



Professor at the centre of a row over free speech, Personal View, p 1334

VIEWS & REVIEWS

REVIEW OF THE WEEK

The origins of the Prozac nation

This cultural history of pill popping will make doctors think twice before writing their next prescription for antidepressants, thinks **Gwen Adshead**

In the United States of the early 1970s about 200 million prescriptions for psychotropic drugs were made each year. The most commonly prescribed types were sedatives and anxiolytics, such as meprobamate (Miltown). By 2005 the annual number of prescriptions had reached 350 million, the vast majority of these being for antidepressants. How US culture changed such that the biggest mental health problem apparently switched from anxiety to depression is the subject of this fascinating book.

David Herzberg is a cultural historian; and here he weaves three strands of cultural history together: the rise of consumerism in the 1950s, the politics of identity and autonomy, and the professional ideal of altruism in medicine. He shows how the consumerist maxim that “things can make you happy” was applied to mental health. Anxiety came to be seen as a disorder that stopped people fulfilling their proper social role; the treatment for this became a “thing” (in the form of a pill) that made you happier in your social identity. Doctors became the intermediaries between the consumer-patient and the pharmaceutical product.

Everyone could benefit from this complex cultural narrative, which was retold endlessly by the pharmaceutical advertising industry: people taking the drugs felt better and more

What happens if you and your doctor fundamentally disagree about whether or not depression is an illness? And who gets to decide?

in control of their inner and social worlds; doctors felt better because they were doing good for others; and the drug companies felt way better as their profits soared.

Herzberg shows how this interplay of cultural tropes in the 1970s was then repeated in the 1990s with fluoxetine (Prozac). Again, we see the marketing of psychological health as something “out there” that can be purchased. We see repeated public stories of people who felt “more like themselves”



Happy Pills in America: from Miltown to Prozac

David Herzberg

Johns Hopkins University Press, £23.50, pp 296

ISBN

978-0801890307

Rating: ★★☆☆

while taking Prozac. And we see “depression” becoming an illness that doctors can successfully treat. He describes how Miltown and Prozac and other drugs like them have resulted in a backlash against the prescription of “happy pills”; but if his figures are accurate this backlash hasn’t lasted long and has not made much impression on prescribing of antidepressants.

Happy Pills in America was not an easy read, but it was a stimulating one. One of Herzberg’s central premises is that “nervous illness” is an affliction of the middle classes and even of middle class success. He sets out, with devastating clarity, how anxiety and distress about social situation have been socially constructed as middle class problems that can be entirely appropriately treated with legal “good” drugs but how the use of “bad” drugs (alcohol or narcotics) by the poor and working classes is demonised. To some extent this is clearly a function of private medicine in the United States, where the middle classes can pay for their treatment, although the rise in prescribing of antidepressants is mirrored in countries with socialised medicine. Nevertheless black, Hispanic, working class, and impoverished people are not prescribed legal drugs to make them happier with their social lot; and they are severely punished in the criminal justice system if they self medicate with illegal drugs.

I was interested in Herzberg’s notion of “cultural spaces” in which medical identity is constructed. He focuses on drug advertising and on

discussions in the popular media, such as magazines, newspapers, and television, and it is reasonable to suppose that these cultural constructs affect doctors as well as patients. I found myself wondering what images of doctors are available for would be medical students: the doctor as the efficient purveyor of a selection of products for ill health that the consumer can select (“choose and book”); the doctor as the harassed professional struggling to maintain service in the face of callous managers (or in the face of endless accidents and disasters, as seems to regularly befall the poor city of Holby); or, finally, the brilliant but dysfunctional Dr House, who despite his drug addiction and evident unhappiness (why isn’t he on Prozac?) is an excellent physician. What do students think they will be doing if they sign up for medicine as a career?

I raise this question because doctors have to deal all the time with people who are distressed and unhappy, and the way these people and their doctors think about these experiences will be, in part, culturally constructed. Herzberg notes the importance for pharmaceutical consumerism of the rise of the patients’ rights movement in the United States, in parallel with the struggle for civil and women’s rights. Surely one of the consequences is that there is a now a public, civic right to define your own illness in a way that was unthinkable before the 1950s. Accompanying this is the wish for the right of the public to define medical practice and conduct, which obviously makes sense at one level (especially where there is a largely socialised medical service) but which undermines professional autonomy and identity. What happens if you and your doctor fundamentally disagree about whether or not depression is an illness? And who gets to decide? Do read this book. It will make you even more thoughtful about your next prescription for antidepressants.

Gwen Adshead is a forensic psychotherapist, Broadmoor Hospital, Crowthorne, Berkshire

Gwen.adshead@wlmht.nhs.uk

Cite this as: *BMJ* 2009;338:b1784

Euthanasia and free speech in Ireland

PERSONAL VIEW **Len Doyal**

I have long argued that both non-voluntary and voluntary euthanasia should be legalised under conditions that are strictly regulated (*BMJ* 2001;323:1079-80 and *Clin Ethics* 2006;1:65-7). Indeed it can be said that doctors already practise a form of euthanasia when they withdraw or decide not to initiate life sustaining treatment for severely brain damaged patients. In so doing they are taking positive steps to end lives that they (and others) deem to be of no further benefit to the patients concerned. The moral good inherent in such actions needs to be recognised and embraced. However, because non-voluntary euthanasia is illegal in the United Kingdom, the death that is then clinically managed may be slow and distressing. It is this reality that lies at the heart of the case for the legalisation of active non-voluntary euthanasia.

Competent and terminally ill patients can already make decisions about the burden of continued life when they refuse life sustaining treatment. But again they may still face a needlessly slow death without dignity. Hence I and many others argue that the law should be changed so that these patients are legally permitted to request and obtain a quick ending of life, from caring doctors who are willing to provide this help. The consequences of such legalisation in jurisdictions where it has already been enacted give little indication that they lead to the "slippery slope" that some opponents have warned against so dramatically (*J Law Med Ethics* 2007;35:197-210).

In the UK and elsewhere I have presented and defended such arguments in a wide range of public settings, and the accompanying debates have always been spirited. Yet nothing could have prepared me for the consequences of my acceptance of an invitation to do so in a yearly

meeting of the Cork University Hospital Ethics Forum.

In 2002 I gave the inaugural address of this forum to an invited audience consisting mainly of health professionals, which was followed by discussion and debate. Beforehand I had presumed that the usual format would apply, but I quickly became aware that this event might be different, as demands for the talk to be cancelled began to appear on the internet. Among those apparently mobilising against it were the local member of the European parliament and the bishop of Cork and Ross.

When I arrived at the university hospital for the lecture I caught a glimpse of protestors carrying placards in front of the entrance. I was not unduly concerned and had psychologically prepared myself for a particularly heated debate in a country and culture that prides itself on such exchanges of views. Shortly after, however, all hell seemed to break loose.

As the forum chair and I entered the lecture theatre we were immediately surrounded by a group of men, screaming that the lecture would not be allowed to proceed. One of them stood directly over me, stating that I would be "stopped" if I tried to say anything. In the background was a much larger group of men and women—many with placards—shouting "murderer," "Nazi," and a variety of other epithets. As tension grew, three hospital security staff finally came in to escort me from the theatre. The crowd then began (ironically) to point repeatedly with raised arms towards the exit, screaming, "Out, out, out!" Gardai were on site throughout but did nothing to protect me or other participants who were singled out for abuse. I was taken back to my hotel, where a security alert had been issued. My main emotion throughout these events was incredulity.

With some notable exceptions, the initial response of the Irish press to all this was disappointing. Most of the reports quoted me correctly as saying that the most important aspect of what had occurred was the abuse of the right to free speech. Yet few were interested in investigating what I might have argued at the talk. Practically, this meant that my views

continued to be misrepresented and to go unchallenged on the internet, including the suggestion that I was generally in favour of the use of euthanasia to ration scarce healthcare resources among disabled people. I found the contents of defamatory websites particularly distressing. It is difficult to describe the unease created by the fact that pretty much anything can be said about you for global distribution on the web (see, for example, the results of entering "Doyal," "euthanasia," and "Cork" in a search engine).

I decided to take matters into my own hands. I wrote an open letter to the president of Ireland, which kept the issue alive in the press (www.irishtimes.com/newspaper/ireland/2009/0418/1224244975850.html). More importantly I was grateful to be given the opportunity by the editor of the *Irish Times* to write an editorial about what I would have said had I been given the chance (www.irishtimes.com/newspaper/opinion/2009/0424/1224245291774.html). Finally, *Prime Time*, a current affairs programme of RTE, the Irish public service broadcaster, gave an excellent account of the disruption of my talk, accompanied by a very moving account of an Irish man with multiple sclerosis who wishes to have the right to die with dignity. It also broadcast a short debate between me and an Irish clinician. This made it more difficult for opponents to continue to misrepresent my beliefs. But of course the original columnies are still on the web for anyone to see.

What is to be made of all of this? Clearly, freedom of speech remains of the utmost importance. To be fair to the Irish press and to some bloggers, this point was made in most reports and in many blogs. What was most disturbing was the hate shown towards me personally by some people on the grounds of religion, clearly reinforced by their fear of arguments that challenge their beliefs (experiences I have also had in the UK). It is now clear to me that the debate about euthanasia—particularly non-voluntary euthanasia—is still in its very early stages in Ireland, and I am grateful that I have been allowed to help move the argument forward. I hope at some point to be invited back to Ireland to continue this process. Len Doyal is emeritus professor of medical ethics, Queen Mary, University of London

l.doyal@qmul.ac.uk
Additional references are available in the version on bmj.com
Cite this as: *BMJ* 2009;338:b2109



Len Doyal (seated) is protected by security and hospital management as a protester tries to disrupt his lecture

Thatcher and Blair

For many years the publishing firm of Victor Gollancz issued its books in a distinctive yellow cover. The works of all its authors, from the most famous to the completely unknown, were given more or less the same cover. A few words on the front were all that were used to attract the buyer.

In 1958 Gollancz published a novel entitled *The Graver Tribe* (a quotation from the poet, clergyman, and doctor George Crabbe), by Edward Candy. Above the title were the words "A novel about surgeons" and below "Should a person of sound mind have the right to his own life-or-death decisions?"

Fascination with the lives and work of surgeons, those who cut into live flesh, is still with us; but the moral question asked only half a century ago seems almost as remote to us as the question of whether heretics should be burnt at the stake.

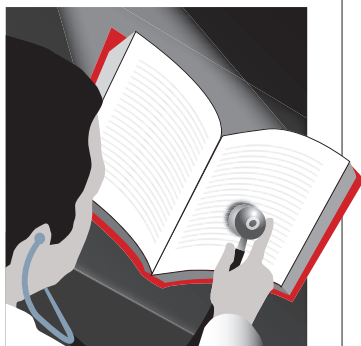
Edward Candy was the pseudonym of Barbara Alison Boodson Neville (1925-93). She was firstly a poet, and in 1944, at the age of 19, she published a poem in *Poetry London* in the company of the most eminent poets of the age. In 1953 she published a classic crime novel, *Which Doctor?* and then another, *Bones of Contention*, in 1954.

She gave up medicine to raise five children, eventually returning to part-time work in electroencephalography. She died from motor neurone disease.

The Graver Tribe was her first non-detective novel. It concerns the machinations of young surgeons at St Chad's, a fictional London teaching hospital, to obtain consultant posts and a professorial chair. The plot is too convoluted to summarise and in any case is not

BETWEEN
THE LINES

Theodore Dalrymple



There is a drunken senior surgeon and a charming but feckless and incompetent registrar. Their names are Mr Thatcher and Mr Blair, respectively

altogether plausible; but a large part of it turns on the question of whether a brilliant young surgeon, Mr Branksome, displays unfeeling arrogance in operating on a patient, Mr Allgood, who has a perforated gastric ulcer and is too ill to give his consent. He had always made plain his opposition to surgery before, long refusing the gastrectomy he had been strongly advised to have; but Mr Branksome decides to operate anyway.

Unfortunately Mr Allgood dies shortly afterwards. The coroner is unsympathetic to Mr Branksome,

who is combative in the witness box; and a national newspaper, using an unscrupulous reporter called Heath, makes hay of the whole episode. There is even a caddish young surgeon called Ellsworthy, who dresses in clothes that appear of higher social class than that from which he originates (nowadays, of course, it would be the other way round) and who tells the reporter tales out of turn. In those days the medical profession did not show the rock-like solidarity it has today.

Should Mr Branksome have respected Mr Allgood's wishes never to be subjected to surgery? Was he playing God in trying to save Mr Allgood's life? It is startling that, in 1958, Mr Allgood was considered a very old man to be having an operation: he was 68.

The book has a cast of secondary characters. For example, there is a drunken senior surgeon and a charming but feckless and incompetent registrar. Their names are Mr Thatcher and Mr Blair, respectively.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2009;338:b2122

MEDICAL CLASSICS

Jewish Medical Ethics

By Immanuel Jakobovits

First published 1959

This year marks the 50th anniversary of the publication of this work by the former UK chief rabbi, Immanuel Jakobovits. The work was originally submitted as Lord Jakobovits's doctoral thesis, and with it was launched the new field of Jewish medical ethics. Although Jewish teachings governing medical ethics were already well developed, they were not collected or organised to allow non-experts easy access to its many directives.

In the second half of the 20th century medical knowledge exploded, and new technologies such as artificial reproduction and organ transplantation called for an ethical response. Arguably the modern discipline of medical ethics was inaugurated by the publication by Joseph Fletcher, a Protestant theologian, of *Morals and Medicine* in 1954. Based on a notion of unlimited human freedom, this work maintained that everyone has the right to control their destiny and decide how they want to procreate or die. This led Fletcher to support artificial means of reproduction, contraception, and euthanasia.

In contrast Lord Jakobovits maintained that: "In Judaism we know of no intrinsic rights. Indeed there is no word for rights in the very language of the Hebrew Bible and of the classic sources of Jewish law. In the moral vocabulary of the Jewish discipline of life we speak of human duties, not of human rights, of obligations not entitlement. The Decalogue is a list of Ten Commandments not a bill of Human Rights. In the charity legislation of the Bible, for instance, it is the rich



Jakobovits: conservative

man who is commanded to support the poor, not the poor man who has the right to demand support from the rich. In Jewish law a doctor is obligated to come to the rescue of his stricken fellow man and to perform any operation he considers essential for the life of the

patient, even if the patient refuses his consent or prefers to die. Once again, the emphasis is on the physician's responsibility to heal, to offer service, more than on the patient's right to be treated." This philosophy led him to take conservative positions on abortion and euthanasia. Lord Jakobovits had no fundamental problem with scientific advancement and took pains to point out Judaism's traditional alliance with rational medicine.

Jewish Medical Ethics is mostly based on a survey of the 2000 year old Jewish literature. Lord Jakobovits remained loyal to the ancient Jewish tradition and was strongly opposed to legal change as a result of social circumstances. As Lord Jakobovits saw it, Jewish ethical decision making uses casuistry to render opinions by a comparison with prior decisions. As this method is based on analytical reasoning, it follows that different decision makers can reach different conclusions.

Alan Jotkowitz, director, Jakobovits Center for Jewish Medical Ethics, Ben-Gurion University of the Negev, Beer-Sheva, Israel
ajotkowitz@hotmail.com

Yoel Jakobovits, assistant professor of medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA

Cite this as: *BMJ* 2009;338:b2138

A real toothache

FROM THE
FRONTLINE
Des Spence



"No fillings!" the dentist beamed. This was odd, as six months ago I had been told that I needed four fillings, but I had moved before treatment. How could this be? I am of the generation whose mouths are full of black amalgam. To us, orthodontists were mythical creatures, and we believed that the Osmonds' teeth were so perfect they must be false. Today dental care in Britain is in trouble, with limited access for many and the rest suffering the excesses of private practice. The Tories are proposing a new dental contract; this is overdue. But what gives a lazy fat cat GP such as me the audacity to pass an opinion on another profession?

At medical school we had lots of lectures on the Krebs cycle but none on dentistry—which is a shame, because over the past 15 years in general practice I have seen more NHS dental patients than many dentists have seen. All have been in pain: broken teeth, gingivitis, dental abscesses. Colleagues in accident and emergency complain of the same problem, and out of hours dental care is a vast empty void. Care is left to doctors with just tongue depressors, a pen torch, analgesics, and some antibiotics. And as ever it is the poor who suffer disproportionately, many unable even to register with an NHS dentist. Yet as I drive home I see advertisements for teeth

whiteners and cosmetic dentistry. My neighbours are always going to the dentist and complain of inconsistent and wild pricing. It is a rotten state of dental affairs.

We GPs may be overpaid, but we are NHS through and through. We turn no one away, offer routine medical access in 48 hours, and provide care on the basis of need not greed. There is no fee for service; money is the essence of private or insurance schemes, encouraging activity and unnecessary treatments, not quality. To refute this statement is blind denial.

There are many excellent and dedicated NHS dentists; but it is regrettable that, after an all expenses paid training in the NHS, so many dentists leave for the private sector, to the squeal of Porsche tyres. So bring in capitation, lock dentists into the NHS for a fixed period, and end the nonsense of six monthly routine reviews. But most importantly, spike private work by allowing the use of more expensive and new materials in the NHS, as this is the reason dentists most often give for offering private treatments. It is time to make NHS dentistry work for all, and especially for the poor. I am tired of filling the holes in dental care.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk
Cite this as: *BMJ* 2009;338:b2154

Mustn't grumble

DRUG TALES AND
OTHER STORIES
Ike Iheanacho



"Ello. Yeh. . . I'm on the bus. . . On the bus. . . THE BUS! Yeh, I'm gonna be late. Didn't you get my email? . . . WHAT?! . . . Look mate, there's a really dodgy signal on this mobile. I'll text you later."

Nowadays you hear far too many of these half conversations in public spaces. However irritating, they actually represent triumphs of multimedia communication. And it would be silly and inadequate to blame technology for the shortcomings of its misusers.

Besides, there's a more insidious factor at work: the desperate impulse too many people now have not only to be stars, directors, and promoters of their personal documentaries but also to make complete strangers an unwilling audience. This is, perhaps, inevitable in an age that prizes "reality" television and sees little wrong with trivial, self centred reportage. (How else to explain the narcissistic horror of Twitter?)

On a more positive note, the

mood for greater self expression has also embraced healthcare services, which increasingly encourage patients to speak up, complain, and say what they want to happen. And many patients don't wait to be asked before offering these views. These are welcome developments, by and large. In truth, though, the NHS, for one, couldn't cope if enough patients spoke their minds, asked probing questions, and didn't take no for answer. Indeed it relies heavily on those who wouldn't dream of behaving like this. It may rarely see or hear from these individuals—not because they're too afraid, scared, or ignorant to seek care but because they don't want to "bother" anyone or show their real feelings.

Such stoicism is deeply unfashionable in modern Western society. In former times doctors could count on it being a dominant streak in many of their patients. But no longer. That's surely a good thing, if it means that fewer people

are overlooked or short changed through making little or nothing of their symptoms.

And it's not that stoics necessarily make easy patients. Yes, it's very helpful that they don't burden the system with trivial, self limiting problems. They can, however, be frustrating in insisting that they're well, even when they could obviously do with medical help (if only to safeguard their dogged independence). There's also little to praise about the person who puts others at risk by, for example, struggling into work with flu.

Despite all this, there remains something eternally noble about those who are self reliant, determined, modest, and reticent in the face of debilitating illness. Perhaps more should be done to celebrate them. But quietly, please. . . no need to make a fuss.

Ike Iheanacho is editor, *Drug and Therapeutics Bulletin* iheanacho@bmjgroup.com
Cite this as: *BMJ* 2009;338:b2111