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Murky waters: the pharmaceutical industry and psychiatrists in developing countries

A multinational pharmaceutical company recently launched a drug for dementia in Pakistan and flew about 70 Pakistani doctors to Bangkok, Thailand for a 3-night all-expenses-paid trip (Khan, 2004). Pakistani doctors were part of a larger group that also included doctors from other countries. A conservative estimate of costs for the Pakistani doctors alone is about 7 million Pakistani rupees (Rs) (£70 000, US\$120 000).

Although the company could justify it, questions linger about the rationale for spending this huge amount in a developing country (Pakistan) without a healthcare system and where all healthcare is out-of-pocket expenditure. The drug in question costs Rs320 (£3.20; US\$5.40) per recommended daily maintenance dose – prohibitively expensive for the vast majority of Pakistani patients.

This article addresses the murky relationship between pharmaceutical companies and psychiatrists in developing countries, using Pakistan as an example.

Mental healthcare in Pakistan

Pakistan's population of 150 million makes it the world's sixth most populous country. Community-based prevalence studies for common mental disorders give high figures: 25–66% women and 10–40% men (Mumford *et al*, 2000). There are an estimated 3 million drug addicts in Pakistan. Suicide rates have increased dramatically in the last few years, from a few hundred to more than 3000 annually (Khan & Prince, 2003). Serious mental illnesses account for another 1–3% of the population.

Health spending is a pitiable 1% of the government's annual budget and mental health does not have a separate budget. There is no health insurance and a poorly funded public health service is accessed by only the poorest. All healthcare costs are borne by patients themselves. Mental health services are almost non-existent and limited to either psychiatry departments of teaching hospitals or privately run clinics.

There are only 150–200 qualified psychiatrists in Pakistan, an alarming ratio of one psychiatrist to a million people. The majority of psychiatrists are urban-based, whereas 70% of the population is rural-based.

Except in a few instances, psychiatry is neither taught nor examined at undergraduate level, leaving most practising physicians with poor diagnostic and management skills for psychiatric disorders.

Sales of psychotropic drugs in Pakistan

The pharmaceutical market in Pakistan is enormous. Psychotropic drug sales for only 1 year (July 2003 to June 2004) were worth Rs2.76 billion (US\$46.77 million) (IMS, 2004). Of these, antidepressants sales were worth Rs821.17 million (US\$13.4 million) (an increase of 23% from the previous year), tranquilisers and hypnotics Rs1.36 billion (US\$23.18 million) (an increase of 18% and 137% respectively from the previous year) and antipsychotics Rs377.02 million (US\$6.39 million).

Interestingly, sales of drugs categorised as 'nootropics' (so-called brain stimulants) were worth Rs187.6 million (US\$3.18 million). These drugs are largely of no benefit but continue to be prescribed for a variety of neurological and psychiatric disorders (mental retardation, post-stroke weakness, depression, etc.) in Pakistan.

To put the above figures in context, the Gross Domestic Product of Pakistan is approximately US\$61.6 billion whereas the per capita income is US\$440.

The situation is further compounded by poor regulation of psychotropic prescription and dispensing. In Pakistan, most medicines, including psychotropics, are available over the counter. Pharmacies are not staffed by trained or qualified personnel and are not regulated by any professional body. These 'chemists' are also important in influencing psychotropic sales (hypnotics and tranquilisers), as many patients present to them with their complaints.

There is good evidence that patients with common mental disorders often present with physical symptoms in Pakistan (Mumford *et al*, 1991; Hussain *et al*, 2004). With few psychiatrists in the country, large numbers of such patients are seen by physicians, including cardiologists, neurologists, gastroenterologists, general and family physicians. These frequently prescribe psychotropics and



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this is reflected in the psychotropic sales figures in Pakistan.

You scratch my back, I'll scratch yours

Pharmaceutical companies and physicians have a well-established symbiotic relationship in Pakistan, not unlike that in many other countries. However, with little or no regulation of medical practice or drug prescribing and dispensing, companies and physicians are free to act as they deem fit. Malpractice litigation against doctors is unheard of.

Although psychiatry is a relatively new specialty, it has benefited just as much from this relationship. Because there are few psychiatrists compared with patients, chances of overprescribing are huge. Pharmaceutical companies have therefore targeted psychiatrists aggressively. The traffic is bidirectional – psychiatrists are as demanding of favours as companies are of providing them.

Forms of inducements

Some of the many inducements on offer include: sponsoring attendance at conferences, underwriting symposia, all-expenses-paid trips for self and spouse for a drug launch abroad, free drug samples and expensive gifts (watches, air conditioners, briefcases, laptops, etc). Other methods include funding a physician's family wedding, holidays and other events of this nature.

One of the latest incentives is for the pharmaceutical company to provide the physician with a down payment for a new car. All the physician has to do in return is write 200 prescriptions for the company's expensive drug.

A pill for every ill?

Kawachi & Conrad (1996) describe medicalisation as a 'process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses and disorders', thus decontextualising human problems and turning attention from the social environment to the individual. They point out the negative consequences, chiefly the extension of the sick role and diversion from other solutions.

The medicalisation of human distress is proceeding at a rate faster than the development of new drugs. Pakistan has one of the highest number of common mental disorders in South Asia, with a third of the population living below the poverty line. Given the clear link between poverty, social deprivation and mental ill health (Patel & Kleinman, 2003), it is likely that in this population there are many who are psychologically distressed. The medicalisation of distress and treatment with psychotropics has boosted sales enormously.

Inappropriate medicalisation carries the dangers of unnecessary labelling, poor treatment decisions, iatrogenic illness and economic waste, as well as costs that result when resources are diverted from treating or

preventing more serious disease (Moynihan *et al*, 2002). At a deeper level, it may help to feed unhealthy obsessions with health, obscure or mystify sociological or political explanations for health problems, and focus undue attention on pharmacological, individualised or privatised solutions (Pilgrim & Bentall, 1999).

The question is: At what point does an understandable response to distressing life events become an indication for drug treatment and a market opportunity?

The acute shortage of psychiatrists in Pakistan and the serious lack of exposure of physicians to psychiatry means that large numbers of patients with medically unexplained symptoms are misdiagnosed, undergo unnecessary and expensive investigations and are invariably prescribed a variety of medications, including psychotropics.

Patients are telling their stories. But is anyone listening?

As the emphasis on drug treatment becomes greater, psychiatrists are under increasing pressure to prescribe psychotropics – especially as newer psychotropics, such as selective serotonin reuptake inhibitors and atypical antipsychotics, are being marketed as panaceas for all mental disorders. It is not uncommon for a general practitioner practising in a low-income area in Pakistan to prescribe a third-generation antidepressant, such as venlafaxine, one of the most expensive antidepressants currently available in Pakistan. Since most doctors in Pakistan have neither exposure to psychiatry nor are obliged to participate in continuous professional development (CPD), prescribing practices reflect the influence of pharmaceutical companies.

This aggressive drug prescribing is not without its victims. What is lost, sadly, is the patient's story and the listening skills of the physician. The danger is that the process may have gone so far that it may be virtually impossible to turn back. The skills of medicine and psychiatry are therefore undergoing a slow and painful death in developing countries such as Pakistan.

Motives of the pharmaceutical industry

Pharmaceutical companies are under intense pressure to garner and retain market share, leading to what the World Health Organization (1993) has called 'an inherent conflict of interest between the legitimate business goals of manufacturers and the social, medical and economic needs of providers and the public to select and use drugs in the most rational way'. It has been shown that doctors with a greater reliance on favours (gifts, etc.) prescribe less appropriately (Wazana, 2000).

Healthcare professionals who think that drug companies' activities are motivated by altruism should seriously reconsider. Promotional activity has a single intention: to increase market share by influencing prescribing habits (Williams, 2002). Today drug company representatives are highly skilled sales professionals



whose training is generally company specific and more oriented to the art of selling than to therapeutics.

Drug manufacturers are in the business of selling products and are held accountable to shareholders who expect a return on their investment. Those who consider that there is any other motive behind these kinds of activities are deluding themselves.

The moral imperative

At the very least, accepting gifts or other inducements from drug companies constitutes a conflict of interest. However, there are other important issues to consider, such as probity and individual and institutional integrity. When a patient consults a physician they do so in the perceived knowledge that the physician will act in their best interest and be completely objective and impartial in prescribing any medication the physician deems fit. What the patient does not know (and has no way of knowing) is what may be influencing the physician's prescribing practice. How would a patient feel if they were to know that the doctor's prescribing habit is influenced by what gifts he has received?

Psychiatry: a unique specialty that is losing its way

Increasingly the global psychiatric agenda is being dictated and driven by pharmaceutical companies. However, the situation is of far greater concern in developing countries such as Pakistan. Here, adverse social conditions lead to high levels of psychological distress in the population and many people end up receiving primary and mental healthcare. The pressure to prescribe drugs that provide rapid but temporary relief of symptoms falls on the physician. This approach is at odds with the foundations of psychiatric teaching and what makes it the unique specialty it is.

This uniqueness lies in psychiatry's humanistic, holistic and bio-psychosocial approach to human problems and the central importance of the patient's narrative. If psychiatry is to retain this uniqueness then it will not be by medicalising human distress or prescribing psychotropics indiscriminately, but by building on and strengthening the very qualities that make it different from other medical specialties. These qualities include the use of communication skills, counselling, problem-solving therapies and support groups. There is now good evidence that many of these approaches are effective in developing countries (Ali *et al*, 2003; Bolton *et al*, 2003).

Cleansing murky waters: regaining integrity

Can the murky waters be cleansed, boundaries redrawn and integrity regained by psychiatrists in developing countries such as Pakistan? I believe they can, providing that there is a serious will to do so.

It is vital that no matter what the circumstances the interest of the patient remains paramount. Anything that compromises this must be identified and eliminated. This includes accepting any kind of inducement – large or small, in any form, shape or size – from pharmaceutical companies. Alternative ways of funding attendance at conferences must be found. This must be strengthened by strong institutional policies limiting direct contact with pharmaceutical sales representatives.

At undergraduate level, both psychiatric training (emphasising non-pharmacological methods of treatment) and a bioethics course (addressing issues of conflict of interest, probity and value ethics) would help in decreasing reliance on drug therapies as well as contribute to the ethical behaviour of physicians. Currently, only a few medical colleges in Pakistan teach and examine psychiatry, or include bioethics teaching at undergraduate level.

Conclusion

Today many developing countries such as Pakistan are facing a serious crisis in mental health, and resources – both manpower and fiscal – are severely lacking. Unfortunately at the level of government planning and policy-making, there is neither an understanding nor a political will to change this status quo. Under these circumstances, institutions and individual physicians assume a far more important role than in countries with well-developed healthcare systems. Both need to be cognisant of the enormous responsibility they carry in dealing with the poor, the ill and the distressed in these circumstances.

Above all, there is need to get away from the culture of greed and profit that has pervaded the psychiatric profession in Pakistan. The medical profession in general, but psychiatrists in particular, need to take a deep, hard look at themselves and ask why have they been so willing to bargain their integrity for a few thousand rupees. As Jung (2002) writes 'once you have sold your soul, it can be a hard item to retrieve'.

A concerted effort to regain our integrity as a profession and specialty is urgently required.

Declaration of interest

None.

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Corrigendum

On page 48 of the paper by Bertram and Howard (*Psychiatric Bulletin*, February 2006, **30**, 48–51, the last two clauses of the 'Results' section of the 'Abstract' should read:

'... and 9% were engaged in vocational interventions with their care coordinator; the latter was less likely if the patient was from a Black or minority ethnic group (OR=0.44, 95% CI 0.18–1.05).'