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The 'rest of medicine' and psychiatry: why paradigms would differ

In their paper, Bracken *et al*[1] have cogently put forth the limitations of psychiatry comparing its differences with the 'rest of medicine'. They turn our attention to some moral and ethical notions viz relationships, meanings and values, which not only have therapeutic scope but also humanistic importance. Applying evidence-based logic, they show the inadequacy of technological interventions (psychopharmacotherapeutics or therapy-specific aspects of psychotherapies), and at the same time cite evidence of effectiveness of 'non-technical' aspects of care. Considering some of these aspects and the online response it generated, it is important that we refocus our attention to a central and some associated issues.

First, unlike what Bracken *et al* propose, medicine's assumptions on causal mechanisms are still a hotly debated issue. Medicine's apparent authority over human health was convincingly questioned in a historical analysis by Thomas McKeown and his arguments much advanced by Simon Szreter. In short, rather than technical innovations in medicine (such as the advent of antibiotics or immunisation), social and political interventions had a decisive role in advancing human health.[2]

Second, as the field of epidemiology progressively advances and uses newer analytic techniques, monocausal explanations (as the germ theory of disease propounded) gave way to multicausal (as in the case of chronic disease epidemiology) and finally to complex eco-epidemiological causal explanations.[3] In fact, an active engagement with the notion of embodiment that explains how biological processes are influenced profoundly by environmental determinants (e.g. social, cultural, economic, political) lies at the heart of social epidemiology.[4] And biological outcomes are not often mediated by our psyche, although the latter may be similarly affected.

Third, an attempt to compare the effect sizes of pharmacological interventions in both general medical disorders and psychiatric disorders show, barring a few exceptions, that effect sizes of psychiatric drugs are in the same range (i.e. small to medium) as most other pharmacotherapeutics.[5]

Moreover, the oft referred crisis in psychiatry also bothers the 'rest of medicine' and healthcare. Some features of this crisis are the increasing difficulty of grappling with the explosive boom in health-related technologies (consequently increasing the cost of healthcare), the challenge produced by the epidemiological shift in disease prevalence and the marked social inequalities in health. In addition, the notions of 'medicalisation of everyday life'/overmedicalisation, healthism, biomedicalisation and the dominance of the technological paradigm in medicine have also drawn wide criticism. In not considering these as entirely good or bad, the problem is the undue attention to individualised solutions and personalised/customised technologies,[6] transforming health to individual moral responsibility.[7]

On the other hand, under the foregoing transformations in healthcare, medical training instils qualities such as objectivity and emotional distancing to maintain clinical neutrality, concepts partly counterposed to values, narratives and meanings. Similarly, clinicians have come to associate professional status and power with increasing technological involvement in clinical practice, rather than with being sensitive to the patient's distress and life story. Although clinical knowledge is based on biological understanding and scientific methods, it is also interpretive and narrative.[8]

Thus to paraphrase Bracken *et al*, it is not just mental health problems but all health problems in general that undoubtedly have a biological dimension, and that by their very nature can reach beyond the body to involve social, cultural and psychological dimensions.

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Authors' reply: We are broadly in agreement with the thrust of Dr Das's analysis. In our original article, we cited Arthur Kleinman's call for 'medicine in general' to go beyond a technicalised understanding of 'caregiving' and we also noted the resonance between our position and that of Iona Heath in relation to general practice.

We agree entirely that 'an active engagement with the notion of embodiment' would represent a very positive agenda for all of medicine. Our experiences as human beings are shaped by our physiology and the particular way it has evolved over centuries. However, they are also shaped by the particular cultural and historical context in which, and through which, we come to know ourselves and the world around us. In the lived reality of human beings, mind, body and social context are inseparable.

But a medicine that sees itself as, primarily, a set of technical interventions will always strive to compartmentalise and conceptualise illness in simplified causal models. This represents a challenge for all branches of medicine.

Are we wrong to distinguish psychiatry from the 'rest of medicine'? Maybe. Bill Fulford has argued convincingly that the widely held view that bodily illness is 'relatively transparent in meaning' and less 'value-laden' than mental illness does not stand up to scrutiny.[1] For him, it is simply that the values inherent in our concepts of bodily disorder are just not as obvious as those involved in our discourse of mental illness. When the presenting problem is pain from an arthritic joint or from a myocardial infarction, there is usually agreement between the doctor, the patient and the carer about what the priorities are and what would count as recovery. However, as medical technologies (such as in reproductive healthcare) develop, more areas of disagreement emerge and ethical issues become more obvious. In the world of mental health, disagreements about values, priorities and frameworks have always been part of day-to-day work and thus value judgements more obvious.

However, although we accept this analysis, we are not entirely satisfied that this is the full story. When we put the adjective 'mental' in front of the word 'illness', we do seem to be delineating a particular territory of human suffering. This cannot be clearly defined and seems to resist easy categorisation. But the word 'mental' implies that this is suffering that emerges from the mind, and whatever the 'mind' is, it is not simply another organ of the body. In this way, there does seem to be some sort of epistemological difference between psychiatry and other branches of medicine such as cardiology, endocrinology or neurology. Problems with our thoughts, feelings, behaviours and relationships would seem to be more intimately entwined with questions of meaning and context than problems arising from lesions in specific organs of the body.

Whatever we make of the relationship between bodily and mental illness, psychiatry grapples daily with epistemological and ontological issues and has a long history of doing so. A psychiatry that is able to 'move beyond the current paradigm' might be one that can offer insights and leadership to other parts of medicine.

1 Fulford KWM. *Moral Theory and Medical Practice*. Cambridge University Press, 1989.

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Low Apgar scores in neonates with prenatal antidepressant exposure

We read with interest the very important and thought-provoking study by Jensen *et al*.[1] The authors have found an increased rate of low Apgar scores in neonates with prenatal antidepressant exposure, especially with selective serotonin reuptake inhibitors (SSRIs).[1] However, the use of other antidepressants (new or old) and a diagnosis of maternal depression were not associated with low Apgar scores.[1] The study has several merits: nationwide data, large sample size, meticulous record keeping, sound methodology, appropriate use of statistics, controlling confounders to a large extent and, most importantly, having been conducted in a clinically relevant area, where data were limited and there were more questions than answers.

However, there are certain issues with the study. First, the authors have not mentioned which of the SSRIs was implicated in having the greatest or least effect on lowering Apgar score. Second, the dose and duration of antidepressant use were not mentioned and adherence to antidepressants was also not assessed. Third, antidepressant data were collected from psychiatric centres only, perhaps because the authors did not have access to data from general practitioners, which further limits the generalisability of the study findings. Fourth, the authors have not mentioned and not controlled for important confounders such as the presence of a physical disorder in the mother, obstetric complications and nutritional status of mothers, which may also contribute to a low Apgar score. Fifth, there is a possible mistake in tabulating the gestational age of all pregnancies, as the interquartile range is stated as 39–39 weeks (see Table 1). Finally, the authors have themselves mentioned about the significant differences in the antidepressant prescription trends. During the study period, use of antidepressants was very limited in pregnant women, but recently antidepressant use has increased substantially, especially that of SSRIs. This may be an important reason for getting high odds ratios for low Apgar scores with the use of an SSRI. Earlier studies have also reported low Apgar scores with maternal SSRI use.[2,3] Exposure to SSRIs at an early age can disrupt the normal maturation of the serotonin system and alter serotonin-dependent neuronal processes in the fetus[3] and these effects are partly moderated by infant SLC6A4 genotype.[4]

Today, authors have advised caution and proper monitoring of infants with prenatal antidepressant exposure. This study will definitely provide impetus for future research in this area, and with more robust data, it may also act as a starting point for the modification of existing treatment guidelines.

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