the way questions were asked of subsequent participants (*Appendix 3: Interview Schedule*). I noticed during the first couple of interviews that I was giving rather lengthy responses to my participants. As a remedy, before each interview I asked the following questions: (1) How can I

⁴⁰ These names are chosen from a book I'm currently reading, as a matter of convenience. The book is *Mindplayers* by Pat Cadigan (1987, Bantam Books).

listen more, and (2) How can I turn comments into queries. This helped me focus my attention on the participant's descriptions of their world.

(c) Interview schedule

The questions I prepared are organized to mimic a natural conversation, with some less intrusive questions to start and working through toward the more conceptual and personal (Palys, 2003, pp.190-191). I began with a discussion of my ethical obligations and background questions in order to help create a comfortable space. In my opinion, "rapport" is the level of comfortableness between participant and researcher, built by common dialogue that is not offensive to either party. It is assumed that there will be a certain level of unfamiliarity because of a lack of prior encounters and perhaps because of "studying up". Yet, these are not insurmountable barriers: sensitive interviewing and questioning, as well as attentive body language and using common terminology are important factors in building the comfort level. Nelson, in particular, had many questions about the nature of the research prior to his participation and gave oral consent only (i.e. did not sign the consent form).

Hathaway and Atkinson (2003) caution that "[i]f the researcher fails to open up the back regions of a social setting, he or she will only assemble a standard or public account of the group practices therein"(pp.162-163). Rubin and Rubin (2005, p.139) suggest that proposing an explanation, providing non-threatening questions, asking for exceptions to a provided generalization, responding to hints in the speech of interviewee, probing for specific experiences, and concentrating on the tangible (as opposed to why questions) can be used to help interviewees open-up.

Understanding that "an informant may be able to generate more than one frame of reference in his or her accounting"(Atkinson, Coffey & Delamont, 2003, p.130) is useful to capture the complexity of our personal experiences. In the words of Becker (1996, p.5), participants "make vague and woolly interpretations of events and people". It is our task to represent the richness of that complexity, while alerting our audience to the places where we move from description to inference (from the emic to the etic)⁴¹. This notion can be illustrated with the

⁴¹ The emic perspective takes the insider's point of view, providing situated meanings; the etic perspective makes comparison across persons in different situations possible, providing a generalized account. These differences highlight the (re)presentation of views that is the work of the researcher.

phrase “mind the gap”. Anyone who has been to the London Underground will be familiar with the phrase, as it is read on the tiles and heard over the loudspeaker to alert travelers to watch the gap between the train and the platform. As interviewers, we must “mind the gap” between describing views and interpreting them. As a result of our role as re-presenters of views, Becker cautions us that “the nearer we get to the conditions in which [participants] actually do attribute meanings to objects and events the more accurate our descriptions of those meanings are likely to be”(p.4).

(d) Roles to be assumed

As a Criminology student interviewing psychiatrists, I feel as though I am viewing psychiatry and medical ethics from an outsider’s perspective. I wonder how training in the sciences would influence my point of view. My position might be comparable to someone studying the prison system, which is both within society and excluded from it thereby inviting outsider interpretations (Bosworth, 2001, p.437). Building rapport is important, especially as an outsider and as someone who is studying-up.

Overall, I found the participants to be articulate and eager to answer. I tried to emphasize that there are no right or wrong answers and I am interested in gaining participant opinions. For example, a couple of them asked “is this what you’re after” or “did I answer the question”. Interviewing the interviewer might be an explanation for this: psychiatrists conduct clinical interviews. Being aware of this possible desire to please, I try to be clear when asking the question and use clarifying probes when needed.

As someone who has family experience with mental illness (depression and anxiety disorders), I am familiar with psychiatric interviews and the options to treat these mood disorders. I have felt torn between advocating for medications in lieu of therapy; torn between advocating for abandoning psychiatry versus “trying a little harder”. These complex emotions surfaced when I had time to re-read the notes and transcripts. At the end of this project, I am no closer to reaching a personal conviction on the “goodness” of modern psychiatric practices for the treatment of depressed and anxious patients. I too hold a “vague and woolly interpretation” of the work done by psychiatrists.

An approach to data analysis

Framework Approach

In the following section, I explore my approach to data analysis. I adopted the Framework method of analysis suggested by Ritchie, Spencer, and O'Connor (2003, pp.219-262; *Appendix 5: Framework Method*). The first phase is *data management*. I read through the transcripts and generated a list of common ideas that emerge through the various interviews. From this list, I refined these ideas into the following initial concepts or codes, which are expanded to include sub-ideas (*Appendix 4: Conceptual Framework*). This process has its roots earlier in my planning because generating questions was, in a sense, an initial pondering of codes and possible themes (Basić, 2003, p.145).

Next, I moved from this index of concepts/codes to the process of working with the transcripts and assigning the codes to the written text. Moving sentence by sentence with coloured pens for each of the concepts, the transcripts were marked using the identifying numbers. Then, I created one thematic chart for each of the concepts (#1 and #2 were placed on one sheet) using the Microsoft Excel program. Each case (each person interviewed) occupied one row and each sub-idea occupied one column. I included one column for my own comments as I was working. I included line numbers as I summarized the ideas of each participant, referring back to the marked transcript. When I felt that an idea was particularly well expressed, I highlighted it (in a colour to match the pen marking). Once a chart was complete, I moved to index cards and copied the quotations onto them, along with code name and concept number. At the end of this process, I had three main products: the thematic charts, the index cards of quotations, and the marked transcripts. I dealt with Dr. Hoffer's transcript separately because it allows his voice to dialogue with the other participants in an interesting way.

The next phase is the *descriptive accounts* stage. For this I moved away from Framework, where charts were recommended, and worked by hand scribbling notes onto paper. This free-form of expression helped me link ideas and detect more meaningful categories. Regrouping concepts, searching for coherence among the concepts, and clarifying the most relevant dimensions of the concepts were the main tasks. I referred back to the index cards as a means of keeping the participant words and ideas in the forefront of my mind.

The final stage of *exploratory analysis* calls for a master chart. I did not construct a master chart because I felt that my small number of participants were easy to

track with the charts already in place. I moved to the method of rough sketching to draw out some connections between the concepts. I continued to work with the index cards. The main tasks are searching for patterns, making sense of the connections and contradictions, and attempting to draw out the implications and possible explanations for the findings. Undoubtedly, there are more connections to be made, even in this small collection of case studies.

As argued by Ritchie and Spencer (1994), the Framework method is generative (driven by original accounts), dynamic (open to change), systematic, comprehensive (full review of materials), and accessible (easy retrieval). The charting allows between and within case comparisons so that every bit of data can be inspected. They note that the strength is that “it is possible to reconsider and rework ideas precisely because the analytical process has been documented and it is accessible” (p.177). Of course, the “creative and conceptual ability of the analyst to determine meaning, salience and connections” is the ultimate requirement for good qualitative work (p.177).

Additional Considerations

Throughout the process, I reminded myself of one useful idea introduced by Weiss (1994), who considered analysis the testing of mini-theories. Weiss stated, “I do ask myself what I am seeing instances of, what I am learning about, and what questions the material raises” (p.155). I also attempted to remain sensitive to the need for reflexivity in my accounting. In this case, the question posed by Mauthner and Doucet (2003) was of value: in what ways is the knowledge partial, situated, historical, developmental, modest? (p.424). The value of reflexivity for qualitative research is the stance that knowledge cannot be separated from context and source. Ultimately, the account presented is my unique re(presentation) of the views of the seven participants.

Quality and Value of Research

Marshall and Rossman (1989, pp.144-143) and Atkinson, Coffey, and Delamont (2003, p.156) discuss Lincoln and Guba’s (1985) criteria for evaluating naturalistic inquiry:

1. **Credibility**, bolstered through in-depth descriptions,
2. **Transferability**, testing of the models and concepts you provide,
3. **Dependability**, considering the world as it is changing,

4. **Confirmability**, including questions requiring explanation and elaboration, possibly corroboration of earlier statements.

The use of the Framework method and careful choice of questions (posed to interviewees and asked of the data) are ways of approaching the Lincoln and Guba criteria.

Trustworthiness, which is the central issue, can be improved by a repeated inspection of “every goblet of relevant data”(Silverman, 2000, p.180). Uncovering the many layers of meaning, testing them against what has been recorded, and explaining anomalies (searching for negative evidence) is part of the process.

Ethical Obligations

It is important to outline my commitment to ethical standards: minimizing the potential for harm and respecting my participants. I obtained ethics approval from the SFU Office of Research Ethics and my project is classified as minimal risk. Prior to asking the interview questions, I informed each participant of the uses of the data, the security of the data, the voluntary nature of their participation, and my intention to provide confidentiality and anonymity for their information. I removed any details that would identify the participant (names, place names, affiliations) from the transcript. The participants will receive either an abstract or direction to the online copy of the finished thesis, as discussed individually with the participants at the time of the interviews.

CHAPTER THREE: RESULTS AND DISCUSSION

The discussion begins with a look at the forces that contribute to the decision making of psychiatrists. Situating psychiatry historically provides a necessary backdrop to the conversation. Following that, the situational context, or the collection of more immediate forces that impact ethical decision making, are discussed. Providing a rich description of the context is a necessary part of talking about ethical decision making because it informs professional judgments. In the words of Dolan, "it's not such a simple thing—what we do in the office" (133-34). The remainder of the chapter is focused on psychiatrists' opinions on pharmaceutical companies and ethical obligations when medicating patients. Finally, the participants' views on the future of psychiatry are discussed. Each section begins with the *Results*, a re(presentation) of the words of the participants, followed by the *Discussion*, a further interpretation of their words. Participant quotes and ideas are referenced using line numbers from the transcripts.

Looking Back at the History of Psychiatry: Where are we now?

Results

Participants were asked to fill the shoes of a historian and describe the past 20 or so years of psychiatry in terms of the major changes to the profession.

One idea shared is in the early days of psychiatry, the focus was on psychoanalysis and talking therapies. Peter, Pearl and Marty comment on the shifts in focus throughout the years. According to Peter, the shift was from psychoanalysis to biological and now it is swinging back to psychosocial and there is a growing realization that art and science are both part of psychiatry (268-69). Pearl places the pendulum at the biological stage and hopes that in the future it shifts toward greater integration of the biological, social and psychological forces (99-100). Marty takes a historical contextual approach and comments on the relationship between the zeitgeist of the decades: from the mechanistic 1950s, to the experimental 1960s, through to the neoconservative approach of brain science in the 1970s until present (306-18). All of the psychiatrists agree that a pure focus on the biological aspect of psychiatry would do a disservice to patients because it cannot offer any complete solution to their troubles. For Nelson, it seems impossible to have a purely technical brand of psychiatry because the honest human relationship is central to the work (84-88).

The characterization of where psychiatric treatment stands today varies among these psychiatrists. For Kitta, “we’re at a wonderful and scary place” (84) because we are learning the causes and finding more specific treatments but the counseling and supportive helps are lacking. Marty explains that psychiatry is “aiming to be a self-important and detached profession” when it should focus on population concerns and integration with the other helping professions, such as social work and nursing (371-75). The needs of patients can get lost when the focus is only on the medication (338-42). Marty also ponders that “instead of responding in science [psychiatry] responded with scientism, it sort of looks like science but it wasn’t so much science” (331-33); “it was like the emperor’s new clothes” (335). Similarly, Dolan is not convinced that psychiatry is on a positive pathway: what stands out is the “loss of humanness in the whole thing” (271-72) and the “physical treatment, physical, physical, physical treatment” (261-62). The focus is on “the quick fix” (258-64).

Dr. Hoffer advocates the use of orthomolecular medicine⁴² to treat mental disorders. He feels that psychiatry has made the wrong choices and “the past 100 years is total tragedy” (474). He feels “awful” about being a psychiatrist and states that he is “often ashamed to tell people that I was a psychiatrist” (475-76). Those who treat mental disorders, according to Dr. Hoffer, should look for allergies or physical causes of the illness and treat those causes (79-83):

Dr. Hoffer: Allergies make up at least 75% of all the people I see with depression. So you have to look at the cause for any physical abnormality. Is it a vitamin problem? Is it a mineral problem? Is it a food problem? Is it a toxins problem? Is it due to a bad relationship? You have to examine why is this person depressed.

Natasha: Hmhm.

Dr. Hoffer: Not promptly throw a drug at them.

Ultimately, Dr. Hoffer says he would feel content with psychologists providing counseling services and general practitioners providing the medication to treat people with mental disorders (249-60). Psychologists are better at doing those tasks, according to Dr. Hoffer, “[s]o why do we need psychiatrists? It should be abandoned, abolished” (256-57).

⁴² Orthomolecular psychiatry can be defined as “the achievement and preservation of good mental health by the provision of the optimum molecular environment for the mind, especially the optimum concentrations of substances normally present in the human body, such as the vitamins” (<http://orthomolecular.org/library/definition/index.shtml>).

Mood disorders in particular and mental disorders in general are commonly discussed using a complex model. Peter describes this “bio-psycho-social-spiritual framework” as “critical” (231-55). In his words, “psychiatry has also realized that symptom treatment, getting people back to recovery, is only one part and a very major part but not the only part” (242-44). Kitta describes the approach as “multifactorial” (72). Similarly, Dolan doesn’t believe that “a relatively rigid view of the illness model” (154-55) helps because wellbeing involves social, mental, spiritual and physical development (70-77). The causes of mood disorders can be far reaching. Nelson notes that personal life experiences need to be discussed when treating patients with mood disorders (19-22).

Discussion

These ideas echo those of McHugh and Slavney (1998), who outline perspectives beyond the disease model. This raises the question of whether the social, spiritual and psychological aspects of psychiatric care are gaining enough attention in today’s practice settings. As noted by Pilgrim and Rogers (2005), psychiatry’s authority is left open to debate when there is a disconnect between the promise of a certain approach (i.e.: biopsychosocial) and the experience of a different reality in the psychiatrist’s office (i.e.: biomedical). It seems that the psychiatrists interviewed agree that such aspects are important for their patient’s treatment. This coincides with Morant’s (2006) finding from his interviews with some psychiatrists and other workers practicing in Paris and London. This author reports (pp.825-26) hesitancy in answering, coupled with themes of difference, disruption and distress discussed in relation to how mental illness is understood by mental health practitioners (82% of cases). Health status of the patient was judged in connection to social impacts, normative behaviour and expectations for behaviour.

Thus, the general focus of psychiatry may have expanded in an effort to integrate the whole person but how well has this translated into psychiatric treatment planning? The acknowledgement of the importance of the counselling aspects of treatment was not acknowledged by Dr. Hoffer, who feels that psychologists are better at it. Dolan, in contrast, fundamentally argues for the link between art and science.

Context Informing Ethical Decision Making

Participants were asked the following questions:

1. What are your thoughts on psychiatrists asking patients to take greater responsibility for managing their use of antidepressants and anti-anxiety drugs?
 - What sorts of activities would management include?
 - Do you think this is common?
 - What are some of the obstacles involved in this approach?
 - Do you encourage patients to do their own research?
 - Do you feel this approach is useful?
2. Have your patients requested drugs by name? How do you feel about these requests?
3. Some patients make the comparison between taking medication for their mood disorder and other patients with physical illnesses (such as diabetes) taking medication for their disease (such as insulin). Do you feel that such comparisons are helpful?
 - Do you feel that this impacts their sense of responsibility?

Patients as active participants in treatment

Results

All of the participants agreed that most patients are better informed about mental disorders today than in years past. Drug companies are one possible source of the information and the aid of the internet is one valuable means of accessing the information (Peter, 105-07; Dolan, 28-29). Some participants display concern that the information from the drug companies might be confusing, incorrect or not useful (Marty, 62-63; Pearl, 22-23; Dolan, 208). In addition, Nelson argues that some information is not based on science (32-34). Dr. Hoffer is extremely skeptical of the kind of information available to patients, arguing that most research is funded by the drug companies who skew results in their favour (123-29). Therefore, patients have no alternatives and there is no real informed consent (120-22). Marty queries whether enough information is geared at the patient audience as opposed to the professional audience (33). Perhaps the general consensus is summed up by Peter, who states, "you have a population that is a lot more sophisticated and questions things" (107-08).

The psychiatrists also agree that patients are often invited to take, and sometimes arrive at the office willing to take, a more active role in their treatment. In Dolan's words, "people are very knowledgeable about what they ask for and what they want" (29-30). Kitta (18-24) and Marty (13-18) describe some of the actions that physicians can request of patients: journal their progress, trial a drug, monitor themselves for side effects, get out of the house, recognize signs of relapse, investigate existing knowledge, attend self-help and support groups, and attend psychosocial rehabilitation. Marty feels that the patient is probably in the best position to avoid problems by doing some of these extra tasks (20-22). This contrasts from the role of patients as recently as 10-20 years ago, where more deference was paid to the physician's opinion (Marty, 55-56; Peter, 105-07). Some patients may even shop around for the opinion they desire (Peter, 136).

There are some difficulties in expecting patients to take a more active role. The degree of patient involvement, according to Marty, "depends on the individual condition and the individual situation" (28-29). Furthermore, Marty doesn't think that educational materials or self-management supports are widely used in psychiatry (43-48). Dolan is concerned that patients may look for negative evidence to support their views. If they see "the half empty glass" (47) then they might ask "why shouldn't I take this and they'll look it up" (48-49).

Collaboration between physicians and patients is viewed by many of the participants as a positive element to the therapeutic relationship. Pearl (10-13) and Dolan (304-07) note that the confidential relationship might be the only place where they can really open up. Pearl argues that this can be empowering for patients. The willingness to discuss the medications, the patient's feelings about taking them, and other elements of treatment are important parts of this collaboration. The "win-win situation" (Dolan, 39) can develop, whereby the psychiatrist "get[s] the buy-in from the patient" (Kitta, 18-19) and "the helper, if you will, gets educated as well" (Dolan, 39-40). For Nelson, it is necessary for the patient to express the choice to take the medication because the patient is a partner (13). Dr. Hoffer is also clear that he is "not ordering" (115) but "just advising" (114) patients, who ought to take an active role in their health decisions.

Discussion

Some participants noted the benefits of collaboration with patients, including the willingness to assist in the treatment, the sharing of information and the necessity of gaining and informed judgment from a patient. The *Madrid*

Declaration (1996) of the World Psychiatric Association encourages psychiatrists to view their patients as partners. This ethic is echoed by some of the participants. Concerns were raised around the quality of the information patients are able to access: sources and motives of companies, accuracy, and understandability. In general, participants note that patients are viewed as being more open to questioning doctors. These concerns echo the discussion of constraints and conflicts that operate within the practitioner and patient communities, and within the space occupied by both, mentioned by Henwood, Wyatt, Hart and Smith (2003, p.604). Indeed, the psychiatrist and patient arrive at the interaction with differing levels of knowledge and there are different expectations placed on each. The lay person may be informed but that state of being is not judged as sufficient for medical persons to rely on lay person knowledge to ground a medical opinion. In other words, the power differential between psychiatrist and patient remains, despite the "empowerment" that some say flows from the "informed patient" state.

Some participants also mentioned the mood disorder as posing some challenges to the patient accessing information and understanding it. This seems like a relevant point for future consideration. How does the psychiatric patient fit within the ideal type of the "informed patient"? Is it perhaps better to think of achieving equity within the relationship, and admitting that value conflicts exist within the medical encounter (Veatch, 1990)? It is difficult to see what this fiction adds to our understanding of psychiatrist patient relations. Furthermore, the pharmaceutical industry has been criticized for providing an exaggerated picture of the effectiveness of the drug treatments (McHenry, 2006). It is clear that the fiction of the "informed consumer" could benefit drug companies, who are eager to sell more drugs and supply drug information to patients. Is their aim to supply relevant, useful information for patients or to increase the potential to sell their drugs? Could it be both? In addition, an open market for psychiatric treatments might initiate greater choice of treatments for patients who can pay.

The costs and benefits of using drugs to treat mood disorders

Results

The participants spoke about the utility of using drugs to treat mood disorders. Kitta (59-61), Nelson (36-37) and Marty (81) mention that there are risks and benefits to taking any drug and the physician is responsible for explaining

these to the patient. According to Peter, physicians should explain even the rare side effects to patients (122-24) and can consult the guidelines for the dosage ranges that might be appropriate in a particular situation (210). Marty questions the quality of this information, suggesting that many studies downplay the side effects leading psychiatrists to feel comfortable over dosing patients on the drugs, often to the patient's detriment (80-81; 221-34). Similarly, Pearl argues that there seems to be "unwarranted faith" in the medications despite showings of damaging side effects (54-55). Dolan appears frustrated with the pharmaceutical industry for recalling good drugs and placing harmful medications on the market: "what do you do with that?" (212-14). Further, Dolan claims that new drugs become "amazingly same old, same old" (144-46) once they have been on the market long enough to realize their full effects.

The utility of antidepressants and anti-anxiety medications has been greatly exaggerated, according to Dr. Hoffer. In his view, this research is focused on "a theory that's never been validated" (331-32). The focus on neurotransmitters "has been accepted as a holy fact but it's not" and "[t]here's some debate as to whether they play any role at all" (333-34). Dr. Hoffer would prefer to use substances that do not cause any harm to heal brain function. These substances include vitamins, in addition to proper nutrition. The focus on drugs can lead patients, who have been on numerous drugs, to sit "waiting for this magic moment when they are going to get their final drug that's going to get them well" (61-62). Dr. Hoffer views this sort of treatment as unacceptable.

Speaking about the overuse of drugs, Dolan, Pearl and Nelson appeared most concerned with the loss of other therapeutic outcomes. For Dolan, a patient will not be able to get over and stay over problems without deeper life changes. In addition, he questions "What happens when there's no more medication, no more access"? (77-80). Pearl expresses that medication can be a good catalyst so long as people are not lost (64), meaning that their needs are being met. Similarly, Nelson argues that drugs can facilitate the process of change but work is needed on the deeper psychological issues (25). Dr. Hoffer, likewise, argues that medications "can be helpful" but they "are being used to the exclusion of anything else" (48-49). Dr. Hoffer states with disdain that psychiatrists often bounce patients from drug to drug because of the many permutations, in an effort to find the right fit for a patient who is becoming increasingly ill (58-63). Only one physician mentioned the medical services plan as a force of consideration for physicians when turning to medications. Kitta argues that the medical plan encourages

short-term solutions, including the use of drugs to treat mental disorders (62-63).

Discussion

The psychiatrists interviewed noted the potential problems with how mood altering drugs are being prescribed currently. The fast output of drugs by pharmaceutical companies, without long periods of trial tests, often leads to recalls once enough people have taken the drug and discovered its long-term effects. Old drugs, which may have done a good job, are taken off the market and replaced. This poses questions for the quality of our regulatory schemes, which have been criticized for their reliance on post-market data and lack of transparency, especially regarding the setting of acceptable levels of risk.⁴³ There is also the difficulty in encouraging acceptance of changes to prescription availability (Maynard & Bloor, 2003), where regulation is implemented. Furthermore, the willingness of some psychiatrists to overdose a patient and/or to use medications to the exclusion of other treatments is a disturbing reality expressed by some participants. These actions fail to show concern for the patient's wellbeing. This might be called a violation of trust (Freidson, 2001, p.216). Codes of ethics aim to make clear the boundaries of acceptable behaviour, creating duties for professionals to uphold. Violations of trust pose challenges for ethicists because of complications in wording and, later, enforcing.

Stigma and medicalizing mood disorders

Results

The stigma of having a mental disorder and taking medication can impact a patient's choice of treatment, or choice to forgo receiving any treatment. For Peter, there is "a bit more openness" about having a mood disorder and this is evident in the willingness of people to discuss it with their neighbours (180-84). It can comfort patients to know that there is something biochemical happening (191). Similarly, Kitta says that knowing there is a biological component can "immunize the stigma" (39-44). Pearl notes that patients can find some comfort knowing that there is nothing to feel guilty about: someone who experiences a backache should not feel guilty and someone who has a mood disorder need not feel guilty (37-8).

⁴³ See the Royal College of Physicians and Surgeons submission to the House of Commons Standing Committee on Health (November 6, 2003).

Yet, Kitta argues that we have a long ways to go in accepting people with mental disorders. Dr. Hoffer agrees, stating that the stigma will not go away “until we can treat it [schizophrenia] as well as the common cold” (458-59). The same can be said for any stigma surrounding mental disorder. He notes that because there are easy medical remedies for tuberculosis and syphilis the stigma has decreased (453-60).

When asked whether it is helpful for patients to compare their mental disorder with a physical disorder, such as insulin dependent diabetes, the answers were varied. Peter and Kitta found that analogy to be somewhat helpful. As noted by Kitta, if your pancreas can go wrong, so can your brain (41-42). This comparison was troubling for Pearl, who prefers to indicate the range of possible responses to problems. She uses the analogy of having a broken car: you can fix it yourself, call a mechanic, see help from friends or let it sit and find alternative transportation. Marty is also troubled by this analogy, saying “you may be telling a mistruth” (84). Whether the medication is as useful to someone with a mood disorder as insulin is useful for a diabetic is questionable. This analogy is effective at encouraging people to take their medication without worrying about dependence: “an antidepressant is not like taking heroin, you are unlikely to become dependent on these medications” (75-76). Medicalization of the problem can improve adherence to the regime (70-89).

Dolan and Dr. Hoffer find this analogy particularly problematic. For Dolan, this analogy is upsetting because it is based on the disease model which “takes away the person’s responsibility for getting better and being well” (62-3) by focusing the attention on someone else or on the medication. For Dr. Hoffer, this is simply what patients have learned: “It’s the idea of one disease one drug. One disease one drug.” (445-46). He notes that it would be nice to simply give one pill to cure depression but “we don’t have these pills yet” (451-52). The need to make changes beyond taking a pill is a message that is lost when patients are taught to focus on a drug cure.

Discussion

Having a mood disorder means something different in today’s social settings than it meant fifty years ago, due to changes in psychiatric theorizing, social attitudes and activism around the issue. Yet, to say that there is no longer any stigma attached would be naïve. To be told that one no longer has the capacity to be reasonable, which is one major focus of psychiatric theorizing (Castel, Castel,

& Lovell, 1982, p.295), is to invite paternalism in all its forms. To be dependent on state funds is to admit that one can no longer take care of oneself; one is dependent on taxpayer money, which is not always willingly given. Persons diagnosed with mood disorders are still heavily regulated and treatment can be forced upon them in certain jurisdictions, including British Columbia.⁴⁴ Furthermore, contact with psychiatry can have a stigmatizing effect, which is not accounted for in clinical descriptions of stigma (Pilgrim & Rogers, 2005, p.2549).

It appears that the analogy between having a mood disorder and taking drugs and having diabetes and taking insulin causes some confusion. When trying to compare the benefits of the medications for each disorder, the analogy seems to lose some of its truth value. However, if the aim was to convince patients that taking the drug is a normal part of their treatment, and their illness state is comparable to others who seek medical attention, then the analogy seems to fulfill that purpose. Of concern is the inability for this kind of analogy to show alternatives, which is an important part of the dialogue between a physician and a patient reluctant to undergo treatment. There should be room for such sensitivities. Perhaps the image of a car breaking down is superior for this reason.

Other Influences Upon Prescribing Practices

Results

One factor that colours the context in which psychiatrists work is the historical shift from talking therapy to a more physical type of therapy. As noted by Marty, psychiatrists may be treating those with more severe mental health issues and other social problems, such as homelessness (237). More than ever before, psychiatrists have been turning to medications, resulting in the increased need to deal with side effects (217-20). However, Marty argues that historically talking therapy was the mainstay and over time it has shifted to using medications that require careful physical monitoring (201-20). He concludes that psychiatrists should be shifting their practices to deal with these changes and if they cannot provide the monitoring, they should share the duties with other clinical professionals (238-42).

⁴⁴ Is the person at serious risk of harming himself or others? An affirmative answer to either can lead to being committed to a hospital for psychiatric care in British Columbia. See Mental Health Act, RSBC 1996, Ch.288, s.22(3).

Dr. Hoffer, as an advocate for orthomolecular medicine, highlights the pressure placed on psychiatrists, by those who regulate the practice, to uphold the same standards of practice. He states most of the orthomolecular physicians in British Columbia have been “gradually suppressed and thrown out” (246-47). The changes to the system cannot be made on an individual level (289-90). He states that modern psychiatry is not a science but a church (357-62):

We have our high priests, our journals⁴⁵, we have our precepts, we have our things we have to do and pay attention to. And if you are not part of the church what are you? You are an outcast. And if they can, they'll kill you and they can't the way they used to but they can take away your license.

One of the problems is self-regulation. He would prefer a working climate where the law is in charge of disobedience, not physicians regulating other physicians (299-301). Another problem is the focus in medical school. He argues that the “major blame has to go against the medical schools who are turning out a group of physicians who are slaves to Big Pharma” (400-01).

The spotlight is shining on the individual patient and her mental disorder when she arrives at the psychiatrist's office. As noted by Marty (342-49), tackling the complex factors that impact the life of someone with a mental disorder would take money; money would be needed to refocus on the whole person and take some of the emphasis away from the defined roles of social workers and nurses. It would also take a restructuring of how psychiatrists earn their money, according to Dr. Hoffer, who argues that the “patient per hour business” of psychiatry means that simply prescribing a drug is the easiest way to make money (367-72). Pearl also worries that people are “getting lost” when talk gets left to the sidelines; people getting lost is a trend (60-63). During her years as a psychiatrist, she too has noticed the increased complexity of cases (92) coupled with greater demands to justify your professional time to administrators who run the office (88-91).

Discussion

As psychiatric theorizing shifts towards a more complex model of mental disorders, the emphasis in practice might be gravitating toward physical treatment. How far one can veer from common practice is a difficult question

⁴⁵ The *Journal of Orthomolecular Medicine* is not carried on Medline, according to Dr. Hoffer who is an Editor (353-54).

because psychiatry is accomplished by common actions (Freidson, 1994, p.25). Furthermore, the power of self-regulation and the tactic of credentialism make it difficult for the boundaries of psychiatry to be overextended. If you fall too far outside common practice, you are causing those boundaries to become fuzzy. It is not surprising, then, that psychiatric professionals who argue for approaches that are too novel or that are not commonly researched will be disregarded.

Managerialism, as noted by Freidson (2001, p.181), is the top-down approach to governing professional decision making. By focusing on the individual client's needs, it becomes easier to monitor the work of physicians. By monitoring the work of physicians, risk is managed. Work is broken down into manageable units. This is key under the administrative principle (Freidson, 1994, p.73). Of concern is the impact on morale of the individual physicians, professionals who are increasingly under supervision by administrators. How do such demands co-exist with the daily duties and expectations? What should psychiatrists be driving at when they "do psychiatry"?

The Pharmaceutical Industry: A Love-Hate Relationship?

Participants were asked the following questions:

1. Some ethical problems resulting from the use of these drugs include failure to monitor medications, overmedication, conflicts of interest, and the severity of reactions caused by the medications.
 - i. What responses are you seeing from your profession in addressing these ethical concerns?
 - Some people have suggested that the relationship between drug companies and the medical profession is at arm's length.
 - How would you respond to this statement?
 - Do you feel that providing education and sample drugs is good practice or necessary?
 - Do patients have access to safe alternatives?
 - ii. Do these ethical concerns receive enough discussion?
 - Do you feel there's a way to discuss them more?

2. What other things do you think pharmaceutical companies can do to help minimize the potentially harmful impacts of their drugs?
 - For example, the makers of apoclozapine, a drug requiring careful monitoring, have created an online tool that allows physicians to track patient blood levels. Do you feel that this is helpful?

Results

The relationship between the pharmaceutical industry and the psychiatric profession evokes the feeling of a love-hate relationship. The industry's money plays a large part in subsidizing medical care. The industry is also aimed at generating profits for the shareholders of the companies. The participants express conflicting views on the "goodness" of pharmaceutical industry participation in advancing psychiatric science. Dr. Hoffer is the most critical claiming that the industry has lied in producing drug after drug, with the promises of drugs that are "better," "safer," and "not addictive" (41-46). All agree that the relationship between psychiatrists and pharmaceutical companies should be viewed with caution, meaning ethical concern.

All of the participants, with the exception of Nelson, note that the psychiatric profession is more aware today than in years past of the potential for conflicts of interest. Peter, Kitta, Dolan and Marty agree that the days of lavish trips and extravagant promotions are over. Dolan notes, "the seduction is cut out of the whole thing" (226). Screening of speakers at conferences and the meetings between the Colleges and the companies are two other features of this improved relationship. Peter describes the relationship between the pharmaceutical industry representatives and the physicians as being "at arm's length" (72). Kitta echoes this by noting that the relationship is not nearly as intrusive (53).

Marty provides a neat summary of what he considers to be the state of conflicts of interest and psychiatrist awareness today (132-34):

[T]here has been a response and the average psychiatrist would certainly probably feel uncomfortable with wholly swallowing information that came from the drug industry and recognizes that there is conflict of interest.

Perhaps it is this awareness that leads to a feeling of moral superiority, the notion that "I cannot be bought by a company". Peter notes that professional discretion is key in the minds of some physicians:

Certainly a number of physicians really take exception to that. Their feeling is that they aren't people who can be bought and they'll prescribe what they want to prescribe. (84-87)

Peter questions whether this can be so. Dr. Hoffer rejects that this can be so: "[w]e all know that's bull—don't we?" (158). On the other hand, Kitta argues that physicians are capable of making their own judgments on these matters, for instance when they listen to a presentation by a "hired gun speaker" (53-54).⁴⁶

Opinions among participants diverge on whether the relationship between psychiatrists and the pharmaceutical companies is an "arm's length relationship". Kitta and Peter are not troubled by the relationship. Peter describes it as an arm's length relationship (65). For Kitta, a psychiatrist's choice of medications isn't really influenced by the companies, who are less intrusive today than in the past (53). Pearl is much more conflicted and says that psychiatrists must ask if there is a vice placed on them by the pharmaceutical company (80-83). She notes that they have tried to suppress negative research findings and are in the business of selling drugs (80-83). Dr. Hoffer expresses similar concerns, asking "[t]o what purpose" is the drug company money being provided (172-78). He argues that so long as researchers and physicians don't discuss alternatives, then the money keeps flowing. Likewise, Marty states that the "problem is there has developed collusion between psychiatrists in general and Pharma and often with the suspension of adequate examination of the ethical issues and the concerns that are involved" (106-09). Dolan (182, 161), Marty (137-141), and Dr. Hoffer (419) are comfortable discussing the lobbies and large political forces behind the industry.

How heavily should psychiatrists rely on pharmaceutical companies for educational support, research support and free samples or tools? These questions provoked a range of responses from participants. Not only is the relationship improving, but according to Kitta (49-56) and Peter (58; 68), pharmaceutical companies are doing good work by conducting research, promoting more tight regulations around conflicts of interest, and providing educational opportunities. Kitta argues that when they provide drug samples for patients to test, they are often in need of a change and trying out new drugs could be an economic burden for patients (51-53). For Pearl, the right thing for the companies to do would be to provide drugs on a compassionate basis (80-101). Unlike his fellow participants,

⁴⁶ The "hired gun speaker" is one who has received funding from a company in exchange for producing research results that are pleasing to the company.

Nelson appears not to be bothered by the relations between psychiatrists and the pharmaceutical industry because the source of good information and good monitoring technologies is immaterial (65-66). For Nelson, physician evaluation and opinion, based on science, is the most crucial factor (68-69).

Dolan and Marty are the most vocal about the problems with the pharmaceutical industry's assistance. The changes encouraged by the pharmaceutical industry might not be in the best interests of patients, as noted by Marty in the following statement (269-273):

It's just as likely that they [the pharmaceutical industry] could implement a change that may actually be harmful because more people are getting say antidepressants with mild depression that actually don't need them, are getting ill from the medications they didn't need in the first place and are having many other problems, which is actually a very common, prevalent problem.

Marty also feels that continuing education, if it is set as a priority, should be funded by the government (145-50); it is "a ridiculous idea" (150) to have drug companies control this education. According to Dolan, it isn't a question of implementing minor changes, the very relationship itself ought to be examined (188-92).

The offering of online monitoring tools received mixed reviews from the psychiatrists, none being surprised at the availability of such technology. It is most important, according to Peter (162) and Dr. Hoffer (317-21), that a physician attend to the patient's needs and observe them; a monitoring tool is not needed for these tasks. Pearl didn't know if she would try it because she would question why institutions don't use similar technology (74-75). It might just be another selling gimmick. Dolan sarcastically comments that if he was into giving drugs, he'd love that tool (156-61). He compares pharmaceutical companies with casino owners:

It's a lot like you can open countless casinos but as long as you have a phone number available for anyone who's got a gambling problem, it's all ok. (188-90)

Dr. Hoffer views it as a terrible compromise, "it's like putting foxes in charge of the henhouse" (189-90). He recalls that in the United States, Eli Lilly will approach a State and offer their monitoring of schizophrenic patients on contract, ensuring that their drugs are used; they will send out instructions to the physicians.

Discussion

The willingness of medical professionals to accept the “generosity” of pharmaceutical companies has received great criticism. For instance, Lexchin (2001) and Kassirer (2005) have been vocal about the need to curb the alliance between the pharmaceutical companies and the medical profession. For some of the participants, relations between the pharmaceutical companies and the psychiatric profession have been normalized. The relationship can sometimes be justified by looking at the good that these companies do for the profession and for patients. For other participants, the relationship is risky because of psychiatrists’ inability to maintain control over research directions and patient care. There was limited concern with the role of the government in providing leadership in patient health.

The participants, on various levels, discussed the interests of the pharmaceutical companies and their feelings as physicians accepting the “generosity” of these companies. Brody (2007, p.24) argues that medicine has an internal morality, based on the standards of the medical community, whereas pharmaceutical companies adhere to a different standard where profit is key. In his view, the public would not accept an ethic that focuses on profit-making as being the acceptable standard for medical professionals (p.24). For Brody, the divestment strategy would see physicians refusing freebies and perks from pharmaceutical companies, with the relations between journal boards, academics and medical societies and pharmaceutical companies being regulated based on acceptable levels of investment (to be determined through careful scrutiny).

Similarly, under Freidson’s (2001, p.218) conception of professionalism, “the *maximization* of profit” is “antithetical” to its ethics. A political economy that supports such a motive is working against this model of professionalism. Greater support for the medical establishment by government and the public would be needed to ensure that professionals can do the best work they can, without undue interference from those with profit motives. Of course, this doesn’t solve the problem of “the greedy physician” who would work to bend the rules in her favour regardless of the payer source.

Brody (2007) also discusses an interesting observation by Leonard Weber (p.28): pharmaceutical companies are doing good by running successful businesses that employ many people, providing potentially life saving medicines, and doing charitable work. The case of ciprofloxacin is cited. In 2001, the United States courts ruled that the company must provide this antidote to Anthrax

poisoning even if it means a loss of profits. Why? Anthrax poses a great danger to public health. Some companies, such as Merck, do seemingly selfless work. Ivermectin, a cure for river blindness, has been supplied to African nations for free by this company.

What areas of corporate life demonstrate a caring, and profitable, business ethics? Green initiatives encourage businesses to care about public health by taking responsibility for environmental impact. For example, a company may switch to using a more environmentally sustainable product in their manufacturing. These changes take time to occur and are sometimes resisted. However, the connection between profit and responsibility makes green initiatives more attractive for corporations, coupled with regulatory initiatives mandating penalties. If businesses can change their behaviour in a way that serves customers, makes profits, and is gentle on the environment, then perhaps pharmaceutical companies can bend their practices to reflect patient health and safety concerns.

Basic Ethics vs. Ethics Plus (+)

Preview

Professional medical ethics could be divided into *basic ethics* and *ethics plus*. The basic ethics is sufficient to fulfill one's legal and professional duties. Ethics plus (hereinafter "ethics+") is the actor's sense of integrity and perceived ability to use discretion, and their personal sense of honesty and judgment when doing their work within the given social and institutional context. Basic ethics is the codified sources of guidance. Ethics+ refers to a personal experience of doing one's work with integrity, discretion, honesty and judgment. The context in which one works has a symbiotic relationship with the actor's sense of ethics and ability to make such judgments.

The *Concise Oxford Dictionary (9th ed.)* defines discretion as "(3) the freedom to act and think as one wishes, usually within legal limits" (p.386). Ethics+ is the professional's reflections on whether there is freedom to meet the ethical standards to be best of his/her abilities. It is the professional's own sense of fulfilling his/her duties. Integrity is also associated with this idea of ethics+. The same dictionary defines integrity as "(1) moral uprightness; honesty" (p.707).

Ethics+ includes the professional's sense of honesty in fulfilling ethical duties. These concerns impact how a person relates to him/herself as "professional".

What I have termed "basic ethics" might be best associated with Freidson's (2001, pp.216-17) idea of "practice ethics", or those problems of ethics arising from the work practice. The "ethics+" concerns are more closely connected with Freidson's (1994) occupational principle, including "the informal attempts of all workers...to do their work as they see fit on the basis of their own sense of knowing how to do it"(p.73-74). These ethics+ concerns are among the "moral problems of work" that Freidson (2001, pp.216-17) describes as being created by "economic, political, social and ideological circumstances". These circumstances are deemed to be part of "institutional ethics", by Freidson.

An example might help clarify the difference between basic ethics and ethics+. If a psychiatrist is working at a busy clinic, with limited resources and little time available for each patient. Some of these patients have other pressing problems, such as lack of adequate housing and food. Basic ethics can guide the psychiatrist during the clinical encounter, creating obligations such as clear explanation of treatment options and gaining informed consent to treatment. Ethics+ concerns can easily arise in this case. The psychiatrist forms a perception of her ability to make good ethical choices in these conditions, due to the social pressures and limitations imposed by the biomedical model. She is faced with time pressure, with limited treatment options, and with a small number of issues she can help with. She may feel capable of doing more, of providing a higher level of care. These are ethics+ problems.

Results

The participants discussed, in great detail, the concrete actions that psychiatrists should take when treating patients with medication. Nelson provided an almost textbook definition of the care involved in prescribing medications: look for dangers of drug interaction, know your patient's drug regime, take patient characteristics into account, be cautious and not too aggressive (42-46). He was also clear to point out that the patient's informed consent is needed and the patient can withdraw it at any time (92). If a patient does not want drugs, then the physician should treat the patient with psychotherapy (78-81). Making yourself accessible and following-up are tasks discussed by Kitta (56-59) and Dolan (104-08), who also mentions the necessity of asking the right questions. Dr. Hoffer puts it simply: "giving patients whatever I

can following that old medical principle ‘do no harm’” (12-13).

Despite an understanding of the ethical obligations, the problems involved with wrongful prescription continue to impact patients. These problems are huge, according to Dolan and Marty. For Dolan, the answer is short: “I think this whole paradigm has to change” (136-37). Pearl mentions that many physicians have a cavalier attitude towards drugs and giving these drugs has become normalized (55-57). Indeed, she argues that a pill cannot do everything and when we set it up as something that does, then problems arise (62-63).

For Marty, two important concerns emerge. First, psychiatrists have not equipped themselves with the skills to deal with physical examinations of patients (238-42). Second, “it’s still up to the individual’s ethical standards to abide by the guidelines” (128-30). According to Marty (125-28):

The problem with those things [guidelines] that have been instituted is that they are voluntary and people disagree with them and decide that they are not willing to abide by them and there’s not likely to be any consequences.

Peter, in contrast, says that psychiatrists “have a lot of what they need” (150) in order to fulfill their ethical duties. Monitoring tools are available in British Columbia via the PharmaNet resource, although none of the participants mentioned this tool as something they were using or something that ought to be used.

One recurring theme in the interviews was individual physician responsibility for ethical decision making. For Peter, it is a legal responsibility to keep patients aware of the relevant information, including side effects, and there is sufficient information and resources around the use of drugs. Dolan argues overmedicating is “not being responsible” (106-08) and a person should not be allowed to prescribe if they are irresponsible. Further, Dolan argues that “access to resources depends on the degree to which the physician himself or herself accesses those resources” (84-85). Nelson also mentions that the public expects high standards and the professional must be responsible (48-49). Finally, Pearl mentions “the individual psychiatrist should hold fast to psychiatry” (83). For instance, it takes “personal resolution” to resist the drug company lore (52-53).

Dr. Hoffer takes an opposing view—any physician who fails to explore alternatives is being irresponsible. He argues that “[a]ll the double blind control studies show that the efficacy of antidepressants is maybe 60% compared to an effect of 50%” (96-98). Dr. Hoffer states, “it’s physician ignorance rather than negligence” (282) that causes problems with treating mood disorders. He

summarizes his position as follows (99-103):

...if you have any disease which is killing for which there is no treatment, you can try whatever you like so long as it is better than the alternative. But when you have an alternative which is safe and economical and can be used and practical and is not used, in my opinion it is malpractice.

The current state of psychiatric practice ought to change, in his view. Dr. Hoffer sees "a total disregard for the patient" when physicians are using the drugs as they are. A psychiatrist must also "be a good internist" (264-66).

Dr. Hoffer would like the focus to be on helping patients lead normal lives. He states, "My only conflict of interest is my desire to get people well" (153-54). He finds it hard to understand why the word "cure" doesn't appear in the psychiatric dictionary when he has a simple definition: "free of signs and symptoms, getting along well with the community, getting along well with their family, and pay income tax" (407-09). It's a problem that psychiatrists "don't even know when a person is well or not" (410), according to Dr. Hoffer.

Kitta, Dolan, Pearl and Marty discuss concerns that are best thought of as ethics+ concerns. Kitta notes that "it's a question of providing the best care possible or good care for a larger number of people" (68-69). For Dolan, the problem is doing psychiatry within the narrow confines of the disease model: "this whole paradigm has to change" (136-37). At the end of the interview, he describes a "loss of humanness" (271-72) in psychiatry and a longing for the days when psychiatrists weren't pressured, by society and by the profession, to prescribe medication or stop seeing a patient who refuses (250-58). He conveys a sense of longing and grief by stating, "I have a loss in my heart for it [psychiatry]" (315-16). For Pearl, the practice of psychiatry has become more managed and this can take away from other important tasks. She questions, where is the bottom line? Should it be patients, or dollars, or both? (95-96). Marty approaches the issue from the point of view of one who practices psychopharmacology. These psychiatrists did not start "necessarily because of the demand but because they truly believe that this is the way for people to live better lives and to be free from pain and suffering" (321-26).

The participants had varied opinions on whether enough dialogue is happening within the psychiatric profession around the ethics of prescribing. For Peter, more dialogue is happening today than ever before, guidelines are being published, and disclaimers are issued (80-99). Dolan takes the opposing

view, stating that within the medical profession it is difficult to have this kind of dialogue (111-14): “the medical model doesn’t lend itself to a lot of that”. Marty’s views are more on par with Dolan’s, stating that trainees have many chances to discuss ethics but when in practice the opportunities dry up (160-63). He notes “there is very little discussion of these kinds of issues” (180-81).

If there isn’t an adequate dialogue happening now, is there any hope of changing this situation in the near future? According to Marty, it is possible that the Royal College of Physicians and Surgeons might set this sort of dialogue as a priority, perhaps as part of the requirement for continuing education (184-87). Marty is not hopeful, especially in light of the absence of discussion around serious issues, such as legal proceedings against local psychiatrists involved in patient sexual assault (171-76). Dr. Hoffer is even more skeptical, saying that Canadian psychiatrists would simply ask for more money, claiming that they are doing the best they can when confronted with allegations of doing an inadequate job (485-86).

Discussion

Medical ethics are steeped in tradition and the duties of physicians are relatively well known and articulated in the various Codes of Ethics, Policies and Guidelines of the Colleges of Physicians and Surgeons and Medical Associations (see “Regulating Prescribing Practices of Psychiatric Professionals, Do No Harm: Professional Medical Ethics” above). *Gain fully informed consent before treating a patient. Above all, do no harm. When you cannot perform adequately, you should not perform the task but refer the patient to another physician. Each physician is responsible for carrying out these duties, or face internal and sometimes legal consequences. Give the best possible medical care—a physician has a fiduciary, trust-based relationship with the patient.* These fall under the purview of basic ethical concerns.

A paradigm change and the need for individual responsibility are two key points raised by the participants. The control of wrongful prescription and its accompanying problems are challenging because their roots are in the use of prescription medications. Perhaps this standard needs closer examination: are these drugs being overused and are we focusing too much energy in this direction? Individual physician responsibility is a problem but it seems to be a truism at first glance. Without personal dedication to high practice standards and to ethical treatment, a physician will cause harm. Knowing the principles of ethics does not always translate into good actions.

The reality of practicing modern western medicine—in this case, psychiatry—is that physicians are not one wo/man shows. Gone are the days when the physician arrives at the door of your home, black bag in tow and sometimes hospital carriage on stand-by. Instead, the physician operates within a larger system, with administrators, billing agents, research scientists and patient/consumers making distinct demands. Kitta, Dolan, Pearl and Marty's ethics+ concerns highlight the strains of working within this larger system.

Denney (2003) calls today's professionalism a "managed form of professionalism" (p.74). For Freidson (2001), reality is a mixture of managerialism, consumerism and professionalism, the three logics. The personal experience of the worker can get lost amidst such discussions. Perhaps that is why Freidson talks of the soul of professionalism as tied to making free choices: what attracts professionals to their work, what motivates them to do good work, and why do they use their discretion to work in novel ways thereby changing practice for the better?

Conflicting opinions emerged as to whether there is sufficient dialogue around the ethical concerns involved in prescribing antidepressants and antianxiety drugs. Without a priority being set for the discussion of these matters throughout a physician's career, it is difficult to foresee any changes being made in this direction. In order to set this as a priority, there must be some level of agreement that a problem exists and deserves time and attention.

The Future of Psychiatry

Results

The participants were asked to speculate as to what the next fifty years might hold for the work of psychiatrists. For Kitta (82-89), Pearl (106-08), Nelson (84-88), and Dolan (279-98), a future where psychiatrists are reduced to the role of dispensing drugs is bleak and they express discomfort with this prospect. Nelson and Dolan also express the loss of humanity involved in resorting to the use of computers in providing psychiatric treatment to patients. The ability to pinpoint specific causes and offer more targeted treatments, especially for the most serious mental disorders, was discussed hopefully by Peter (271-81), Pearl (104-05), and Kitta (82-89). The integration of biological, social and emotional factors, on a larger scale, was discussed by Pearl (99-105).

Dr. Hoffer is optimistic that orthomolecular medicine will become mainstream

but it will “be very slow and tedious, with a lot of infighting and bickering with the drug companies doing their level best to protect this information” (494-96). He states, “I’m hoping that it [psychiatry] will be a lot more sane” (478). He also advances an idea of slow change, where people advocate for a better means of treatment. Dr. Hoffer notes, “I think it’s going to take fifteen to one-hundred years before we become so intelligent that we realize that we mustn’t harm our people” (197-98).

Another changing aspect of the profession, noted by five of the participants, is the impact of the shrinking number of psychiatrists. This is partially due to mass retirements and a low number of new recruits. Peter (273-78) and Marty (375-77) express the view that as the numbers of psychiatrists decreases, other helping professionals will take their place. Peter speculates that the role of psychiatrists may become more focused on the medical model, while others will deal with the psychosocialspiritual components of patient care. Marty argues that the replacement professionals are “less expensive and more valuable”. The young psychiatrists who are entering practice are viewed with a critical eye by some participants. Dolan, who views himself as “a dinosaur in a sense”, feels that the younger professionals are “more into money, technology, the business”, which makes psychiatry “a different sort of animal” (285-89). Pearl hints that the “younger generation are in touch with different things” (106-07). For Dr. Hoffer, “[t]radition is so important in medicine” (382-84) and the medical schools are “letting the drug industry take over the teaching of how to use drugs” (182). Therefore, Dr. Hoffer does not feel that psychiatrists are taught any new approaches or alternatives to treating mood disorders.

Speaking for psychiatry in general, Marty and Dolan offer two visions for the future. Marty comments on the necessity of psychiatry to respond to the real concerns of the population and work with other professionals in order to solve the problems at hand. In Marty’s words (352-54):

I think that psychiatry is at a kind of cross-roads. It will either respond to the real needs so that the population can survive or it will suffer a lot and will become extinct, or become even less relevant than it is now.

Dolan, in contrast, looks at the quality of treatment being provided at the physician-patient level. For Dolan, the answer lies in rediscovering the aims of treating patients (300-02):

I would love to have nobody to see. Truly. That is what I hope for. I hope that the helpers and healers become real helpers and healers. Which really hasn't got anything to do with pushing buttons and writing prescriptions. That's what I hope for.

Discussion

Some participants express faith in the power of science to advance such that better treatments are found, more specific and smarter. There seems to be a hopefulness on the part of some of the participants that psychiatry can survive and not deteriorate into a profession where physical science is the only form of practice. Of course, for Dr. Hoffer, this would be the best case scenario because physical causes are key to treating our mental problems. For Dolan, this would be the worst scenario because psychiatrists would not be acting to their full potential as "healers". Dolan views mental problems as complex, irreducible to purely physical causes. These questions are real because the death of institutions and their grizzly afterlife is a probability, as evidenced in Beck 's (1994) conception of "zombie institutions" (p.40). For Marty, psychiatry is already becoming useless for many people and a critical direction must be turned. Furthermore, most participants were not optimistic that the next generation of psychiatrists would fair any better than the current generation of psychiatrists at proving the value of the profession to the public.

CHAPTER FOUR: IMPLICATIONS

The Re(viewing) the Research Process

For this project, I conducted individual, face-to-face qualitative interviews with seven psychiatrists from Vancouver, British Columbia and the surrounding area. In this flexible and emergent process, I was guided by two mission questions. First, what, in the views of the psychiatrists, is the impact of prescribing mood altering drugs on their practice of psychiatry? Second, what, in the views of the psychiatrists, are important or needed ethical obligations when prescribing these drugs? I opted to use the Framework method of analysis (Ritchie, Spencer, O'Connor, 2003) as a means of organizing and dissecting the data. The approach provided a means of making sense of the viewpoints of Kitta, Dolan, Marty, Nelson, Pearl, Peter, and Dr. Hoffer. I also intended to provide sufficient details for readers, so that others can draw their own meanings from the data.

This project has various limitations. The seven case studies presented cannot provide, nor are they intended to provide, a representative view of psychiatrists in British Columbia, or elsewhere. A researcher who has connections within the local community, or perhaps using online survey methods which are less time consuming than interviews, might be able to achieve a higher participation rate. However, survey methods do not always ensure high participation, as evidenced by the Mayo Clinic study (Lineberry, 2007). In addition, the aim of protecting participant confidentiality seemed to limit the workability of the chain referral sampling technique. Utilizing an informant, who would make connections and contacts, might be one means of improving on the sampling for this kind of study. The majority of participants are male. The psychiatrists are also seasoned to the work, which might impact their views of this problem. Hence, different psychiatrists in different locations, at different stages of their careers, might hold differing opinions on the ethics of prescribing. Likewise, a closer focus on comparing different jurisdictions and their efforts to address wrongful prescription could assist us in understanding the problem. I also could not address a number of important concerns, including the impact of gender and concurrent substance abuse problems.

This study presents the views of a limited number of psychiatrists who chose to participate in the research. Many psychiatrists contacted declined to participate. The views of these others might be very different from those of the

psychiatrist participants. It can be speculated that they have little problems with the way antidepressant and anti-anxiety drugs are being used, or that they feel the administrative and legal bodies responsible for overseeing negligence are the ones tasked with finding solutions to any concerns. Alternatively, they might have declined due to time constraints or simply not wanting to be interviewed, yet they may share similar concerns.

To be of any merit, a qualitative study must be judged to be trustworthy. Providing varied bases of comparison would be one means of bolstering the trustworthiness of this study. As noted by Arskey and Knight (1999, p.21), "rather than just gather[ing] data from one particular group with an interest in the study, you could seek out the views of several sets of stakeholders and, in that way, provide a comparative aspect". This is triangulation. Possibly non-psychiatrists, naturopaths, pharmaceutical industry experts, or patients would have different points of view. Focus groups with different stakeholders, possibly through an online venue, would be a start in the direction of opening up dialogue, possibly representing a form of action research. Observing behaviour in a clinical setting would also provide validation of the ideas shared by the participants.

Dependability and credibility would be bolstered if participants could be given a greater opportunity to explain their ideas. One means of clarification would be for the researcher to do more work at the front-end of the study, gaining psychiatrist meanings and then drafting appropriate questions. Another possibility would be to ask participants to create maps of their ideas about ethics, such that the complex ideas are made more understandable to others. The keeping of an ethics journal might also be one way of receiving a time sensitive account, one that might be alive with examples and greater detail. The provision of scenarios for comment might also allow for more in-depth questioning.

Re(capturing) Participant Opinions

Psychiatrists work with patients who are generally more active in the relationship than their counterparts of fifty years ago. It is generally viewed as a good thing for patients to be in agreement with the treatment and show an interest in the treatment plan. The growth of the internet and advertising access by pharmaceutical companies have expanded the transmission of marketing information about the newest drugs. Many participants questioned the quality of the information that patients could access. Dr. Hoffer argues that patients have been offered the message of "one disease one drug" (445-46). Furthermore,

patients are able to be active participants to varying degrees, given the severity of their illness and personal factors. It seems that patients continue to experience stigma due to their diagnosis, although that stigma might be lessening given the growth in the number of persons taking mood altering drugs and the biological approach yielding the ability to medicalize depression and anxiety.

Patients sometimes require convincing by their psychiatrist to take the prescribed medication. Some psychiatrists worry that the explanations offered to patients are only somewhat truthful. Whether an antidepressant or mood altering drug is as effective as insulin is for treating diabetes obscures some important concerns, namely the social factors involved in mood disorders and the relatively low success rate of antidepressant drugs over placebos. Relieving self-blame is also of importance but some care is needed to remain truthful. Another concern is the relative lack of alternatives and patient-focused information sources. Dolan questions this, stating that psychiatrists can access other resources but they might be unwilling to do so (84-85).

There is concern by some that psychiatrists have placed "unwarranted faith" in medications and have a cavalier attitude when it comes to prescribing (Pearl, 54-57). For Dr. Hoffer, medication can be "helpful" but "it's being used to the exclusion of everything else" (48-49), namely safe, economical and practical vitamin and mineral therapies (99-103). This faith in medications might stem from the growth of science side of psychiatry. Marty argues that psychiatry responded with "scientism" and "it was like the emperor's new clothes" (331-35). Hence, some psychiatrists feel comfortable narrowly focusing on prescribing drugs and various combinations of them, sometimes overdosing patients, because they believe in that science and feel "they aren't people who can be bought" (84-87). Therefore, psychiatry is "at a wonderful and scary place" (Kitta, 94). The growth of new technologies are opening up clues to how the brain functions and this might lead to more specific remedies for serious disorders. On the other hand, scientism with a blind faith in medication to the exclusion of other issues can yield a cold brand of pseudo-psychiatry. A brand that shows psychiatry to be self important and losing relevance (Marty, 371-75).

The need for individual physician responsibility is a key point made by the participants. Peter argues that physicians "have a lot of what they need" (150) to fulfill their duties. The participants also viewed pharmaceutical companies with skepticism and had mixed reactions about their involvement in medical care. The research dollars and samples can benefit psychiatrists and their patients, and the

capacity for conflicts of interest have been discussed and guidelines drafted. On the other hand, the aim of drug companies is to generate dollars, not safeguard patient wellbeing. Dolan likens this to casinos who are doing good so long as they open a phone line for problem gamblers (188-90). For Marty, net-widening is a “very common, prevalent problem”: people with low levels of depression are medicated and they don’t necessarily need medication.

Individual psychiatrist responsibility for patient harm due to wrongful medication is stressed. There was also concern expressed around institutional ethical concerns—those social and economic factors that impact ethical choices. This is the point where ethical action meets one’s feelings on their ability to meet those goals, within a given social context: ethics+ concerns. The toss-up between providing good care for many or the best care for the few (Kitta, 68-69), the administrative work that surrounds work in some clinics (Pearl), and the push for providing physical treatment (Dolan) were mentioned as significant concerns. Individuals too need guidance and speaking about ethical concerns is one component of generating solutions to the problem of wrongful prescription. There may be more dialogue happening today about these ethical concerns than years ago, but is there enough dialogue, what is the subject matter for discussion and at what stage of the professional career does that occur?

Marty also notes that the individual psychiatrist is largely responsible for his own ethical commitments because the regulations are voluntary (125-28). Although regulation on ethical matters may be left up to the individual, Dr. Hoffer would argue that in the “church of psychiatry”, the heretics are quickly dealt with through excommunication, at great personal and professional peril (357-60). He notes the rigidity of those rules as they relate to some physicians who lost their licenses for their practice of orthomolecular medicine. The utility of legal sanctions and the responsibilities of the government were only mentioned briefly in a few of the interviews.

The history of psychiatry shows the great malleability of this science. The chameleon changes its appearance to suit its surroundings as a defense mechanism. Perhaps the many appearances of psychiatry is also a defense mechanism for the survival of this profession. For Marty, “psychiatry is at a kind of cross-roads” (352-54). A greater understanding of the physical factors involved in depression holds the promise of providing more focused treatment options. Is it possible to ensure that people don’t get lost (Pearl, 54-55) amidst growing interest in (and some say exclusive use of) the biomedical approach. Will

psychiatry respond with more than simply some new clothes, holding remedies out before the public as cure-alls. If, as suggested by Dr. Hoffer, the “foxes [are] in charge of the henhouse” (188-90), then what might this mean for psychiatry’s future. Will the role of psychiatrists be relegated to distributing medications and conducting research on the brain? Can it, and should it, aspire to be more?

Re(assembling) Insights

Patient Characteristics and Drug Treatment

The distinction between expert and lay knowledge is problematic (Morant, 2006, p.833) because medical judgments are seen as involving a “ubiquity of values” (Veatch, 1990). The fiction of the “informed patient” casts further doubt on the once sacred place of physician opinion. This fiction depends on a patient who is interested and able to inform themselves, who is articulate and willing to challenge physician authority, and on a physician who is open to that dialogue (Henwood, Wyatt, Hart & Smith, 2003, p.164). This fiction is even less believable when you have a person who is often judged to be of unsound mind, and whose access to resources and ability to research health matters might be limited. Veatch (1990) argues that within this context, the practice of writing prescriptions will “collapse as [a] conceptual muddle” (p.24). If freedom and safety are not matters for physician judgment (Veatch, 1990, p.32), then the need for equity within the physician-patient relationship becomes crucial (Henwood et al., 2003, p.604).

Bioethics seems to suggest that psychiatrists ought to be concerned with patient collaboration, which serves to invite trust on the part of the patient. The place of power and values within the relationship is not highlighted to the degree it deserves. How close does the psychiatric clinical encounter approach a negotiation, with the “maintenance, restoration, or promotion of the patient’s autonomy” being “determined by negotiation” (Childress & Siegler, 1984, p.141)? If I were entering into negotiations, I would choose a seasoned mediator, armed with the best information and the best rhetorical skills to represent me. Patients do not have such an option. The packaging of the partnership metaphor fits the development of the fiction of the “informed patient”, who arrives ready for mutual participation and a sharing of power in the interdependent interaction. The compromise and exchange of services, made visible by the rational contractor model, are largely hidden in the partnership metaphor. Although the therapeutic goods of having a patient as a partner in their own health care cannot be

overlooked, a metaphor or model capable of capturing the power dynamics involved and the conflict inherent in the relationship would be useful.

What kind of a future worth living is being offered to patients with mood disorders (Mattingly, 2004, p.74)? Are patients encouraged to consider possible alternatives to accepting drug treatments as remedies for their mood disorders? Atkinson (1994) argues that “the production, reproduction and use of medical knowledge” (p.113) is the work of physicians, who use “written and spoken rhetorical formats” to convey meaning (p.115). The prominence of the disease model (McHugh & Slavney, 1998, pp.14-16) and weighing of risks creates challenges for psychiatrists faced with a more questioning patient population. The perfect patient is one who is aware of the possibilities for treatment, can actively take part in education, and is capable of self-care (Becker, 2005) and monitoring to ensure the chosen treatment is carried out. The impact of such regulation on one’s life must be a weighty prospect (Busfield, 1996, p.233), and it is often one that remains hidden until the patient has accepted treatment and is living with the label of “mood disorder” (Penfold & Walker, 1983, p.188).

The grand claims of drug manufacturers, without the associated years of research required to make valid and reliable claims on efficacy of some of the drugs, seem to encourage anyone feeling sad or worried to ask their physician about a drug remedy (Van Praag, 2003). Patient illness falls on a spectrum of severity, as does psychiatrist intervention in terms of invasiveness and restrictiveness. “Therapy of the normal” (Castel, Castel, & Lovell, 1982, p.263) is not abstract, living within the pages of a science fiction novel, but seen creeping into reality with the growth of lifestyle drugs (Lexchin, 2001) and the expanding base of disorders in the *Diagnostic and Statistics Manual* (Kirk & Kutchins, 1992, pp.10-11). Drug companies, with their focus on expanding profits, are providing new drugs for whatever ailments are seen as “medicate-able”. For patients who arrive at the office of a psychiatrist, the physician provides an important schema for understanding their problems. Hence, very characterization of a mood disorder is an important concern, as there is a vast difference between the analogies of “a broken car” and “taking insulin for diabetes”. Therefore, guarding against “therapy of the normal” is another important concern when discussing patient sophistication.

The collusion between the pharmaceutical industry and psychiatry casts an ugly shadow on fiduciary obligations. It is easy for psychiatrists to be armed with drug company materials, promoting SSRIs (see *Appendix 1: Classes*

of *Antidepressants*) as the best treatments (Brody, 2007, pp.300-04). It takes a responsible psychiatrist to maintain an eye toward providing more. Although some psychiatrists would take offence to the suggestion that they can be anything but objective (Brody, 2007, pp.37-38), patients are depending on the strength of the convictions of their psychiatrists. This is echoed in the caution provided by the Royal College of Physicians and Surgeons of Canada to eliminate conflicts of interest and minimize or eliminate their effects when they cannot be avoided. Although it seems that many psychiatrists would be aware of the dangers of conflicts of interest, the more subtle harms created by limited resources and treatment options are more difficult to create awareness around.

As one of the three logics (Freidson, 2001, p.181), professionalism demands that the professional remain the bastion of sound information, academic freedom, and trustworthiness. The further one strays from these ideas, the more open to questioning professionals become, casting doubt on their claims of exclusivity and power over their field of information and technology (Freidson, 1994, pp.173-75). Doubt on the part of patients and other members of the public need not paralyze the growth of psychiatry, but provide a reconsideration of how drug treatments are related to doing psychiatry (Becker, 1996, p.33). Careful and controlled prescribing, and a questioning of this approach (Leszcz, 2001), thwarts fears that psychiatrists are gambling with patient welfare.

Monitoring Patients, Information Keeping, and Aggressive Prescribing

Principles of Management (Reesal & Lam, 2001) and Codes of Ethics (Canadian Medical Association) put into words the ethical obligations of psychiatrists when treating patients with mood disorders. An approach that relies on the provision of antidepressant and antianxiety drugs necessitates the need to physically examine patients, a task that was remiss with the older talking therapies. The addition of administrative tasks and managed work (Denney, 2003), the patient-per-hour fee schedule, and a general partition of each individual health care professional into separate working units provides further pressure on psychiatrists working within that context. Problems with record keeping should be red flags (Atlantic Provinces Medical Peer Review Program). The pharmaceutical companies along with the government (PharmaNet British Columbia) have tried to step-in in various ways, to assist in the management of patients with mood disorders.

Drug safety, especially post market surveillance, and aggressive prescribing, such as over-dosing patients, raise serious concerns for patient welfare (*Little*

Helpers, 2003). Despite the ethical language “do no harm”, patients are taking a risk when using drugs that have unknown long-term side effects, at the upper limits of the acceptable range. The element of prevention of wrongful prescription seems to be dealt with at the education phase of professional life, where psychiatrists are learning the fundamentals of using these drug treatments and the associated ethical approaches. For the practicing psychiatrist, it is unclear what continuing education happens around wrongful prescription.

When patients do experience physical harms, emotional impacts, and social repercussions from taking the drugs (Breggin, 1991; Chetley, 1995), where can they turn for assistance, assuming they can reflect on the source of the harm? The courts in Canada have not been generous and there is no guarantee that the Colleges will discipline their members and raise awareness of the misbehaviour. Ignorance of the harms caused by wrongful prescription weakens psychiatrist claims to a strong commitment to professionalism, giving credence to those who prefer the other two logics of managerialism and consumerism (Freidson, 2001, p.181).

The ability of business ethics to account for public safety concerns is a new territory, especially for pharmaceutical companies (McHenry, 2006). It is predicted that the percentage of persons with diagnosed mental disorders will continue to rise. This expanding potential market for drug consumers must be an attractive prospect for pharmaceutical companies. Growing questions concerning the goodness of these drugs, coupled with skepticism surrounding the close relationship between the medical community and the drug industry, might spur another consideration of commonly held ideas of the best way to market and sell pharmaceutical drugs. Accountability for drug manufacturers is another key to changing the ways that drug companies do their business. Examining the parallels with environmental regulation might expand our notions of the marriage between profit and care, as well as the importance of setting acceptable standards of safety and the importance of prevention. Whether we can learn from these parallels is uncertain because the harms due to wrongful prescription are often seen as driving from expert opinion, in an effort to help (regulate) sick people. The larger connection to health and wellbeing are sometimes masked.

The Future of Psychiatry

Psychiatrists and the profession of psychiatry is embedded within an ever-changing social context (See *Appendix 6: “Doing Psychiatry” (Contextualized)*). The

challenges are, in part, created by interactions with a questioning public and managers of medical work (Denney, 2005), the doubt cast by the discourse of risk (Beck, 1994), the questioning within bioethics of the superiority of medical judgment (Veatch, 1990), and the impact of the pharmaceutical industry on the shape of medical thought (McHenry, 2006; Brody, 2007) and on the fiction of the “informed consumer” (Henwood et al., 2003). What is the role of the psychiatric professional in this changing context? Control over one’s work and the importance of establishing legitimacy and credibility as professionals are key issues to watch in the future.

The ethics+ concerns discussed by participants seem to be an indication of the desire for change in how physicians are “doing psychiatry” today. Macro-level theorizing about the goodness of ethical precepts and the induction of improved regulatory systems are only a couple of pieces to resolving the problem of wrongful prescription. The daily efforts of psychiatrists and their sense of how they make ethic judgments, within the social and institutional context in which they work, is a crucial part of our understanding of the problem. The cultivation of self-awareness in terms of the work we do, in relation to the context in which that work is done, is one step toward encouraging ethical examination of professional practice. Ethics+ concerns underscore the importance of viewing ethics not as a static collection of codes coupled with punishments, but as a living enterprise impacted by the actions of those who do the regulated work. Perhaps we can borrow a metaphor from Lord Sankey who opined, “the *BNA Act* planted in Canada is a living tree capable of growth and expansion within its natural limits”.⁴⁷ Our ideas about medical ethics should be equally fluid and open to the ideas of ethics+, which highlight the symbiotic relationship between social context and professional integrity and judgment.

I am left with one overpowering conclusion at the end of my research: “psychiatry is at a kind of cross-roads” (Marty, 352-54). In what direction will the pendulum shift and what place will patient safety and wellness hold in the psychiatric toolkit of the future? Speculating on the future of psychiatry allows us to place our hopes and fears in full view and speak about the essence of psychiatry. What is necessary to doing psychiatry? What is necessary in order for professionals to do their best, in terms of patient care and research, and for job satisfaction to remain high? The actions and (in)actions of individual psychiatrists

⁴⁷ *Edwards v. A-G. Canada*, [1930] AC. 114, 136.

are key for the scientific breakthroughs projected (targeted treatments, mapping of the brain, gene therapy), as are they instrumental for preventing horrors (irrelevant outlook, lack of coordination between disciplines, over-focus on physical treatment). The battle for the "soul of professionalism" (Freidson, 2001, p.217) is waged not in the public sphere, the legal realm, or even in the marketplace. It is waged daily by the physicians who practice and create what we know as psychiatry, within the boundaries created by our social relations (Busfield, 1996, pp.53-60). Time is needed to witness whether the words of Lewis (2003) will hold truth for psychiatrists: "it is not that medicine is simply wrong or bad, it is more that medicine is too powerful, too hegemonic, too self-serving, and too unresponsive to alternative points of view"(p.60). The question is how long those harmed by wrongful prescription can wait for answers and solutions to their problems.

Farewell Glance

The piece of shiny Apo-Clozapine origami sits beside my desk. A gentle reminder of the many ways the pharmaceutical industry reaches people. Although not a practicing psychiatrist, their message reaches me. I pick up this feather-light abstraction and invert it. Inverting their message too. I question how the world of medical ethics is being transformed by the relationships between the pharmaceutical industry and the medical profession. I question how many physicians have folded and unfolded this object's many kin. Perhaps their questions are not so different from my own.

APPENDIX 1: CLASSES OF ANTIDEPRESSANTS⁴⁸**TRICYCLIC ANTIDEPRESSANTS**

- First antidepressants (1950s)
- Receiving neurons get extra stimulation, helping to regulate the levels of the neurotransmitters norepinephrine and serotonin
- Sedating and alerting properties
- Side effects and hazards include: faintness (falling of blood pressure), confusion, constipation, difficulty urinating, rapid heart beat, weight gain, drowsiness

SSRI (SELECTIVE SEROTONIN REUPTAKE INHIBITORS)

- Selectively raise serotonin levels in the brain
- Marketed as being nonaddictive and nonsedating
- Pregnant women should use with caution because newborns may experience adverse effects
- Side effects and hazards include: may be at risk of harming self or someone else, vomiting, diarrhea, insomnia, anxiety, tremor, loss of sexual desire

MAO INHIBITORS

- Monoamine oxidase inhibitors inactivate an enzyme that normally breaks down neurotransmitters, leaving more neurotransmitters available for use
- Atypical symptoms are often treated with this class of drugs
- Side effects and hazards include: consumption of tyramine rich foods leads to adverse effects, faintness, dizziness, headaches, insomnia

OTHER REMEDIES

- Lithium (bipolar disorder); St. John's Wort

⁴⁸ Source: *Merck Manual of Medical Information, Home Edition, 17th Edition (2000)*, from <http://www.cbc.ca/news/background/mental-health/depression-medicaitions.html> (October 17, 2006, CBC News)

APPENDIX 2: LETTER OF INTRODUCTION

[letter head] School of Criminology
Simon Fraser University
8888 University Drive
Burnaby, British Columbia
V5A 1S6

Date

Dear Dr. Xxxxx:

I teach at the School of Criminology at Simon Fraser University, and I am a member of the Law Societies of British Columbia and Alberta. Natasha Durich, one of my graduate students, is doing her Master's thesis on the prescription of antidepressants. She holds both a B.A. (Psychology and Philosophy) and an LL.B. from the University of Victoria. Natasha is interviewing local psychiatrists on this topic, and I hope that you would assist her by granting her an interview.

The focus of Natasha's questions will be psychiatrists' opinions on the prescription of antidepressant and anti-anxiety drugs and the ethical guidelines surrounding such practices. Your opinions would greatly contribute to an understanding of such matters.

The in-person or telephone interview requires approximately one hour of your time, to be set at a location of your choice. Your contribution to her research will be kept confidential and anonymous, through the use of pseudonyms and removal of identifying information.

If you have any questions or concerns about this project, I can be reached at by email (XXX) or telephone (XXX). Natasha can be reached at XXX (or XXX). She will be in phone contact within the next week to request an interview. Your participation would be greatly appreciated.

Sincerely,

APPENDIX 3: INTERVIEW SCHEDULE

Introductions

- Nature of the research—psychiatrists views on prescription drugs and their assessment of ethical guidelines around the use of prescription drugs.
- Purpose—to assist in my academic work, forming the basis of my MA thesis.
- Discuss confidentiality, anonymity, and ensure that they voluntarily wish to participate.
- Tell them that they can access my thesis upon completion.
- Get permission to tape record the conversation.

(A) Preliminary Questions: Background

1. How long have you been practicing psychiatry?
2. Have you used antidepressants and antianxiety drugs as part of your treatment plans?
3. Could you describe the work you do briefly?
 - What kinds of mental disorders do you treat?
 - What brought you to work at XXX?

(B) Questions stemming from mission question #1 (How do clinical psychiatrists view the impact of prescription drugs on their practice of psychiatry): Context

1. What are your thoughts on psychiatrists asking patients to take greater responsibility for managing their use of antidepressants and antianxiety drugs?
 - What sorts of activities would management include?
 - Do you think this is common?
 - What are some of the obstacles involved in this approach?
 - Do you encourage patients to do their own research?
 - Do you feel this approach is useful?
2. Have your patients requested drugs by name? How do you feel about these requests?
3. Some patients make the comparison between taking medication for their mood disorder and other patients with physical illnesses (such as

diabetes) taking medication for their disease (such as insulin). Do you feel that such comparisons are helpful?

- Do you feel that this impacts their sense of responsibility?

(C) Questions stemming from mission question #2 (What guidelines or ethical principles do clinical psychiatrists view as important in their use of prescription drugs): Ethical Concerns

1. Some ethical problems resulting from the use of these drugs include failure to monitor medications, overmedication, conflicts of interest, and the severity of reactions caused by the medications.
 - i. What responses are you seeing from your profession in addressing these ethical concerns?
 - Some people have suggested that the relationship between drug companies and the medical profession is at arm's length. How would you respond to this statement?
 - Do you feel that providing education and sample drugs is good practice or necessary?
 - Do patients have access to safe alternatives?
 - ii. Do these ethical concerns receive enough discussion?
 - Do you feel there's a way to discuss them more?
2. What other things do you think pharmaceutical companies can do to help minimize the potentially harmful impacts of their drugs?
 - For example, the makers of apo-clozapine, a drug requiring careful monitoring, have created an online tool that allows physicians to track patient blood levels. Do you feel that this is helpful?

(D) Conclusions

1. There have been many changes to the face of psychiatry within the past 20 years or so. What do you think the historians of the future will note about this time period for the profession of psychiatry?
2. If you were asked to project 20 or 30 years, even 50 years, into the future, what do you think the work of psychiatrists will look like?

(E) Wrap-Up

- Do you have any general comments about our conversation you'd like to add?
- Could you recommend any other psychiatrists who might wish to be interviewed? (any psychiatrists with diverging opinions?)

APPENDIX 4: CONCEPTUAL FRAMEWORK

(1) Personal Details

- 1.1 Years in practice
- 1.2 Years as a general practitioner
- 1.3 Administrative work
- 1.4 Other

(2) Patients

- 2.1 Sophistication (information, knowledge, resources)
- 2.2 Active patient (questioning, researching, requesting)
- 2.3 Physician-patient collaboration (sharing, educating)
- 2.4 Other

(3) Drugs

- 3.1 Utility
- 3.2 Cost-benefit analysis
- 3.3 United States drug regulations

(4) Pharmaceutical Companies

- 4.1 Changes to conflict of interest (the good old days)
- 4.2 Pharma companies as businesses
- 4.3 Positive relationships with physicians?
- 4.4 Skepticism by physicians regarding motives of Pharma companies
- 4.5 Role in improving patient care
- 4.6 Other

(5) Ethical Obligations and Concerns

- 5.1 Responsible physician
- 5.2 What is needed?
- 5.3 Sense of integrity

5.4 Factors external to professional responsibility

5.5 Dialogue within the profession

5.6 Other

(6) Views on Mental Disorders

6.1 Complex model

6.2 Stigma

6.3 Value to patients of comparing mental disorder with other illness

6.4 Other

(7) Views on Psychiatry

7.1 Art and science relationship within psychiatry

7.2 Feeling on changes

7.3 Hopes for the future

7.4 Other

(8) Other key issues not covered

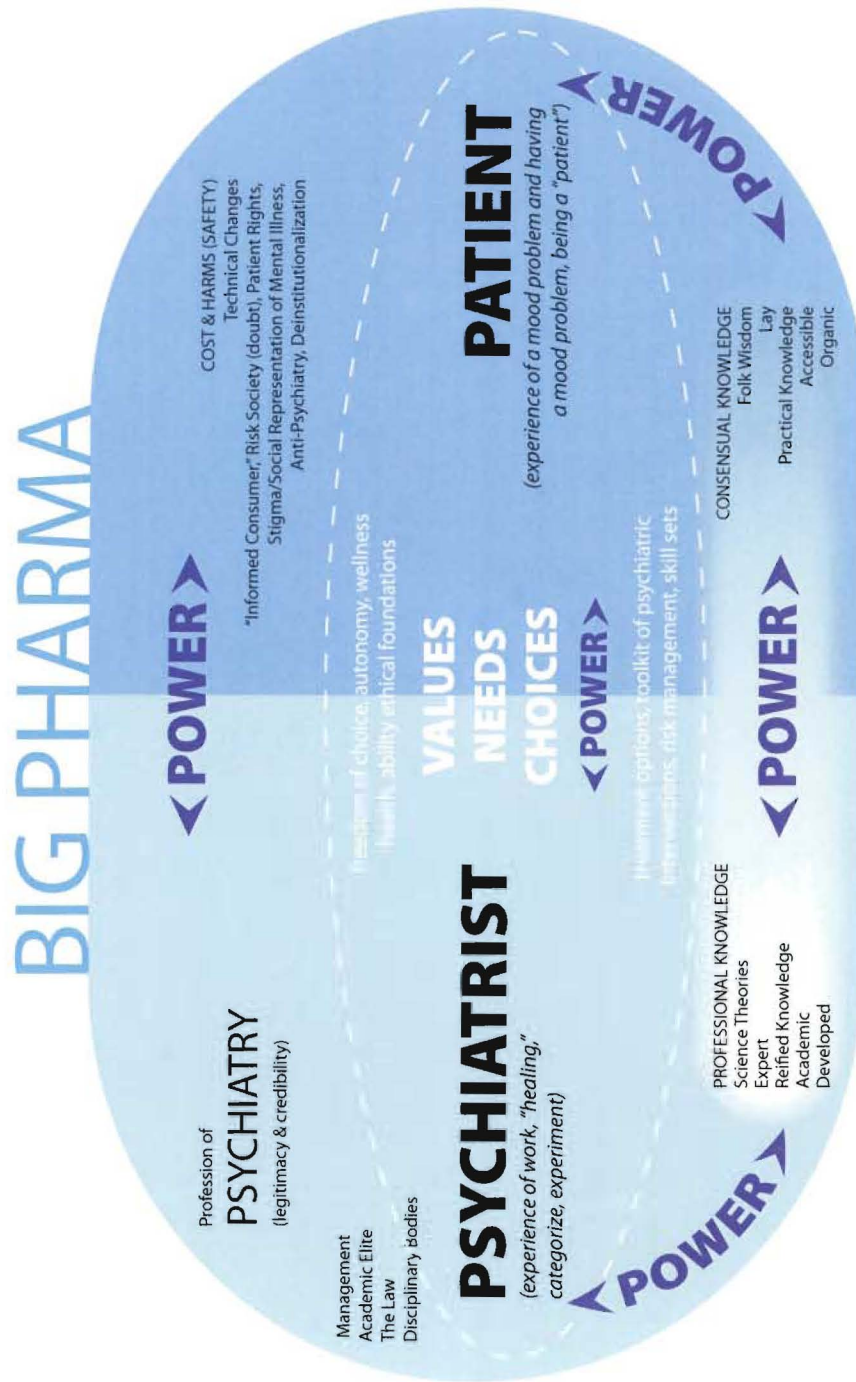
NOTE: Concepts 2, 3, 5.4 and 6 (not 6.1) are combined to form a meta-concept
"Context Informing Ethical Decision Making"

APPENDIX 5: FRAMEWORK METHOD

The following is a brief description of the tasks at each of the three stages of the Framework method of data analysis (adapted from Ritchie, Spencer, & O'Connor, 2003, pp.219-262).

STAGE	DESCRIPTION
<i>Data Management</i>	<p>Familiarization: looking for recurring ideas or themes</p> <ul style="list-style-type: none"> • Silverman (2000, p.185): use of counting techniques might be one means of understanding the data. Indexing (coding): looking at words, sentences and paragraphs to place the themes <p>Charting (rows for cases and columns for subthemes; different charts for different themes): summaries reflect the essence of the point without losing voice (indicating * for useful quotations in the transcript)</p>
<i>Descriptive Accounting</i>	<p>Detection/Categorization/Classification:</p> <ul style="list-style-type: none"> • Looking within a theme, across all cases, noting the range of views that have been tagged • Incorporating new ideas and discriminating between dimensions of the theme • Are the concepts coherent wholes? • Create a master chart or visual of the themes and their connections
<i>Explanatory Accounting</i> <i>See also: Silverman (2000) and Fraser (2004)</i>	<p>Detection of patterns</p> <ul style="list-style-type: none"> • Are there clusters of cases or associated cases, and links between the ideas? • What about the outliers or deviant cases? How can you craft an explanation that would account for them? • Development of explanations: all scenarios and cases must be examined • The explanations range from (and can combine) explicit reasoning, inferring an underlying logic, using common sense, developing an explanatory concept, drawing on other empirical explanations, and using theoretical frameworks. • Considering wider applications: what implications?

APPENDIX 6: "DOING PSYCHIATRY" (CONTEXTUALIZED)⁴⁹



⁴⁹ This diagram is my own creation, with graphic design assistance from Lydia Del Bianco. It is based on the ideas gleaned from Pilgrim and Rogers (2005, p.2554) and Morant (2006, pp.833-34). I married these insights with my own research on the connections between psychiatry, the management of the psychiatric profession, and the relationship between the pharmaceutical industry and the profession (see *Chapter One*).

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