

Biting the Magic Bullet, A Look at the SSRI Litigation

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Psychotherapeutic drugs are the number one class of drugs in the United States with sales of over 23 billion dollars in 2001 (considerably higher than drugs used to treat cardiovascular disease, cancer, and diabetes).¹ Selective Serotonin Reuptake Inhibitors ("SSRIs" -- Prozac, Zoloft, and Paxil in particular), constitute a large, if not the majority, proportion of the psychotherapeutic class of drugs making it the number one therapeutic class. (Id. 56-57.)

The extraordinary increase in the psychotherapeutic drug market appears to have begun with the advent of the SSRIs, the first of which was Lilly's Prozac. Coincidentally, since the approval of Prozac in the United States in 1988, the number of cases of depression have nearly doubled from 14 million to 25 million in 2001.² If nothing else, the story of Prozac is a remarkable demonstration of what can be accomplished through effective marketing. Pfizer (the maker of Zoloft) and SmithKline Beecham (the maker of Paxil) have successfully followed in Lilly's footsteps utilizing such marketing messages as: "You may be suffering from a chemical imbalance -- [Prozac/Zoloft/Paxil] can help correct this imbalance." This advertising slogan is parroted by each of the companies despite the fact that there is no scientific evidence to prove that such a chemical imbalance actually exists. In fact, according to documents obtained in the SSRI litigation, this is little more than a clever advertising gimmick which, through marketing research, has been proven to be an effective means of getting consumers to reach for a bottle of Prozac, or Zoloft, or Paxil.

Apparently, there is no end in sight for drug manufacturers in the business of developing psychotherapeutic drugs. With the statistics cited above and the billions of dollars generated

from sales, it is no wonder pharmaceutical companies do virtually whatever it takes to ensure their prospective psychotherapeutic drugs are approved for marketing and, once approved, protected with a vengeance. As a consequence, drugs reach the market without their true nature being fully known. Litigation uncovers what the drug companies do not want known – that their “wonder drugs” are not all they are cracked up to be and can cause some serious adverse reactions, including death. Indeed, the truly damning question – when did the company know – may be exposed, at which point the fight is at its apex.

Each of the top selling SSRI drugs has been found in courts of law to be a causative factor in acts of violence and/or suicide. For instance, Prozac was implicated, based on the testimony of the treating psychiatrist as well as various psychiatric expert witnesses, in a bank robbery committed by a Milford, Connecticut man, Christopher DeAngelo. The court found DeAngelo not guilty as a result of diminished capacity caused by ingestion of Prozac and Xanax.³

The Supreme Court New South Wales ruled on May 24, 2001, that a man’s ingestion of Zoloft caused him to murder his wife.⁴

On June 6, 2001, a verdict in the plaintiff’s favor was rendered in *Tobin v. Smithkline* in a Wyoming district court. In that case, Donald Schell killed his wife, daughter, nine month old granddaughter and then himself. The jury instructions and jury findings were: “1) Can Paxil cause some individuals to commit suicide and/or homicide? (general causation): YES. 2) Was Paxil a proximate cause of these deaths? (specific causation): YES. 3) What amount of fault do you attribute to each of the following: SKB - 80%, Don Schell - 20%. 4) Damages - \$8,000,000.”

In lawsuits alleging that Prozac, Zoloft, or Paxil caused or contributed to a suicide or homicide, each of the top-selling SSRI manufacturers, Lilly, Pfizer, and SmithKline Beecham

has asserted, unequivocally, that its respective drug does not cause suicidal or violent behavior. They base their assertion on their review of the clinical research, *however*, according to documents obtained through discovery in these cases, each of the companies has determined, either through its own clinical researchers and/or internal scientists reviewing the researcher's data, that its drug has caused some people to become suicidal and/or violent.

Despite these admissions from their own researchers, the SSRI companies attack plaintiffs' scientific evidence as "junk science." The truth of the matter is that the "scientific evidence" upon which *the drug companies* rely is anything but. Each of the SSRI manufacturers argue that the Plaintiffs cannot prove that these drugs cause suicide because no double blind randomized placebo controlled clinical trial (which are conducted to prove efficacy and *general* safety for FDA approval) has demonstrated to a degree of statistical probability that they cause suicide. What the companies do not state is that none of these studies was designed to determine whether these drugs cause suicide and/or violence. What is worse, none of the companies have conducted a single safety oriented clinical trial specifically designed to answer this question: do these drugs trigger violent or suicidal behavior in some people; and, if so, what is the strength of such association?

Notwithstanding the drug companies' refusal to engage in legitimate study of the issue, sufficient evidence has been established through peer reviewed medical literature, testimony from the companies' own witnesses, and internal documents obtained through discovery, that demonstrates that these drugs increase the risk of suicide and violence in some people, particularly in the first few weeks of treatment.

Even the drug companies' own expert witnesses have acknowledged a causal connection between SSRIs, akathisia, and suicide. While it can hardly be disputed these days that SSRIs

cause akathisia, the drug companies continue to deny a connection between akathisia and suicide. However, according to the testimony of Dr. J. John Mann, a Pfizer expert: “Q. Do you believe that akathisia precipitates suicide in some people?” to which he responded, “A. I believe that *akathisia is a risk factor for suicidal behavior.*” Eli Lilly’s expert witness, Dr. Victor Reus, gave similar testimony — refusing to admit that akathisia “causes” suicide, but readily conceding, at minimum, that “what akathisia does is it creates a state of severe anxiety which can exacerbate pre-existing proclivities, tendencies, in an individual to engage in either suicide or violence.”

The latest version of the DSM IV, the clinical bible for diagnosing mental disorders, now acknowledges a link between SSRIs, akathisia and suicide.⁵

As of late, pharmaceutical industry-influenced studies appearing in medical journals have come under fire. Several of the most prestigious medical journals in the world, including the New England Journal of Medicine (NEMJ), The Lancet, and the Journal of the American Medical Association (JAMA), have recently made scathing remarks on the problems (and lack of scientific rigor) of studies controlled by the pharmaceutical companies. In a recent letter, titled “Sponsorship, Authorship, and Accountability,” the editors of these journals state, *inter alia*:

As editors of general medical journals, we recognize that the publication of clinical-research findings in respected peer-reviewed journals is the ultimate basis for most treatment decisions. Public discourse about this published evidence of efficacy and safety rests on the assumption that clinical-trials data have been gathered and are presented in an objective and dispassionate manner. This discourse is vital to the scientific practice of medicine because it shapes treatment decisions made by physicians and drives public and private health care policy. *We are concerned that the current intellectual environment in which some clinical research is conceived, study subjects are recruited, and the data are analyzed and reported (or not reported) may threaten this precious objectivity.*” (Emphasis added.)

“As CROs [Clinical Research Organizations] and academic centers compete head to head for the opportunity to enroll patients in clinical trials, corporate sponsors have been able to dictate the terms of participation in the trial – terms that are not

always in the best interests of academic investigators, the study participants, or the advancement of science generally. Investigators may have little or no input into trial design, no access to the raw data, and limited participation in data interpretation. These terms are draconian for self-respecting scientists, but many have accepted them because they know that if they do not, the sponsor will find someone else who will. And, unfortunately, even when an investigator has had substantial input into trial design and data interpretation, the results of the finished trial may be buried rather than published if they are unfavorable to the sponsor's product. Such issues are not theoretical. There have been a number of recent public examples of such problems, and we suspect that many more go unreported."

The situation has become so extreme that it can now be statistically demonstrated that the greatest determinant of the outcome of a study lies in the identity of the sponsor.⁶ Companies, in other words, get the results they pay for.

The SSRI litigation has also revealed that there is an ever-increasing proportion of medical journal articles that are being ghost-written by the drug companies themselves or by PR agencies with important commercial messages and the names of recruited authors (often considered to be "thought leaders" in the field) inserted. In fact, a substantial number of studies undertaken by the SSRI companies are never published (and for those that have been published, not all the data has been included) because the results have not been favorable to the particular SSRI.⁷

The efficacy or effectiveness of these drugs has also come under serious scrutiny lately. Recent studies have found that placebo is as effective, if not more effective, than antidepressants in relieving depression! For instance, according to a study conducted by Northwest Clinical Research Center in Washington, more than half of the 96 antidepressant clinical trials analyzed, the effect of the antidepressant could not be distinguished from that of placebo.⁸

The combination of a failure to test, the unpublished clinical trials, and the ghost-writing makes it clear that the SSRI field of study does not meet the criteria of science. Even worse, the

companies are

commandeering the appearances of science for the purpose of selling their drugs, then attempting to convince the courts, through Daubert motions, that “there is no scientifically reliable evidence to prove that these drugs cause suicide and/or violence.”

While the litigation related to SSRIs and suicide/violence continues to this day, a new era in the litigation has just begun. On August 24, 2001, 35 plaintiffs filed a nationwide class action lawsuit against SmithKline Beecham claiming that its drug Paxil causes a significant percentage of those taking it to suffer severe withdrawal reactions when they attempt to stop taking the drug. When word of the suit hit the lay press, our offices were deluged with telephone calls from thousands of Paxil withdrawal victims seeking representation. The lawsuit alleges that SmithKline has known for years that Paxil can cause severe withdrawal reactions, yet chose not to provide adequate warning about this problem. The case is currently pending before Judge Marianne Pfaelzer in the United States District Court for the Central District of California.

On December 14, 2002, the FDA required SmithKline Beecham to revise its label to recommend close monitoring and gradual, rather than, abrupt discontinuation of Paxil. While, in our view, the label remains inadequate, it is a step in the right direction. Despite the label change, however, SmithKline Beecham has continued its intense advertising campaign which includes commercials television claiming that the drug is “not habit forming.” On July 2, 2002, the class representatives filed a motion for injunctive relief seeking a court order that would require SmithKline Beecham to pull from the airwaves those television commercials that claim Paxil is not habit-forming. The injunction also asks that SmithKline’s promotional brochures which make claims that the drug does not cause dependency and causes only mild side effects be pulled. The motion is scheduled to be heard on August 12, 2002.

The implications of these cases, in the words of British journalist, John Cornwell, who covered the first Prozac trial to reach a jury in the United States, goes “far beyond the tragic incident[s] and the subsequent postures of the litigation parties . . . [They] embrac[e] new brain science and profound issues of personal responsibility; competitive business practices . . . the gulf between authentic public-health needs and commercial goals of the pharmaceutical industry; the public’s right to know the unadorned truth about medication and the pharmaceutical industry’s tendency to withhold selective information in the interest of corporate aims . . . At the heart of this story . . . is the growing crisis over reductionist solutions to individual suffering and social disorder.”⁹

Cornwell concludes by stating: “The past ten years have seen the development and marketing of new pharmaceutical products that claim to offer antidotes not only for clinical depression but for individual unhappiness and general discontent. The philosophy that underpins this notion is based on a belief that our happiness and misery, our joys and sorrows, our vices and virtues, are to be found not in the way we habitually live and work as members of families and communities, but exclusively in the state of our brain molecules. If this philosophy prevails, it follows that we shall increasingly turn from social and communitarian solutions to pharmacological ones, with inevitable and far-reaching consequences.”

In the years since Cornwell wrote these words, “this philosophy” has not only prevailed, it has flourished. Through SSRI and other similar litigation, it is hoped that the pendulum will eventually swing back to a more balanced position where the risks and benefits are known and true risk-benefit analyses are being conducted to determine whether a particular drug is really appropriate for a given patient given all of the circumstances.

1. PharmaTrends, *2001 Year in Review, U.S. Sales*, NDCHealth p. 48
2. *Against Depression, a Sugar Pill is Hard to Beat, Placebos Improve Mood, Change Brain Chemistry in Majority of Trials of Antidepressants* by Shankar Vedantam, Washington Post, May 7, 2002, page A01. See also, *The Emperor's New Drugs: An Analysis of Antidepressant Medication Data Submitted to the U.S. Food and Drug Administration* by Irving Kirsch, Thomas J. Moore, et al., Prevention and Treatment, July 15, 2002.
3. *State of Connecticut v. Christopher DeAngelo*, Superior Court Judicial District of Ansonia/Milford at Milford, February 24, 2000.
4. *Regina v. Hawkins* [2000] NSWSC 420.
5. DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, page 801. "Akathisia may be associated with dysphoria, irritability, aggression, or suicide attempts." "Serotonin-specific reuptake inhibitor antidepressant medications may produce akathisia that appears to be identical in phenomenology and treatment response to Neuroleptic-Induced Acute Akathisia."
6. Freemantle N, Mason J, Phillips T, Anderson IM (2000). *Predictive value of pharmacological activity for the relative efficacy of antidepressants drugs*. Meta-regression analysis. *British Journal of Psychiatry*, 177, 292-302; Gilbody SM, Song F (2000).] [Publication bias and the integrity of psychiatry research. *Psychological Medicine*, 30, 253-258.
7. Healy D (2000) The assessment of outcome in depression. *Measures of social functioning*. *Reviews in Contemporary Pharmacotherapy* 11, 295-301.
8. *Many Psychiatric Medications May be Ineffective in Preventing Suicide*, 6 June, 2002, Business Wire.
9. British journalist, John Cornwell, who covered the first Prozac case to go to trial (Fentress v. Shea Communications et al.) from the book about the Fentress trial titled *The Power to Harm*.