Iatro-epidemiology

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Fifteen years ago the psychotropic drug prescribing habits of a group of general practitioners were assessed by analysing the drug treatment of all patients referred by them to a psychiatric out-patient clinic (Tyrer, 1978). Of 287 patients studied over a four year period, 220 were taking one or more of 56 different psychotropic drugs at referral — most commonly Diazepam. Benzodiazepines and barbiturates were reported to have been taken for significantly longer periods than other drugs, and of a total of 342 drugs, 61 had been prescribed regularly for over a year.

Tyrer (1978) considered that half of the drugs were incorrectly prescribed on pharmacological grounds, the main errors being unnecessarily prolonged regular treatment, incorrect dose (particularly with antidepressants), and polypharmacy with drugs of similar pharmacological action.

The belief that there is a standard dose and duration of treatment is deeply rooted in recent medical tradition and has been fostered by the advent of the randomised controlled clinical trial. Clinical experience belies such conviction. Moreover, from an epidemiological perspective, disorders and treatments are often best conceived in dimensional rather than in categorical terms: on this basis, depressive disorders of different severity might conceivably respond to different doses and durations of antidepressant drug therapy.

Cochrane (1972) drew attention to this issue in his monograph on effectiveness and efficiency, where he made a distinction between effectiveness-assessed by the randomised controlled trial; and efficiency — assessed by the successful delivery of treatment to patients. The gulf between the two concepts has seldom been bridged by research workers in psychiatry.

Johnson (1981) illustrated some of the problems associated with the adequate drug treatment of medical conditions by reference to an observational survey of depressive illness and its treatment by general practitioners. Over 200 patients attending 14 family doctors in five different practices in Manchester, England, took part. Only patients with a primary depressive illness which was of sufficient severity to score 11 or above on the Beck Depressive Rating Scale were included. In order to monitor treatment, both doctor and patient were interviewed separately within hours of the initial consultation and repeated interviews took place over the next four to six months. Medical records and prescriptions were examined and the whole evaluation was carried out blind to both doctors and patients as to the real reason for repeated contact.

Two samples were studied: the first was of 119 patients with a new depressive illness presenting to their family doctor for the first time; the second was of 82 patients with a primary depressive illness who had been under drug treatment for a minimum of three months.

At initial interview 98% of all patients seen were given a prescription for drugs, and 92% were prescribed a tricyclic antidepressant. Of these, 25% received more than 75 mg of Amitriptyline per day, 32% received 75 mg per day and the rest received less than 75 mg per day of the drug or its equivalent (20% were prescribed 30 mg or less per day).

When the treatment prescribed for those who remained depressed at 4-6 weeks (n = 72) and 16-18 weeks (n = 33) was examined there were three trends: the proportion of depressed patients receiving treatment which consisted solely of drugs fell with time; the proportion of those patients remaining on drugs who were prescribed tricyclic antidepressant drugs also fell with time; and, when a patient was kept on a tricyclic drug the dose tended to remain constant. When the prescriptions given to the second sample were considered the trends were similar.

All patients attending the general practitioner af-

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ter the three month interval (n = 88) were receiving drugs as the principle treatment. Only half of these patients were given drugs usually classified as antidepressants, and only half of this latter group were prescribed a 'potentially therapeutic dose'. Forty per cent of these patients were prescribed tranquillisers.

A study of treatment adherence in the 112 patients with a new depressive illness was made after the initial consultation. Medical records were examined as were prescriptions issued and drugs collected. There were also tablet counts and interviews with patients and their families. Within one week 16% of patients had stopped medication, 41% had done so within two weeks, 59% within three weeks, and 68% within four weeks. About one third of the sample claimed a remission of their symptoms within this period. It was calculated that 57% of patients who were still depressed at 4-6 weeks had defaulted from their drug treatment.

At the time of the initial consultation all patients were requested to return to see the general practitioner as part of the management plan. Thirty-eight per cent complied with this request and only 9% returned for a further or subsequent consultation during the first six weeks following the first consultation.

Solutions to the problems of psychotropic drug prescribing involve increased self awareness of the public; mass education and the mass media; changes in physicians' perceptions of symptoms; the impact of advertising and other activities undertaken by the pharmaceutical industry; and, most importantly, the production of adequate research which keeps doctors sufficiently informed (Cooperstock, 1974).

Another line of enquiry has been highlighted by Enid Balint (1974). In an assessment of her husbands' work shortly after his death, she chose to concentrate on a seemingly narrow topic delineated by him in *The Doctor his Patient and the Illness* (Balint, 1971). An introductory chapter of which suggests that by far the most frequently used drug in general practice is the doctor himself. He continues: "no guidance whatever is contained in any textbook as to the dosage in which the doctor should prescribe himself, in what form, how frequently, what his curative and his maintenance dose should be and so on...".

Balint then said that when at the first seminar this state of affairs was realised, the doctors decided that one of their aims, perhaps their chief aim, should be to start devising a new pharmacology. That is to say, to describe in what doses the doctor himself should be prescribed, the side-effects etc.

We remain confronted by this challenge, delivered, ironically, by a psychoanalyst. The answer lies clearly within the scope of epidemiological psychiatry.

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