PE1651/PPPPPPP
Hunter Watson submission of 20 January 2018

Having watched the Public Petitions Committee take evidence on 18 January 2018 from the Minister for Mental Health and a consultant psychiatrist about antidepressant use, I formed the opinion that these two witnesses displayed unacceptable complacency.

Given the risks of taking antidepressants, I was disappointed when the Minister expressed the opinion that the increased level of their use is to be welcomed. I was surprised when she asserted that there was no evidence that having greater access to psychological therapy would reduce antidepressant prescribing: she seemed to be implying that if a GP diagnosed depression then an antidepressant would normally be prescribed even if psychological therapy were available. It should be of concern if the situation is as the Minister implied.

All drugs have undesirable side-effects, the most common of which are listed in the British National Formularly (BNF), a publication to which the consultant made reference. As can be confirmed from the BNF, one of the numerous side-effects of the antidepressant Venlafaxine is hallucinations, a symptom of a psychotic condition. I once represented a woman called Mrs M who, against her better judgment, was persuaded to take that antidepressant. Unfortunately after starting on Venlafaxine, Mrs M did appear to hallucinate. I have written at length elsewhere about the consequences of this. However, the basic point is that Mrs M should not have been persuaded to take any antidepressant since, although she was unhappy about certain matters, she was not suffering from severe depression. That can be deduced from her medical notes.

The BNF makes clear that the taking of antidepressants will cause some patients to die prematurely. It notes, for example, that overdosage with certain antidepressants is associated with a relatively high rate of fatality, that the use of antidepressants may be a factor in the sudden death of patients with cardiac disease and that some antidepressants should be avoided in severe liver disease. Counter-intuitively, the BNF also advises that suicidal behaviour has been linked with antidepressant use. Note should also be taken of the following:

- an article published in JAMDA in July 2017 entitled "Associations of Neuropsychiatric Symptoms and Antidepressant Prescription with Survival in Alzheimer's Disease" - The researchers found that "Prescription of an antidepressant, both before and after dementia diagnosis, was significantly associated with higher mortality after adjusting for a broad range of potential confounders ..." (JAMDA = Journal of the American Medical Directors Association);

- an article published on September 23, 2017 in Natural News and entitled "Antidepressants are killing people: Risk of early death increased by 33%".

Although, some GPs might believe that psychological therapies are insufficient to treat patients with depression, the BNF advises that antidepressant drugs should not be used routinely in mild depression, and that psychological therapy should be considered initially. Further, the depression care standards, produced by Quality Improvement Scotland in 2007, state that "Mild depression is usually self-limiting and may respond to simple reassurance, direction to self-help materials and other community resources". They also state that "Advice should include lifestyle changes, such as planned exercise, healthy eating and sensible drinking". Clearly a ten minute appointment is insufficient for a GP to adequately assess and then to discuss treatment options with a patient who wishes help to cope with symptoms of depression. The witnesses were asked about this matter, but seemed unwilling to concede that a ten minute appointment might be insufficient. It is, perhaps, worth observing that the limited length of time which GPs have with their patients may be a significant factor in their occasional failure to take sufficient care when diagnosing or prescribing, failures which can result in avoidable adverse drug reactions.

According to an article entitled "How too much medicine can kill you" which appeared in the Guardian of 1 September 2015, professor Peter Gotzche estimated that "prescription drugs are the third most common cause of death after heart disease and cancer. " The same article claimed that "Between 2007 and 2012, the majority of the largest 10 pharmaceutical companies all paid considerable fines for various misdemeanors that included marketing drugs for off-label uses, misrepresentation of research results and hiding data on harms." It is possible that some of the views of the Minister about antidepressant use could be traced back to the marketing of antidepressants by pharmaceutical companies.

Some deaths due to prescription drugs will have occurred even though the prescriber took care but decided, with the consent of the patient, that the potential benefit was such that the small risk of death was justified. However, in other cases the deaths will have occurred because of a mistake on the part of the prescriber. Unfortunately, the incidence of such mistakes is unlikely to decrease significantly since, for fear of litigation, the norm is to cover them up. Hence in healthcare there is little opportunity to for the profession as a whole to learn from the mistakes of individuals.

That doctors do make mistakes which harm patients has been well established by several pieces of research, notably that by Munir Pirmohamed et al (Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients.

BMJ, 3 July 2004). My own investigations in the course of representing a man whose mother, Mrs D, died only eighteen days after entering a nursing home made it obvious that GPs can and do make mistakes which harm patients. I have written about this case extensively elsewhere. Some of the essential facts are the following:

- nursing home staff persuaded a GP to prescribe an antibiotic to Mrs D in case she had a urinary tract infection which was affecting her behaviour;
- the GP prescribed trimethoprim even though Mrs D was known to have renal impairment and trimethoprim is nephrotoxic;
- the GP ignored the advice in the BNF about prescibing for the elderly and prescribed the normal adult dose even though Mrs D was in her eighties.

I reported my findings to the Procurator Fiscal's office. Eventually the death was investigated and a report sent to the Crown Counsel. Unfortunately the Crown Counsel instructed that there was to be no Fatal Accident Inquiry and hence no lessons were learned. In particular, it is unfortunate that it was not established that the clinical judgment of doctors can sometimes be in error: Scottish mental health legislation seems to be based on the premise that it never is.

At the meeting of the Public Petitions Committee the witnesses were asked about informed consent. An attempt was made to persuade the Committee that informed consent would be sought before medication was prescribed. If the experiences of others are similar to mine, then it will be realised that GPs do not normally attempt to obtain the informed consent of their patients before issuing them with a prescription; instead they leave it to their patients to read the notes that accompany the prescription. It is unlikely that these notes will always detail all material risks.

Regrettably there are some doctors who believe that they are entitled to treat patients without seeking their consent far less their informed consent. I represented one such patient, a Mrs A, who had been treated by force against her will while in hospital. She was traumatised as a consequence of that experience and later required psychotherapy. The responsible consultant refused to accept that a patient with capacity has the right to withhold consent and that there must be a presumption of capacity unless it has been properly established to be lacking. Instead, he insisted that his "duty of care" required that he should use force if he considered that necessary. Not only was he mistaken in his understanding of the law, but he was also mistaken in his diagnosis of the condition which had led to Mrs A's admission to hospital. So much for clinical judgment!

The Ombudsman upheld the complaint which I made on behalf of Mrs A. He concluded

his report by stating "For the sake of patients and health practitioners, lessons from this disturbing incident must be learned not only across the Board concerned but across the NHS in Scotland". In spite of that conclusion, so far as I am aware no attempt has been made to ensure that lessons were learned from this incident.

Perhaps the Scottish Government should accept that the importance of informed consent is such that it should take steps to ensure that health professionals are made aware of the importance of the 2015 Montgomery v Lanarkshire Health Board judgment. According to an article in the BMJ on 12 May 2017 (Montgomery and informed consent: where are we now?) "The Montgomery case in 2015 was a landmark for informed consent in the UK." According to the authors of the article, the Montgomery case established "a duty of care to warn of material risks". The fact that an attempt was made to give the Public Petitions Committee the impression that Scottish GPs seek informed consent before prescribing suggests that the Minister had been advised not to concede that GPs might be failing to make their patients aware of the significant risks of taking antidepressants or, indeed, other prescribed drugs. It would be interesting to find out whether the Scottish Government has made any attempt to ensure that GPs are made aware of the need to do this.