

From the Editor's desk

By Peter Tyrer

Prudence for students

I once had a junior psychiatrist working for me who was very reluctant to make clinical decisions. She was very well read and when I asked her why she had not taken a course of action that most others would have thought was commonplace she defended her decision with the words 'I thought it was imprudent to do so', together with a long explanation which essentially could be summarised in the words I have used previously in this column, 'If our predictions are wrong and we intervene unnecessarily, we create iatrogenic disease and much more.'¹ This issue illustrates both the merits and handicaps of this philosophy. If we listen carefully to evidence and act accordingly, we may sun ourselves in the warmth of the latest guidelines but fool ourselves. Kessing *et al* (pp.266–271) and Vinogradova *et al* (pp.272–277) show both the higher risk of diabetes with antipsychotic drugs (although some may be surprised at the main offenders) and their mortality risk, yet such treatment is recommended almost universally. My passive junior colleague would never initiate antipsychotic drug treatment on account of its dangers and could point to Munafò & Flint (pp.257–258) in suggesting that much of their value is based on false positives, and that when schizophrenia is untreated the mortality is still the same.² But the proponents of focused medical intervention, including now an Italian support axis to our UK group colleagues (Altamura & Goodwin, pp.261–262),^{3,4} would point not only to clinical evidence of symptom relief, but to the disability created by psychosis, even at an early stage in the disorder (Velthorst *et al*, pp.278–284). We also need to be aware of cognitive impairment, particularly in core schizophrenic illness,⁵ and the potential importance of this in classifying and treating the condition.⁶ The evidence that cannabis impairs memory is therefore particularly relevant to the debate over its association with schizophrenia⁷ and the apparent reversal of this effect by cannabidiol, also found in cannabis but in differing proportions,⁸ reported by Morgan *et al* (pp.285–290) offers the enticing possibility that cannabidiol may offer an acceptable alternative to other antipsychotic drugs (Henquet & Kuepper, pp.259–260) that is not associated with increased mortality.

So if we are to advance our knowledge and therapeutic wisdom, we have to take some chances and throughout this process we have to have a judicious balance between benefit and risk. I would be surprised if anyone disagreed with this; the problem is deciding how 'judicious' is defined. I have to say I found my younger colleague's approach infuriating because it seemed such a negative view of our craft – the Hippocratic dictum of *primum non nocere* was perfectly appropriate in ancient Greece when most medical interventions had no demonstrable benefit, but we now have much more of value from which to choose. I remain an enthusiast and optimist with regard to new treatments.

'Prudence keeps life safe, but does not often make it happy', said Samuel Johnson, and we should be prepared to offer the chance to give our patients joy – cannabis excepted.

Service users centre stage

My views about service users – I still prefer the term 'patients' as it is more accurate and universal in medicine – have changed somewhat over recent years. Not so long ago I felt that the growth of the user movement might handicap research in mental health because consumerism might take over from evidence, 'accelerate out of control and drive mental health research into the sand'.⁹ It has not done so, and I am pleased to admit I was wrong. I think the reason for this is that service user opinions have become much more representative and less individual-focused. An 'expert by experience' is a limited expert if he or she has only direct personal experience of care to report. But 'collections of experience', obtained systematically from a wide range of service users, comprise very useful data and are illustrated well by Singh *et al* (pp.305–312) in their study of the general inadequacies of the transition from child to adult mental health services. When all the data, both qualitative and quantitative, point in the same direction then we have a powerful combination indeed. What a pity ethical considerations prevented service users outside the system from contributing to this valuable database. We have similar powerful evidence from other studies, particularly in the management of self-harm where attitudes have changed enormously in the past few years, largely because service users have spoken out and their voices are being heard.¹⁰ Collaboration is the essential word in this context and, although one of my non-English colleagues says he detests the word as in his country all collaborators are shot, we need to reclaim it for the team effort that makes lasting progress.

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