Few things in life afford more pleasure than that of a job well done. Medical professionals know this and are committed to offering patients high-quality service, genuine caring, respect, personal integrity and ethical conduct. This requires not only skill and dedication but also up-to-date knowledge of the field, sound judgment and reasonable strength of character. As never before, modern psychiatrists must be able to keep abreast of new scientific information, of changes in societal values and expectations, and of constantly evolving patterns of standards and practice. No longer are patients willing to accept a passive role with regard to their medical care. Enhanced access to information and the increasing emphasis on shared responsibility and physician accountability have created new challenges for patients and caregivers alike.

We as psychiatrists can respond to these challenges by developing practice standards based on the latest scientific evidence and by stimulating meaningful discussion of important issues among experienced practitioners. The Bulletin will be publishing articles related to professional standards and ethics on a regular basis throughout the year—articles that will be timely, relevant and practical. Some will reflect current best practice, others will offer informed opinion, and some, we hope, will stimulate lively discussion and debate. We look forward to your responses, contributions and creative ideas to make this section interesting, thought-provoking and clinically useful.

The first article in this series has been provided by Dr. Joel Paris, Professor and Chair of Psychiatry at McGill University. Dr. Paris was a proponent of evidence-based medicine long before it became fashionable. He discusses aspects of evidence-based medicine that apply specifically to psychiatry. We hope that you will enjoy reading his paper and that you will reply with some of your own views and opinions.

Evidence-Based Psychiatry:
What It Is and What It Isn’t

Joel Paris, MD
Chair, Department of Psychiatry, McGill University; Psychiatrist-in-Chief, McGill University Health Centre; Research Associate, SMBD-Jewish General Hospital, Montreal, Quebec

Abstract: Evidence-based psychiatry is a growing movement within the discipline. Its basic principle, that practice should be based on data, can be applied to all forms of treatment, including psychotherapy. Clinical practice guidelines can also help practitioners to recognize patients who are likely or not likely to respond to standard treatments. The movement toward evidence-based practice also reflects a change in the nature of physician authority.

Résumé : La psychiatrie fondée sur des données probantes : ce que c’est et ce que ça n’est pas
La psychiatrie fondée sur des données probantes est un mouvement qui prend de l’ampleur au sein de la discipline. Son principe de base, selon lequel la pratique doit être fondée sur des données, peut s’appliquer à toutes les formes de traitement, y compris la psychothérapie. Les lignes directrices de la pratique clinique peuvent aussi aider les praticiens à reconnaître les patients qui sont susceptibles ou pas de répondre aux traitements réguliers. La tendance vers la pratique fondée sur des données probantes reflète également un changement de la nature de l’autorité du médecin.

Key Words: evidence-based medicine, psychiatric treatment
This article’s title is inspired by an editorial, “Evidence-Based Medicine: What It Is and What It Isn’t,” published in the British Medical Journal in 1996 (1).

The 1996 editorial described evidence-based medicine (EBM) as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

EBM has strong Canadian roots, and many of its originators worked at McMaster University in Hamilton, Ontario. In recent years, EBM has become a powerful movement within medicine, with particular influence on the younger generation of physicians. In a “cultural shift,” evidence-based psychiatry has also become a force to reckon with (2). Psychiatric journals contain as much quantitative hard science as do publications in any other specialty and give little space to unsupported clinical opinion. The Canadian Psychiatric Association (CPA) has taken up the cause, as a recent and insightful position paper demonstrates (3). Both the American Psychiatric Association (APA) and the CPA have published a series of clinical practice guidelines based on empirical evidence concerning treatment effectiveness.

Some academics have questioned the value of evidence-based psychiatry (4). The objections centre on the limitations of randomized controlled trials (RCTs) and metaanalyses, and on the lack of high-quality evidence to support clinical practice guidelines. These concerns can be answered simply: EBM has identified principles, but it will take decades to collect the detailed data clinicians need.

Some clinicians have also expressed qualms about evidence-based psychiatry. They see EBM as a way to justify budget cuts and to exclude psychotherapy from practice. These concerns can be answered by looking at what EBM isn’t: its principles do not tell clinicians how to talk to people or how to be sensitive, empathic and caring.

Psychiatrists may have more problems basing their practice on evidence than did other specialists. Many chose the field because it was one of the few ways to become a humanistic physician. These psychiatrists may oppose EBM because they associate it with reductionism and loss of interest in relating to patients. Yet there is no contradiction between EBM and humanism. To practice in accordance with data does not mean that a psychiatrist should be restricted to making algorithmic diagnoses according to DSM criteria and writing prescriptions. EBM does not apply only to the choice of drug treatments. Although few psychiatrists follow developments in psychotherapy research (there are no pharmaceutical representatives to promote them), talking therapies should also be prescribed on the basis of evidence. It is no longer acceptable for psychiatrists to recommend extensive courses of psychological treatment that lack empirical data about their effectiveness.

A few years ago, spurred by an enthusiastic resident, I conducted an EBM seminar at the McGill Department of Psychiatry. The format involved asking residents to bring in clinical questions arising from their work with patients and then exploring the literature for answers. Almost without exception we either found that there was insufficient research on most questions or that some clinical principles we knew to be “true” had never been scientifically proven. As an example, we found no good evidence that the long-term use of valproate helps to prevent relapse from bipolar disorder (5).

Let us consider examples of how EBM can make a difference in clinical practice. In recent years, psychiatrists have routinely prescribed selective serotonin reuptake inhibitors (SSRIs) to patients with major depression. Unfortunately we have been conditioned—partly by the DSM algorithms and partly by the seductive influence of the pharmaceutical industry—to believe that depression is a disease. This is far from the case. Depression is a syndrome with multiple causes, as are jaundice or heart failure. Rational treatment does not follow just from identifying a syndrome.

What can the evidence tell us about treating depression? First and foremost, different patients need different forms of treatment. As shown many years ago in the National Institutes of Mental Health (NIMH) Collaborative Study of Depression, antidepressants and psychotherapy are equally effective for the mild-to-moderate range of symptoms (6). This means that patients in this subgroup can be given a choice. Some people are not very interested in talking; others are horrified at the idea of taking medication (and may have increased side effects leading to noncompliance if the doctor insists on prescribing.) Still others will want to have all bases covered and demand both. Psychiatrists should routinely discuss all these treatment options with patients diagnosed with depression.

Patients with severe depression may not always be in a position to negotiate reasonably with physicians, although
families will often be involved. In these cases, psychiatric expertise rooted in empirical evidence becomes even more crucial. Patients with agitated depressions often require electroconvulsive therapy. Patients with psychotic depressions require neuroleptics. Some patients may do better with tricyclic antidepressants, while a few need adjunctive agents like lithium.

Most of this information can be found in clinical practice guidelines (7) and is well known to psychiatrists. But let us look a little deeper. Not all clinicians are aware of data about the clinical profile of those patients who fail to respond to antidepressants. Understanding treatment failures is also an important aspect of evidence-based practice. The NIMH Collaborative Study showed that a comorbid Axis II diagnosis made patients less responsive to treatment, whether drug therapy or psychological therapy (8). These comorbidities are sometimes mistakenly referred to as “treatment-resistant depression” (9), a concept often taken to imply that psychiatrists have only to find the right drug for each patient. Instead, knowing the evidence should make clinicians think about prescribing psychotherapy (10). The depression associated with personality disorders tends to be chronic, and most patients who develop dysthymia early in life also have an Axis II diagnosis (11). That psychiatrists need to pay more attention to personality disorders is a surprising but practical consequence of applying evidence-based psychiatry to a clinical problem.

The rise of EBM as a guiding principle reflects a change in physician authority. Patients now expect to be informed about their treatment and to be a part of the decision process. They often come in with information garnered from the Internet. In many ways, this development makes clinical practice more challenging. Doctors used to be expected to know the answers to any and all patient questions, and psychiatrists have been particularly guilty of speaking from a position of authority, even on issues far outside their own area of expertise. Contrast that past image with the present reality. Physicians, including psychiatrists, are sitting down with their patients in front of the computer and looking up answers together. Medical practice has become more of a collaboration.

Finally, the practice of EBM should bring more doubt than certainty to the physician. This is a good thing, because doctors know much less than they think they do. Harrison (12) and Kaplan (13) will be as antiquated for the physicians of the future as Osler’s textbook of medicine (14) is for us.

A few months ago I ran into an old friend who is a humanities professor and we talked about the new role of EBM in psychiatry. Looking at me with dismay, he asked, “Do you mean to say that you people haven’t always been practising on the basis of evidence?” Whatever the limitations of EBM, the public expects, and has the right to expect, that we base clinical decisions on scientific data. At this time EBM is an ideal and not yet a reality, and most decisions in practice are still based on clinical experience. The percentage will shrink gradually, but it will never reach zero. Even with the rise of evidence-based practice, medicine and psychiatry will remain as much art as science.

References