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BOOK REVIEW

Salvaging the Shipwreck

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David Healy. *Shipwreck of the Singular: Healthcare's Castaways*. Samizdat Health Writers' Cooperative Inc, 2021, 516 pgs, ₹499 (Kindle), ₹1796, (Paperback), ISBN: 978-1-989963-12-8

David Healy's 2021 book *Shipwreck of the Singular* comprehensively challenges modern medicine's fundamental assumption that expanding medical knowledge enables "progress" and the capacity to promote health. Healy links evidence of falling life expectancy in Western countries to the transformation of healthcare to a service industry, alongside myriad examples of consequent overdiagnosis and iatrogenic harm. Unremittingly pessimistic, Shipwreck paints a bleak picture of healthcare among other societal ills, suggests there is no remedy, and yet invites us to respond.

It must be acknowledged that *Shipwreck* is not an easy read, loaded as it is with the author's impressive historical scholarship and punctuated with his relentlessly provocative opinions. Those who follow Healy's work may have noticed an earlier journal publication of the same name [1], which sets the stage for this exhaustive extension of its themes. Likewise, the 17-page Introduction gives a broad overview of what is to come, including important examples of common yet woefully under-recognised adverse drug effects, such as antidepressant-induced sexual dysfunction.

Shipwreck's central tenets regarding treatment-related harms deserve careful consideration. Chief among these is Healy's enduring emphasis on patient experience, interpretation and reporting of harms, as illustrated by his development of the popular www.rxisk.org portal. I share his view that patient reports are to be encouraged, taken seriously, and indeed provide an essential basis for highlighting neglected treatment harms. For example, he and I independently used patient reports to demonstrate largely ignored but important interactions between alcohol and the selective serotonin reuptake inhibitor (SSRI) antidepressants [2,3]. Healy gives multiple examples of such treatment-related harms and goes further in asserting that patient reports should take priority over conventional medical expertise, notably adverse drug effects detected in randomised controlled trials (RCTs). His critique of RCTs is scathing and multifaceted, buttressed by examples of how this supposed cornerstone of evidence-based medicine (EBM) can mislead in various ways — from faulty trial design and failure to measure (or euphemistically conceal) key outcomes, through statistical obfuscation and the mindless aggregation of heterogeneous outcomes. The tendency for commercial interests to massage and exploit data from their own RCTs is an unsurprising feature of the dominant pharmaceutical industry business model; more shocking are the examples Healy marshals of clinical trial evidence being mishandled by the FDA and other regulators. *Shipwreck* details examples of corresponding commercial and regulatory failures in this regard and alludes to the revolving doors between industry and government, notably in the USA.

Although he devotes little explicit attention to conventional [World Health Organization and national government-funded] pharmacovigilance, Healy's promotion of the RxISK team and website implies a critique of existing systems. No doubt, the latter are imperfect, and there is a clear need to develop better and more sensitive systems of adverse event detection and assessment [4]. Healy's inclination to prioritise the patient voice is laudable but runs the risk of discounting important psychosocial determinants of adverse event experience and reporting, including suggestion, attribution, and nocebo [5]. Careful medical assessment, taking these factors into account, is demanding but necessary to establish causality of drug-related harms [6]; developments in information technology may help [7] and it's worth emphasising that some national pharmacovigilance systems, for example in the Netherlands and in New Zealand, are relatively well-developed and offer models that other countries seek to emulate.

Central to *Shipwreck's* argument is the view that patient experience of adverse effects is crucial to reckoning a drug's benefit/harm balance for individuals and, as noted above, provides the basis for assessing causality. So far, so good. But I must admit to being startled by Healy's assertion, "no doctors today are trained in how to establish if a drug is causing an adverse event" (p 6). While medical curricula doubtless require development in this regard, such a

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sweeping, unqualified claim won't help to persuade those who aren't already on board with his thesis that Western medicine is irretrievably broken. Similarly, I am in full agreement with Healy that many doctors, and indeed healthcare systems, are inadequately prepared to recognise, investigate, and address drug-related harms. This crucial point is, however, diluted by his disturbing and unsubstantiated claim that medical denial of drug harms "is more profound than the denial experienced by those who have been sexually abused" (p 7).

Another of Healy's key points is that optimising outcomes from the use of medical technologies depends on our willingness (and presumably, ability) to take responsibility for them. Indeed, responsible decisions depend on reliable information about these technologies and their effects, both good and ill. As detailed in *Shipwreck*, contamination of the evidence base by commercial bias means that both doctors and patients struggle to find relevant, balanced information to guide decision-making about treatments; largely for this reason, Healy pulls no punches in his critique of EBM's evil twin, "evidence-*biased* medicine". In part due to direct-to-consumer advertising (DTCA) of medicines, many patients now come to the doctor with well-developed views about what is wrong with them and what treatments they seek. Among Western countries, only New Zealand [8] and the USA currently permit DTCA, but "spillover" effects due to geographical proximity (Canada) or disseminated online media (everywhere) stimulate visits to the doctor, overdiagnosis, overtreatment, and iatrogenic harm.

On the other hand, too much information, for example about potential but rare side effects, can have the opposite effect and, at times, jeopardise access to urgently needed treatment. As a fellow psychiatrist, Healy will have also encountered cases in which a patient's capacity is compromised by a head injury, delirium, or the acute phase of severe mental illness. Practising doctors thus often find themselves sympathetic toward Holmes' paternalistic edict delivered to graduating doctors in 1871, "Your patient has no more right to all the truth than he has to all the medicine in your saddlebags…He should get only just so much as is good for him" [9]. While all parties are challenged by the information glut of the internet era, it is heartening to find the doctor-patient relationship can still provide a "safe space" for medical expertise to support informed decision-making [10]. This process ideally includes balancing the likely benefits and harms of treatment as well as taking patient preferences and values into account, thus aligning with the ethos of EBM [11]. This principle accords with my experience and that of colleagues that well-informed consumers, while often presenting challenges to clinicians and their schedules, are better placed to participate in responsible treatment decisions.

I was left with continuing admiration for Healy's passion and scholarship, but uncertainty regarding his beliefs and intentions. Did he really intend his raft of extreme statements to be taken literally, or is *Shipwreck* designed as a polemic to provoke reassessment of modern medicine's structure and function? I was also surprised at his willingness to link his dismal assessment of healthcare to the climate crisis, with the rather fanciful suggestion that both might be addressed together. Apart from eliminating the waste of "too much medicine", how this would happen in practice, is left to the reader's imagination. While generally sympathetic to Healy's analysis of the pervasive dysfunction that besets Western healthcare, I have taken exception to some of his extreme assertions, for example regarding the prevalence and extent of the sexual side effects of antidepressants "these drugs compromise the sex life of everyone who takes them…" (p 4). Such general, unqualified statements undermine both the coherence and face validity of Healy's case.

Many readers will be persuaded by *Shipwreck's* case that Western healthcare has been largely transformed into a toxic, impersonal service industry. How this trend manifests in different countries remains largely unexplored, and there is a lack of convincing evidence to support Healy's prognosis that healthcare is well and truly wrecked and cannot be rescued. One might wonder why, if Healy believed that things were so irretrievably bad, he would have written such a powerful, impassioned polemic, with its broad historical sweep, trenchant political analysis, and critical appraisal of the twin perils that beset modern medicine, overdiagnosis and overtreatment.

In conclusion, *Shipwreck* is a provocative response to an insidious crisis in modern medicine. The path forward, if there is one (as noted, Healy casts doubt on the possibility of progress), will certainly depend on the development, curation, and maintenance of trusted sources of information regarding medical treatments and their effects, both good and ill. No doubt, the patient voice needs to play a larger role as an information source, strengthened by better systems of detection (moderated by empathic understanding of context and motivation), causality assessment [12], and communication [13, 14]. While effectively calling attention to this yawning gap in medical evidence, Healy's extreme rhetoric may, unfortunately, fail to persuade many who aren't already on board the *Shipwreck*.

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