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counterpunch

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Prozac, Suicide and Dr. Healy

By Rick Giombetti

Dr. David Healy of the Department of Psychological Medicine at the University of Wales in the UK is hardly a household name in the United States and that is a shame.

One of the world's leading research psychopharmacologists, Healy's expert testimony in last year's Paxil civil trial was one of the

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deciding factors in the plaintiff's jury victory in that case. Wyoming resident Donald Schell, 60, killed his wife, daughter and granddaughter and then himself with a gun in 1998 after only two days on Paxil. Schell's surviving family members sued Paxil manufacturer UK-based Glaxo-Smith-Kline (GSK), the world's largest pharmaceutical manufacturer, and won. The decisive factor in the case was the company's own internal data demonstrating that they knew Paxil could cause agitation and suicidal ideation in research subjects. A month after the June verdict in the case, GSK caved in to the British Medicines Control Agency's request to put a suicide warning on Paxil.

The fact that a jury verdict in a civil trial here in the United States has led to a suicide warning being put on labels for a popular psychiatric drug in another country has hardly been headline news. Two weeks after the verdict in the Paxil trial, Houston area mother and convicted murderer Andrea Yates drowned her five children while she was on not one, but two antidepressant drugs with strong stimulant profiles. What could have been an opportunity for the mass media to educate the public about the dangers of antidepressant drugs, instead has been a non-stop awareness campaign for the mental health industry about the need for more psychiatric "treatment." The real story that has been missed in the Yates case is the fact that it is a story about psychiatric treatment failure. Yates had been getting psychiatric drugs for her post partum depression for years. She was on high doses of two antidepressants drugs at the time she drowned her children but went ahead and did what these drugs are supposed to prevent anyway.

Meanwhile, Dr. Healy Hasn't shied away from linking Prozac, Paxil and the other SSRI's to suicide. He figures at least 250,000 people have attempted suicide worldwide because of Prozac alone and that at least 25,000 have succeeded.

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Amira Hass

He was offered a job at the University of Toronto affiliated Center for Addiction and Mental Health (CAMH) in 2000. Healy was making arrangements for moving his family to Toronto when he gave a lecture at the CAMH on November 30, 2000 where he reiterated his position on Prozac and suicide. He also made a lot of other statements, backed up by statistical data, that are politically unpopular with many of his psychiatric colleagues. Such as the fact that psychiatrists have more patients in their care then ever before. Healy was unceremoniously turned down for the CAMH job. Speculation has it that Prozac manufacturer Indianapolis-base Eli Lilly may have had a hand in Healy's firing. An international controversy has ensued about Healy's case and the implications it has for academic freedom in academic medicine. Healy filed a multi-million dollar breach of contract lawsuit against the CAMH and the University of Toronto on September 24 of last year.

A summary of the entire David Healy affair can be read on the Internet at **http://www.pharmapolitics.com**.

I recently completed an e-mail interview with Healy about Prozac and suicide, the CAMH lecture and many other contemporary issues in psychiatry today. Below is the transcript.

--Rick Giombetti Seattle

RG: How do Prozac and the other SSRI's (Selective Serotonin Reuptake Inhibitors) like Paxil cause suicidal ideation ("We can make healthy volunteers belligerent, fearful, suicidal and even pose a risk to others," you wrote in the June 2000 Primary Care Psychiatry. "People don't care about the normal consequences as you might expect. They're not bothered about contemplating something they would usually be scared of)?

DH: There is a greater difference between Prozac and other SSRI's on the one side and placebo on

Are the Occupied Protecting the Occupier?

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the other side in the rate in which they cause agitation, than there is between Prozac and the other SSRI's and placebo and the rate at which they get people who are depressed better(i.e. the SSRI's cause more agitation in testing subjects than sugar pills, but they also tend to outperform sugar pills at getting depressed people better). The fact that companies have chose to market them as antidepressants rather than agents that cause agitation is a business decision rather than a scientific matter. It is certainly not one that was "ordained by God." You could say that the fact that some people who are depressed get better is a side effect.

These drugs are drugs that primarily work on the serotonin system. There is no evidence for any abnormality in the serotonin system in people who are depressed. There are however variations in the serotonin system in people who are depressed. There are however variations in the serotonin system in all of us so that some of us will have quite different effects from these drugs than others. It would have been a relatively simple matter to do work on this 10 years ago to find out which of us were more likely to have problems with the drug than which of us were more likely to do well on them.

RG: You testified in the Paxil trial in Wyoming on behalf of the plaintiffs. The plaintiff's position in the case, vindicated by both the jury and judge in the case, was that Paxil was the primarily responsible for Donald Schell shooting his wife, daughter and granddaughter to death before killing himself with a gun in 1998. Schell had been taking the drug for two days. Based on the internal Glaxo-Smith-Kline(Paxil's UK-based manufacturer and world's largest pharmaceutical company) documentation you reviewed as an expert witness in that case, what would you have to say about Paxil and suicide to an individual contemplating a prescription for the drug?

DH: The evidence across the board from all of the

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The Great Chicken War: Bush v. Putin

Dave Marsh
10 CDs Playing On My Desk

John Chuckman
Footprints in the Dust

Norman Madarasz
Max Steel in a Time of Chaos

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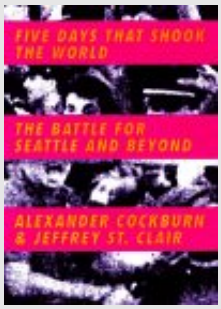

By Alexander Cockburn and Jeffrey St. Clair
Photos by Allan Sekula

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companies producing SSRI's is that their drugs can make 1 in 20 of us agitated to the extent that we drop out of trials. This agitation in some cases will include thoughts of suicide, self-harm or strange out of character thoughts. The agitation may even develop to psychotic proportions.

Part of the problem with SSRI's is the they have been prescribed to many people by a doctor who may not be aware of these side effects and may not have warned you about the side effects. If you then develop problems on the drugs you many not link the drug to the problem or you may feel now that you have a very severe nervous problem that and your physician is the only way out of the problem. A hostage dynamic can develop.

There is a particularly difficult scenario where a patient is faced with a physician who tells them that any increased nervousness they now have is not being cause by their pills and that the answer to this is to continue with the pills. In this case many people may not even let the physician know how serious this increased nervousness is - as they feel they are not being listened to. This situation can arise in part because physicians are dependent on companies for information about any problems that can be caused by the drugs are informed that there is no problem of this kind that stem from the drugs, that any problem of this kind stems from the illness. In such circumstances where a physician is relying on what they have been told by the company and not listening to their patient, there is a real risk of things going badly wrong. Some people will only escape disaster if they halt their pills.

RG: The story of Houston area mother Andrea Yates drowning her five children has led to quite a campaign of awareness about mental illness in the mass during the past several months. First, it was post-partum depression and now, with the recent revelation in the testimony in the Yates' murder trial that she believes she is possessed by Satan, schizophrenia. What hasn't happened with the

Yates case has been an honest accounting of what it really is about: Another case of psychiatric treatment failure. Andrea Yates' post partum depression had been getting treated with drugs for years and she was on two antidepressants at the time she drowned her five children. I'm not asking for much from the mass media on the reporting of this case. Just the barest mention of two words with this case would be helpful: Effexor and Remeron.

At the time of the drownings Yates was on 450 mg/day of Effexor, or 75 mg above the maximum recommended dosage, and 45 mg/day of Remeron, or the maximum recommended dosage. Yates had been taken off 4 mg/day of the tranquilizer Haldol two weeks before she drowned the children and the Remeron was added to her prescription, which continued to include the Effexor. Now there is a wealth of clinical date out there about these two drugs but the media has to look at it instead of helping the mental health industry promote mental health awareness.

It turns out that a gem of study titled "Mirtazapine(Remeron) Versus Venlafaxine (Effexor) in Hospitalized Severely Depressed Patients With Melancholic Features" was published in the August 2001 Journal of Clinical Psychopharmacology. It's a gem with regard to the Yates case not only because it compares two groups of patients put on the same antidepressant drugs she was on at the time of the drownings, but because it does not omit the fact that concomitant medications were being administered to the patient/subjects(a rarity for the published results of clinical studies, indeed).

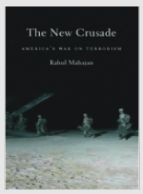
Out of the group of 78 patient/subjects put on Remeron, 56 percent of them were administered the benzodiazepine tranquiler Oxazepam to counter agitation and 35 percent were administered the hypnotic Zolpidem to counter insomnia. Out of the 79 patient/subjects in the Effexor group, 49 percent were administered

Out How the CIA's Backing of the Mujahideen Created the World's Most Robust Heroin Market and Helped to Finance the Rise of the Taliban and Osama bin Laden

Whiteout:

CIA, Drugs & the Press
by Alexander Cockburn and Jeffrey St. Clair

The New Crusade: America's War on Terrorism
By Rahul Mahajan



The New Crusade: America's War on Terrorism by Rahul Mahajan

The Memphis Blues Again:
Six Decades of Memphis Music Photographs
Photos by Ernest Withers
Text by Daniel Wolff

Oxazepam and 41 percent were administered Zolpidem.

Here are the other vital statistics provided by the article: 62.8 percent of the Remeron group were female and 68.4 percent of the Effexor group were female. The maximum dosing of the Remeron group ranged from 45-60 mg/day and 300-375 mg/day for the Effexor group. The study lasted eight weeks and 23.1 percent of the Remeron group dropped out, plus 35.4 percent of the Effexor group dropped out of the study.

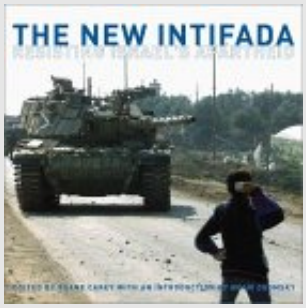
Well, am I on to something here? Is it unreasonable to suggest that Yates was suffering from extreme agitation and/or insomnia, given that she was taking high doses of both Effexor and Remeron, and that this might have been a factor in her actions the day she drowned her children? What do you know about Effexor and Remeron? (Effexor is known as a "Serotonin and Norepinephrine Reuptake Inhibitor" or "SNRI" and Remeron is known as a "Noradrenergic and Specific Serotonergic Antidepressant," "NaSSA")

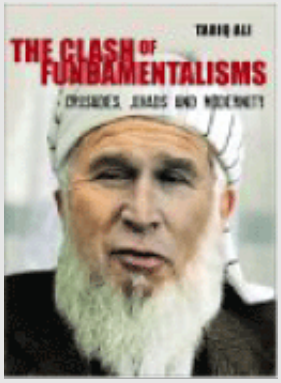
DH: The European tradition had been that all antidepressants could cause a problem. This included the tricyclic antidepressants which like Venlafaxine (Effexor) inhibited both serotonin and norepinephrine reuptake. The clinical trials of Mirtazapine (Remeron) submitted to the FDA that got it a license contain an excess of suicides and suicide attempts in those trials compared to placebo. I don't know the details for Venlafaxine (Effexor).

Your point about it not being unreasonable to suggest that Yates was suffering from extreme agitation and/or insomnia on the combination of Effexor and Remeron is a reasonable one.

(At this point Healy thanks me for the reference to the study and asks me for the name of the first study author in order to find out more details about it -RG)

The New Intifada: Resisting Israel's Apartheid
Edited by Roane Carey





The Clash of Fundamentalisms
By Tariq Ali

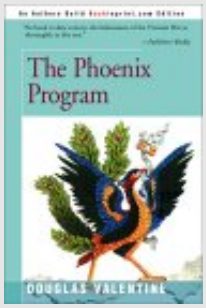
A Pocket Guide to Environmental Bad Guys
by James Ridgeway and Jeffrey St. Clair

RG: "No Such Thing As An Antidepressant" is the title of one of the chapters of Peter Breggin's book **The Antidepressant Factbook**. Breggin writes, "Is it possible that there is no such thing as a genuine antidepressant? Before the scientific data had confirmed my suspicions, I doubted that a drug could actually 'treat' depression. After all, if depression is a product of our conflicts, stressful life experiences, and stifled choices, a drug would have no direct effect on treating it. Meanwhile, study after study has confirmed that antidepressants typically perform only a little better than sugar pills. In some studies, antidepressants actually turn out to be less effective than the lowly sugar pill." Breggin then goes on to cite the clinical data in a review of the performance of seven antidepressants in 45 clinical trials. Is there such a thing as an antidepressant drug and is controlled clinical testing anyway for us to answer this question?

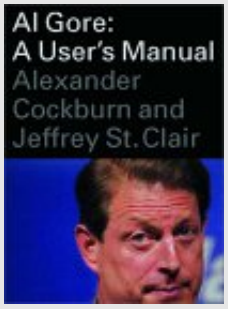
DH: The Breggin line that there is no such thing as an antidepressant because depression arises from conflicts and you couldn't expect a drug to treat that does not follow a coherent medical logic. The problem with a wide variety of nervous states we are faced with is that we don't know the origins of these. To say that they arise from conflicts is too simplistic.

But even if they did arise from conflicts it is not clear that an entirely artificial solution that had little to do with conflicts wouldn't be a way of treating the problem. In many medical states from broken legs through to cardiac problems the answer may be to insert something artificial like a metal plate or a plastic valve in order to produce a new modus vivendi(manner of living). The origins of these problems are not a deficiency of metal in the leg or plastic in the heart but the metal in one case and the plastic in another may provide a workable solution. However, having said this antidepressants are not a cure in the sense that they do not correct either the biological abnormality that may be involved in depression or

The Phoenix Program
by Douglas Valentine



Al Gore:
A User's Manual
by Cockburn
and St. Clair



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Private Warriors
by Ken Silverstein

event the biological predisposition to depression. Some antidepressants are energy enhancing. Others like Zoloft, Prozac and Paxil are more anxiolytic(anxiety relieving). This may or may not be helpful thing to do in the case of someone who is depressed.

Controlled clinical testing doesn't answer the question of whether there is such a thing as an antidepressant or not. What trials do is to show whether a drug can do something or not. Whether it is wise to then do that something or not is an entirely separate question and it is probably the case that many clinicians don't take the time to make a clear decision as to the wisdom of using an antidepressant in the case of each of the patients that they ultimately go on to prescribe for. The overwhelming majority of who are prescribed antidepressants are at little or no risk for suicide or other adverse outcomes from their nervous state. Treatment runs the risk of stigmatizing the person as well as giving them problems that they didn't have to being with.

RG: I'm looking at a copy of the August 2001 issue of Primary Psychiatry. Of course, it's filled with psychiatric drug ads almost exclusively featuring middle-aged and older female models. Most of the models are smiling widely because of the happy pills they are on (Effexor, Risperdal, Remeron, Celexa, Vivactil). The Zoloft add features a portrait painting of a female face filled with anxiety and depression. The Paxil ad features a model whose face is filled with anxiety and worry, obviously because she hasn't had a prescription filled for her happy pill yet(Of course, there is no suicide warning anywhere to be found in the ad, which I assume is now required by law in the UK). There is one ad featuring a male model for the narcolepsy drug Provigil. In one frame the professional looking male model with thick glasses is overcome with fatigue. In the next frame he is as happy as can be with a wide smile across his face.

[CounterPunch's Booktalk]

Has the aggressive marketing of psychiatric drugs as happy pills(to the general public as well as doctor's in professional journals) over the past decade and-a-half turned MD's into Dr. Feelgoods?

DH: I spend a good deal of time cutting out adverts for psychotropic drugs to use to illustrate my talks. The marketing of psychiatric drugs and the change of climate that this marketing brings about has turned what used to be physicians into what lawyers now refer to as pharmacologists. It has become standard practice in the US for you to get your drugs from a pharmacologist and to get therapy from a psychologist or counselor paid at a lower rate. This split is, I would have thought, disastrous. It means that the people who monitor the impact of therapy on you are not trained at all to know about the hazards of that therapy.

RG: Out of curiosity, I wonder if you have any analysis and/or opinion about Loren Mosher's Soteria experiment (This was an experiment in drug-free psychiatric treatment conducted under the auspices of the National Institute of Mental Health during the '70s. The experiment went well by all accounts. It's just that not only was Soteria drug-free, but Mosher staffed the experiment with non-professional counselors. Soteria was quickly defunded and forgotten by the late '70s). I bring this up because I don't recall it being mentioned in **The Anti-depressant Era** and it is a case often brought up by critics of the politicization of clinical testing in psychiatry (The most recent example being Robert Whitaker's book **Mad In America**).

DH: Unfortunately, although I have recently met Loren Mosher, I haven't analyzed or come up with a view on the Soteria experiment. This is an omission, particularly in the light of the fact that I have a new book out from Harvard University Press this month on the antipsychotics called The Creation of Psychopharmacology. It picks up many of the issues touched on in a variety of your questions but unfortunately not Mosher's Soteria

Experiment.

It sounds like Whittaker's book Mad in America is one that I need to get.

RG: At the press conference announcing your lawsuit against the University of Toronto and the CAMH, you said that any punative damages you might win in your suit would be put into an academic trust fund. The reaction to the events of September 11 has lead to new threats to academic freedom. For example, a Palestinian professor was recently fired from his tenured position at the University of South Florida and calls for the firing of University of Texas journalism professor Robert Jensen soley for his anti-war beliefs have been made (here in Seattle by right-wing talk radio host Michael Medved). How would such an academic freedom trust fund be made available to professors who believe their academic freedom has been violated?

DH: I have no idea how academics suffering from violations of academic freedom post-September the 11th would be able to access an Academic Freedom Trust Fund into which I've made contributions. I have no idea for the simple reason that if there is money that results from the lawsuit I will be handing it over to others to manage and would not wish to have any say on how it should be accessed or who should be able to access it. My plans would be to walk away from the management of any such funds so that no one could argue that I was using it to further my own ends.

The CAMH Lecture

RG: In The Antidepressant Era you took exception to Breggin's argument in **Toxic Psychiatry** that pharmaceutical companies exercise undue influence over research and the medical literature that gets published. Has your treatment by the CAMH changed your position on the influence of the pharmaceutical industry over research and

academic freedom in publication?

DH: The Antidepressant Era is all about the extraordinary influence that pharmaceutical companies can have over research and the medical literature. The difference between the position I take in this book and Peter Breggin's argument is that I believe that psychotropic drugs can be helpful where he seems to think that physical treatments generally are both unhelpful and ethically dubious. My treatment by the CAMH hasn't altered my perceptions on this issue.

RG: At the beginning of the CAMH lecture you mentioned a couple of the crucial laws passed during the 20th century that were landmarks in the "War On Drugs" here in the United States (The 1914 Harrison Narcotics Act, which made the opiates and cocaine available by prescription only and the 1951 Humphrey-Durham Amendment to the 1938 Food, Drugs and Cosmetics Act, which made the new antibiotics, anihypertensives, antipsychotics, antidepressants, anxiolytics and other drugs, available by prescription only).

I argue I should have the right to go across the street to the coffee shop I frequent and have my afternoon cup of coffee spiked with 5 mg of Ritalin or 5 mg of Prozac or 5 mg of Remeron or 5 mg of Cocaine or whatever I want. It's laws like the one mentioned above that stand in the way of me being able to do this. Furthermore, my government shouldn't be granting exclusive patents over drugs I paid to develop. Public Citizen has pointed out that the majority of the costs of brining a prescription drug to the market is put up by tax payers and our reward for this is to have to pay the the extortionately high prices for drugs made possible by exclusive patents. In a decriminalized free market, I don't have to pay the Mob's high drug prices or have the blessing of a doctor to take a drug. I can report any adverse event I might experience to a doctor without fear of legal sanction against me. If the FDA made adverse event reporting mandatory for doctors

and adverse event forms widely available to the public for the purpose of voluntary reporting, then researchers could probably get more good data on drugs than they currently do from the clinical testing controlled by the pharmaceutical industry.

What is your opinion of a free market for drugs (I ask because you mentioned in The Antidepressant Era the fact that you could prescribe anything you want for yourself while your patients don't have this privelege)?

DH: My use of the idea of making all these drugs available over the counter was as a thought experiment to try and bring home to people how much prescription only status channels us down a disease model. This shows up clearly in the difference between the marketing of St John's Wort and the marketing of Prozac. You can get St John's Wort to treat yourself for stress and burnout, to get Prozac you have to be made depressed. There are implications for this.

There are a whole lot of other ways to solve many of the problems we have however. One would be to insist that pharmaceutical companies have to make their data and not just their trials publicly available. It would be a simple matter to say that the data is inherently unscientific while it remains proprietary. There is no other branch of science in which the raw data remains inaccessible to investigators generally and indeed essentially to the public.

The whole area of how to handle drug misuse etc. is a complex and fraught one. I see my role in the debate as trying to bring certain angles of the problem to light, angles that are not ordinarily commented on. I don't presume to know the answers.

RG (The following are two question for Healy that are answered below) "Coming from my perspective the antipsychiatry arguments that madness does not really exist are simply wrong."

All right, then define what a mental disorder is. Your colleagues at the American Psychiatric Association haven't helped with this issue with each new edition of their burgeoning Diagnostic and Statistical Manual of Mental Disorders. Having read about a third of the DSM-IV-TR so far, it's easy to see the politics and difficult to see the science driving the most popular diagnoses such as AD/HD for unruly school boys, Delusional Disorder of both the Grandiose and Persecutory Type for the homeless or JFK assassination conspiracy buffs, Generalized Anxiety Disorder for middle and upper income women, etc., etc.,.

"In the same way fear of God was once seen as a good thing that held social order in place. The fear then became anxiety and anxiety disorders - something to treat. What this shows is that there are forces at play, that can change not only the kinds of drugs we give, not only the conditions we think we are treating, but our very selves who are doing the giving. Forces that can change us more profoundly than we can be changed by a handful of LSD containing dust," you said near the end of the CAMH lecture. You are sounding a lot like Thomas Szasz here(author of the "Myth of Mental Illness") yet you don't see eye to eye with him on the existence of madness. I mean something like the above quote suggests that mental disorder has been invented to replace the Church in managing social order, i.e. Szasz's "Therapeutic State." Elaborate further on what mean by the above quote because something like it could confuse people about your position on these issues.

DH: In the case of Thomas Szasz he was arguing that it was unreasonable to say that psychoneuroses were diseases. I agree with him. However I have not been a psychotherapist earning my living out of treating minor mental disorders. I'm at the coalface in a District General Hospital setting managing psychoses. Many of these patients can end up in states of rigid immobility that we know can last for months or

years if left untreated. Others are consumed by nihilistic delusions of various sorts. Yet others have thought disorder of a kind that most clinical observers looking at it have said indicates frontal lobe dysfunction. It is these states that I am happy to say look like real diseases.

Saying that these look like real diseases does not mean that they have to be treated with physical means. I am happy to respect a person or their families wish to leave the state untreated. I also believe that when we finally understand the biological underpinnings of things this will put us in a better position to know how to handle many of these states by non-physical means. Genetic testing for disorders like phenylketonuria makes it possible to avoid the damage that this illness causes by simply managing your diet properly.

I believe the real concern the antipsychiatrists had was not so much whether mental illness was real or not, but rather a concern at the extension of the psychiatric reach out into the community that took place in the 1960s. Who were these guys who were telling us how to live our lives - what training do they have in how to live life.

If you read **The Creation of Psychopharmacology** you realize that the origins of operational criteria as found in DSMIII and IV etc etc are not because the people who came up with the idea of operational criteria knew what these diseases really were. Operational criteria are a confession of ignorance. They do not legitimate the existence of any of the disease entities that people are particularly keen about nowadays.

RG: One of the more controversial aspects of the CAMH lecture was your assertion that psychiatric patients in Britain are being detained at 3 times the rate today than they were 50 years ago. What prompted me to contact you was a report about suicide in the UK I read at Organon's <PsychiatryMatters.md> website back in

January(Organon is the manufacturer of Remeron). The report stated that the number of patients being admitted to John Radcliffe Hospital in Oxfordshire for self inflicted harm had increased from 1,000 per year in 1990 to 1,600 per year by the end of the decade. The annual suicide rate for men aged 15-24 in the UK increased from 10 deaths per 1,000 in 1983 to 15 deaths per 1,000 in 1992. Today the suicide rate for young men in the UK is double what it was in 1968. Do these kinds of statistics buttress your argument that psychiatrists now have more patients in their care than ever before? Could one argue that this is an example of treatment failure on the part of psychiatry(The 60 percent increase in suicide admissions at one hospital in the UK during the '90s, a decade when medical science had purportedly made on revolutionary pharmacological break through after another in the treatment of depression, hardly comes across as something for psychiatry and the pharmaceutical industry to write home about, much less to use as the basis for bankrolling awareness campaigns about the need for people to seek "treatment" for depression)?

(Healy provided me with the text of a lecture he gave at the University of Toronto a year ago. This lecture went over the statistical data underlying Healy's claim that psychiatrists are treating more patients than ever before. It compares admission statistics at North Wales Hospital in 1896 to 1996. The implications from the data are clear enough. Patients in 1996 were being discharged from the hospital with prescriptions for neuroleptic and antidepressant drugs that can cause agitation and suicidal ideation. This may be the reason why the 1996 patients have much higher suicide rates than the 1896 patients. The most embarrassing implication of all for modern psychiatry is that psychiatric patients of 1896 may very well have had better outcomes in the area of death rates than patients of 1996 when the lack of antibiotics in 1896 are taken into account. One conclusion to draw from this data is clear: psychiatric patients

at North Wales Hospital in 1896 were dying primarily from physical causes while a century later they were dying far more often from self inflicted harm. A major indictment of the claim that the past half-century has been a golden age in the treatment of psychiatric illness. I would recommend everybody interested in this subject e-mail Healy for a word copy of this interesting lecture at: Healy_Hergest@compuserve.com.

RG: You noted the unceremonious retirement of Thorazine's co-discoverer Jean Delay. His office was ransacked during the May 1968 strikes and protests in Paris and that at the time "he has no sympathy for the new world, in which students can expect to address the professors in informal terms." You go on to argue that "Both psychiatry and antipsychiatry were swept away by a new corporate psychiatry. Galbraith argues that we no longer have free markets; corporations work out what they have to sell and then prepare the market so that we will want those products. It works for cars, oil, and everything else, why would it not work for psychiatry? Prescription only status makes the psychiatric market easier than almost any other market - only a comparatively few hearts and minds need to be won."

Do you think your firing by the CAMH and your suspicions that Eli Lilly had a hand in it vindicates your argument about the take over of the profession by what you call corporate psychiatry?

DH: I have never voiced suspicions that Eli Lilly had a hand in my firing from CAMH. Lots of other people have voiced those suspicions. Yet others again have made strong cases for the possibilities that Pfizer or SmithKline may have brought influence to bear on this issue.

It's a bit too early to judge whether my firing by CAMH gives a good indication of where the profession of psychiatry generally is at. Leaving my case aside however I think the takeover by corporate psychiatry is fairly complete at this

point in time.

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