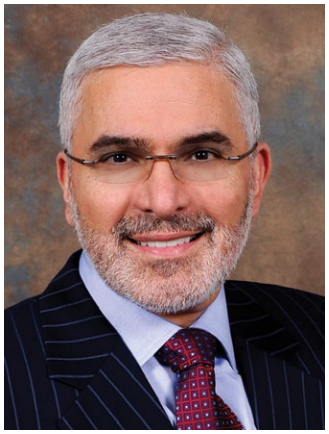

Henry A. Nasrallah, MD
Editor-in-Chief

Shattering dogmas

Like all other medical specialties, psychiatry has its share of dogmas that are perpetuated via the clinical apprenticeship model from one generation of physicians to the next, despite the lack of hard evidence. They become "articles of faith" that go unchallenged by trainees who acquire them from their supervisors. A dogma masquerades as a truism and eventually becomes a sacred feature of the "clinical lore."

Sooner or later, however, the bright light of scientific evidence will reveal the ersatz nature of a dogma and it will come crashing down. Similar to a revolution to depose a dictator, the demise of a dogma will have a salutary effect on medical practice and a liberating effect on practitioners.

Here are examples of psychiatric dogmas that were part of my training but have been/or are in the process of being taken to the slaughterhouse of obsolete tenets:

Psychiatrists should not touch their patients. Really! How can we be practicing physicians if we don't? This dogma arbitrarily sexualized the physical exam, including drawing blood, measuring blood pressure or waist circumference, assessing neuroleptic-induced cogwheeling, or checking the body for a drug-induced rash. This dogma is the antithesis of good medical care for psychiatric patients, who frequently suffer from serious physical ailments and often do not have a primary care provider. It was created during the primordial phase of psychiatry (aka psychoanalysis) and is irrelevant in modern-era psychiatry.

Push the dose of neuroleptics higher and higher until the patient becomes parkinsonian, which is the sign that psychosis will improve. This dogma dominated the pharmacotherapy of schizophrenia for 40 years because of the erroneous linkage of extrapyramidal symptoms (EPS) with therapeutic response to antipsychotics. We did not realize the neurologic harm of this dogma until the computer revolution and related scientific advances enabled researchers to measure the dopamine receptor occupancy in patients' brains.[1] Positron emission tomography (PET) scan studies revealed that only 60% to 65% of dopamine D2 receptors need to be blocked to suppress psychotic symptoms, whereas EPS will occur at ≥78% occupancy. Millions of patients needlessly suffered intolerable rigidity, dyskinesia, restlessness, and tremors and routinely received large doses of anticholinergic drugs that destroyed their quality of life due to memory loss, dry mouth, constipation, and blurry vision.

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The best way to rid our specialty of unproven tenets is to seek scientific basis for everything we do

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Medications must be administered daily. The same landmark receptor imaging studies described above may soon debunk this ubiquitously entrenched clinical dogma. Recent data showed that administering the same antipsychotic dose every other day instead of every day was equally efficacious.[2] Dopamine receptors do not require 24/7 blockade to treat psychosis as was formerly believed; apparently, intermittent occupancy is sufficient. Shattering this dogma can save 50% of the cost of the (expensive) antipsychotic medications, which chronic schizophrenia patients have to take for many years.

Patients with schizophrenia will ingest their oral medications as prescribed. This dogma continues to dominate clinical practice despite numerous studies that show up to 80% of schizophrenia patients relapse due to poor adherence to oral antipsychotics. Yet many psychiatrists continue to prescribe oral medications even though they know core symptoms of schizophrenia—lack of insight, amotivation, impaired memory, suspiciousness, and substance use—contribute heavily to nonadherence. The dogma of oral meds has been "attenuated" in Europe, where 30% of patients are treated with long-acting injectable depot medications, compared with about 7% in the United States.[3]

Academic psychiatrists must not collaborate with the pharmaceutical industry. This dogma was hatched recently and ignores the huge unmet needs of psychiatric patients. More than 80% of DSM-IV disorders do not have any FDA-approved drug.[4] Whether we like it or not, the pharmaceutical industry is the only source of new medication. Instead of avoiding an academic-industry collaboration, Europe has boldly moved ahead of the United States by formalizing a unique initiative called Novel Methods leading to New Medications in Depression and Schizophrenia (NEWMEDS).

This large collaboration intends to accelerate new drug discovery via a partnership between several prestigious European academic psychiatry institutes and global drug companies. By discarding the strident, dogmatic attitudes of shirking collaboration, NEWMEDS promises to expedite and accelerate the discovery and development of urgently needed therapeutic agents with innovative mechanisms. Dr. S. Kapur, the PET imaging pioneer, serves as the academic leader of NEWMEDS.

Psychiatrists are experts at detecting erroneous thinking in individuals or groups. We should vigorously rid our specialty of unproven tenets and detrimental dogmas. The best and only way to accomplish that worthy goal is to seek scientific basis for everything we do or teach.

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