Letters to the Editor

Re: Reducing the Burden of Depression

Dear Editor:

The article by Dr Gavin Andrews[1] on the burden of depression in the July 2008 In Review on the epidemiology of depression intends to inform our psychiatrist colleagues and Canadian policy-makers about the prevalence of depression and its policy implications. Policy-makers need to be informed on the nature of the disorder to better allocate health funds adequately between treatment, rehabilitation, prevention, and promotion.[2]

Insufficient attention has been paid to the prevention of depression. The examples of prevention (or promotion?) cited by Andrews can be seen as "reinforcing the individual" but ignoring what can be done in the environment, in particular the workplace. Seminal Whitehall's and later studies have shown that undue stress related to work organization is associated with increased arterial blood pressure, cardiovascular diseases, common mental disorders, substance abuse, and behavioural problems. Recent intervention trials introducing good organizational practices taught in administrative schools, showed a reduction in both arterial pressure and psychological distress.[3]

England has introduced workplace norms regarding stress, and the Canadian Mental Health Commission is working in that direction as presented in Quebec City, September 5, 2008, at the Third Canadian National Congress on Mental Health and Addiction in the Workplace—research supported by the Canadian Institutes of Health Research.[4]

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What is a Randomized Controlled Trial for the Canadian Institutes of Health Research?

Dear Editor:

> The Randomized Controlled Trial (RCT) Division at the Canadian Institutes of Health Research (CIHR) has determined that your application is an RCT.

With the October 10 issue of *Science* (Clinical Trials and Tribulations) as a backdrop, this one-liner is the gist of the communication that some researchers may receive after they submit an operating grant proposal to a CIHR competition. But how does CIHR determine that a proposed study constitutes an RCT?

CIHR's policy states that RCTs are not funded through the Operating Grants Program. Therefore, researchers whose applications have been flagged with the RCT appellation have to resubmit their proposals to the next RCT competition because CIHR withdraws their applications from the Operating Grants competition. If your research spans the behavioural and social sciences (for example, psychiatry and psychology) and draws on clinical populations, you may run a higher chance of an RCT hit. As the principal investigator, you may contend that your grant proposal is anything but an RCT, yet reversing CIHR's decision can be difficult.

CIHR's current definition of an RCT is

> an experiment in which investigators randomly assign eligible subjects (or other units of study, for example, classrooms, clinics, and playgrounds) into groups to receive or not receive one or more interventions that are being compared. The results are analyzed by comparing outcomes in the groups.

Further, to determine whether a specific proposal is an RCT

> Applications will be examined for the relevance of the question posed, and the appropriateness of the methodology and of gender representation in the study design and selection of research subjects.

Whereas this definition may seem innocuous, it engulfs a large corpus of clinical population research that is not trial (and should not be judged as such). In this regard, a strong editorial wind should winnow CIHR's definition because the current description is so broad as to label almost any patient or human population-based study an RCT.

With the definition as it presently stands, CIHR guidelines seem to offer considerable latitude regarding what constitutes an RCT. In addition, certain reserved words and expressions (for example, randomization, placebo, control group, blinding of data, and comparison across groups) may inveigle reviewers to label experiments as RCTs, but these terms of art are independent and often appear in research proposals even in the absence of a trial (that is, no T in the RCT) and without comparing treatments. For example, many experiments involving psychosocial research tend to allocate participants randomly and compare group outcomes following some kind of manipulation. Because this paradigm is a common occurrence in experimental psychology, CIHR may speciously identify such experiments as RCTs. However, these studies are not even in the grey zone and should go to the Operating Grants Program, where they stand a funding chance. Otherwise, research proposals of this ilk may be too medical for the Social Sciences and Humanities Research Council but potentially flagged as RCTs by CIHR.

To prevent such applications from slipping between the cracks, we should provide CIHR with feedback on this problem and suggest refinements to a definition for RCTs. Failure to do so may influence funding and academic careers for entire research domains. Further, if this type of RCT

confusion is common it may cause considerable disruption and represent a systematic problem. In such a case, our community should work with CIHR to address, educate, discuss, and rectify the situation.

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Re: Toward a Hippocratic Psychopharmacology

Dear Editor:

Dr S Nassir Ghaemi's[1] interesting proposal for a Hippocratic psychopharmacology can be challenged on various grounds. The Hippocratic view, "that nature is the source of healing, and that the job of the physician is to aid nature in the healing process"[1]—fails in many cases, such as autoimmune disorders. Therefore, it seems that a mixed Hippocratic and non-Hippocratic framework is required for psychiatry as medicine, as argued elsewhere.[2]

Osler's rule of "treat diseases, not symptoms"[1] may be largely, if not fully, irrelevant to contemporary psychiatry, as etiology is unknown for any psychiatric disorder, and psychiatric pathophysiology is in its infancy,[3] so that active alleviation of psychiatric symptoms may currently require symptomatic treatment, that is, treatment of psychiatric symptoms and their clusters, as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision and the International Classification of Diseases, Tenth Revision. A diagnostic hierarchy of psychiatric disorders with (presumably major) mood disorders trumping all other diagnoses, similar to that which Dr Ghaemi[1] argues for, was widely accepted until the last few decades, and did not prove useful. For example, psychiatric comorbidity, viewed as symptoms or disorders, was commonly ignored then, to the detriment of patients; moreover, Dr Ghaemi's[1] claim that such a diagnostic hierarchy determines the required treatment can be refuted, as illustrated by the example of major depressive disorder with psychotic features, which commonly does not respond to, or worsens with, antidepressant medications and requires antipsychotic medications or electroconvulsive therapy (which is not a specific antidepressant treatment).

Hippocratic philosophy of disease and treatment implies the importance of self-organization in health, illness, and care, and as such, is associated with some of the foundations of modern medical science, for example, as illustrated by the notion of homeostasis.[4] Yet this philosophy does not entail Hippocratic ethics. Physicians nowadays should not and mostly do not accept the ethics of the Hippocratic oath, at least the aspect that ignores patient self-determination or autonomy,[5] which is a fundamental principle in contemporary bioethics,[6] including in psychiatric ethics.[7] Patient choice is a mainstay of contemporary psychiatry, as illustrated in the growing literature on recovery of people with severe psychiatric disorders.[8] Admittedly, people with psychiatric disorders are sometimes impaired in their self-determination or autonomy. Established institutions such as substitute decision making, as well as novel participatory frameworks such as dialogical bioethics,[9] support such patients in the determination of their care.

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