**Mona Gupta.** *Is Evidence-Based Psychiatry Ethical?* Oxford University Press 2014. 224 pp. $53.00 USD (Paperback ISBN 9780199641116).

Although it grew out of longer-standing concerns, Evidence-Based Medicine (EBM) has only been around under that description since the early 1990s when members of the Faculty of Medicine at McMaster University in Hamilton, Ontario, Canada began to systematize procedures for 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (1; see also Guyatt, et al. 2008, 783). It has spread widely since then. The movement began in Internal Medicine, and the aim was not only to identify the best evidence available, but to work out techniques to apply it in the treatment of the individual patients presenting to specialists in the field. The movement early on offered systematic procedures for assessing the quality of evidence presented in relevant studies and for determining how it should be used in the treatment of particular patients (chapter 2). It could be fairly said that the aim of the movement was set by an ethical concern: getting the best possible health outcomes for the patients treated, even though there was no method available to test the claims of EBM that could both satisfy its own methodological requirements and survive the scrutiny of an Ethics Review Board. Without such evidence about the procedure itself, its use presents levels of uncertainty. There is a methodological uncertainty about the cogency of conclusions drawn, about the general value of the diagnostic and therapeutic techniques examined, even regarding what it considers high quality studies. There is also uncertainty about how to apply the conclusions in the treatment of particular patients.

Gupta's book begins with a succinct presentation of EBM, considers the role of value considerations in even the most routine applications of it (chapter 3), and then proceeds to investigate the special difficulties (but strong attractiveness) of its application to the practice of Psychiatry. In the process, Gupta addresses the special problems of method raised by attempts to study psychiatric treatment procedures. The fact that mental disorders are not like ordinary diseases, and produce behavioural effects in a context where institutions of social control and a range of power relations are involved, raises particular concerns about treatment and its aims. EBM is hard to apply to these conditions, though they provide an impetus to use it as a way to establish that there are available *effective* treatments for *genuine illnesses* and not mere management procedures for deviants with disturbing ways. Once questions of method have been discussed, the ethical concerns associated with the practice of EBM in general, and its application in psychiatry, are confronted.

At various points, Gupta enhances her discussion with the results of interviews about EBM and its role in psychiatry with three key sets of informants: developers of EBM, psychiatric practitioners, and philosophers and bioethicists who have reflected on EBM. Since EBM is an approach to medical practice, and the members of the first two groups have been engaged in the relevant practices, their responses can be instructive even if the samples questioned turn out not to be representative, and if, as is the case in this monograph, the responses are not reported systematically.

Gupta's presentation of standard textbook accounts of EBM as a general practice sketch it as a programmatic, even formulaic, approach. There is a hierarchy of research methods based on the supposed reliability of the results (18); a 5-step application procedure for employing the results of these studies to the treatment of individual patients (23), the first step of which involves a highly prescriptive approach (summed up by a mnemonic: PICO) to asking 'answerable' questions about specific treatment methods (23-4), and the final step of which is an evaluation of how efficiently and

effectively the first four steps were employed. For those not fully capable of critically evaluating research found in particular studies (and a number of the practitioners interviewed confess limitations in this, [34-35]) the use of synopses and summaries of research are recommended in what amounts to an argument from the authority of the compilers of for-profit, on-line guides to research, at least some of whom are among the authors of the standard texts of EBM (26). In its ideal form, EBM would link a system of research results about the diagnosis, prognosis, and treatment of a particular condition to a patient's electronic medical records in a way that would suggest exactly what information is relevant to that patient's care given various diagnoses on the symptoms presented (24). Treatment methods examined by numbers of randomized controlled trials (or by even more rigorous methods) will be evaluated by assigning a number representing the Likelihood of Help or Harm (LHH, a ratio of the Number Necessary to Treat–NNT to the Number Necessary to Harm–NNH). Patient values can be integrated into a decision about treatment made jointly with the patient by assigning numerical weights to the various beneficial and harmful outcomes possible, based on patient preferences. Presumably, in an ideal situation, a patient would be presented with the expected gains and losses of various treatment options, their risk-aversion or risk-preference could be factored in, and they might then be expected to act as preference-maximizers.

Of course, no such calculus is possible when dealing with the limited character of research into even the best-understood conditions and treatments, and patient values in a clinical situation can only be loosely grasped, even by the patient. Moreover, making useful judgements about a patient's condition based on the symptoms, observed and described, requires both clinical experience and highly developed puzzle-solving skills in difficult cases. As a consequence, EBM in its standard application must amount to a recommendation to draw on the best evidence available in diagnosis, prognosis, and treatment recommendations to patients under care, and then paying thoughtful attention to how the patient responds to the information that she or he gets.

Moreover, the notion of best evidence is itself problematic, even for well-established fields such as internal medicine. If a clinician reviews published materials, she should be aware of persistent biases in what does get published: studies that indicate interesting correlations between treatment and positive results for the sample investigated tend to get published; those that show no correlation or no statistically significant correlation, do not (51-3). Studies need to be funded and the interests of the funders, rather than merely therapeutic interests, may affect the procedures studied and the questions asked about them (47-51). In a field like psychiatry, this can mean that pharmaceutical modes of treatment may be much better studied than others, simply because drug companies both wish to find effective products to distribute and need to get government approval for their distribution. The studies favoured as good quality by EBM will also tend to show a strong technical bias: procedures that can apply precisely measured quantities of an active ingredient (or precisely specifiable treatment procedures) to a condition with readily specifiable symptoms and prognosis, and can be evaluated against clearly measureable outcomes, best suit EBM assessments.

Mental disorders are harder to diagnose reliably; do not have stable, clear prognoses if untreated; and often affect the sufferers several at a time, in ways that do not permit the isolation of the observable effects of one from those of another (chapter 4). What is more, since simple interaction with patients, and concern their well-being—and even the patient's own account of symptoms—can have a treatment effect, it is hard to isolate the impact of single active ingredients, even when the treatment under study is 'purely' pharmaceutical (chapter 5). Moreover, there are simply no measures of patient 'improvement' clear enough to permit trustworthy comparisons with placebos or alternate

modes of treatment. As a result, the 'best' information available about diagnosis, prognosis, and treatment in psychiatry is often likely to fall low on the scale of evidence offered by EBM.

Despite these problems, and despite some confusion about the proper aims of treatment, particularly in psychiatry, (for example, ought the ultimate aim be the maximization of patient preferences within a framework of justice, or a maximization of health outcomes?), Gupta discerns some ethically valuable concerns in the application of EBM to psychiatry. It is creditable that psychiatry seek effective means of treatment, and look for the best evidence about what those involve. Concerns about the integration of patient values into treatment decisions are important in the evidence-based approach (and a reason to seek reliable information about the treatments available: it aids patient decision-making). The desire to distribute scarce treatment resources justly and efficiently, to treat only disorders, not nonconformity, and to minimize fear about and stigmatization of mental disorders are all worthy motives for applying EBM to the field. However, the limitations of the approach and the need to respect the complexity of mental disorders leads Gupta to suggest that responsible practitioners should place it alongside moral treatment, the recovery movement, antipsychiatry, and other frameworks as guides to good practice.

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