CONVERSATIONS

***Peter Gøtzsche** tells **Denise Winn** that psychiatric drugs may be a cause of many mental health conditions, including bipolar, dementia and autism, and why drug trials cannot be trusted.*

Psychiatry beyond repair

WINN: Peter, you have an incredible CV. I'll give the truncated details here. Your first qualifications were in biology and chemistry, then you became a physician in 1984, specialising in internal medicine, and then a professor of clinical research design and analysis at the University of Copenhagen in 2010. You were co-founder of the Cochrane Collaboration in 1993, a non-profit organisation made up of professionals in different countries who were concerned about the poor quality of much of the medical literature; and you established the Nordic Cochrane Centre the same year, where you set about assessing medical research to find out if it was reliable or not and publishing systematic reviews of the benefits and harms of healthcare interventions. Your scientific works have been cited over 150,000 times and you are the author of several books.

The Nordic Cochrane Centre in Denmark was the biggest in the world. Yet, in 2018, you were expelled from it, an act which led to shocked headlines in journals such as *Nature*, *Science*, *The Lancet* and *BMJ*, and consequently also lost your job at the university. People can read the story themselves for free, if they want to,[1] but you believe it was largely to do with your criticism of psychiatric drugs, after you published your book *Deadly Psychiatry and Organised Denial* in 2015,[2] based on your findings from analyses of drug trials and outcomes, and your interviews to newspapers. You said in one that, while psychotropic drugs can be useful sometimes for some patients, particularly short-term, in acute situations, "After my studies in this area, I have arrived at a very uncomfortable conclusion: our citizens would be far better off if we removed all the psychotropic drugs from the market, as doctors are unable to handle them." Do you stick by that?

GØTZSCHE: I have studied psychiatry and psychiatric drugs since 2007 – that is 16 years – and like everyone who comes from a strict scientific background and looks into psychiatry, I got horrified because I realised pretty early on that the way we use psychiatric drugs causes far more harm than good. The number of people who go on to disability pensions increases when you increase the use of psychiatric drugs, as has been shown in all studies where this has been looked at. If psychiatric drugs were so good, there should be fewer people on disability pensions, but it is the opposite. Psychiatry is the only medical specialty I have ever heard about which does more harm than good and therefore it needs to be reconstructed totally. As this still hasn't happened, we can at least decide to use psychiatric drugs very little.

WINN: Your earlier book was called *Deadly Medicines and Organised Crime*[3] and you are pretty sure that you were the first person to use in print the term 'organised crime' for the business model of pharmaceutical companies, pointing out that Pfizer, once the world's biggest drug company, was convicted by a jury of organised crime, and other drug companies work in the same way. You said in the book, which created headlines all over the world and has been translated into 18 languages, that prescription drugs are the third leading cause of death, after heart disease and cancer. Perhaps we ought to say, at this point, that you started your own career in a pharmaceutical company.

GØTZSCHE: The term 'organised crime' has an interesting story attached. When I wrote a paper for the *BMJ* about the drug industry and organised crime, they wouldn't accept the term because they were very anxious about possible lawsuits, and changed it to corporate crime, which is, I suppose, a little milder! Yes, I was a biologist and didn't know much about drugs when I got a job in the drug industry, working with clinical trials and regulatory affairs. I realised very quickly that the research was flawed and sometimes fraudulent and that what the drug reps told the doctors was outrageously wrong and harmful for the patients. I got out.

WINN: I think it would be fair to point out that, as you yourself have said, the salespeople commonly believe that they are selling a very good drug. When I was a freelance medical journalist, I would be invited to events put on by PR companies to introduce us to new drugs and their amazing potential. I remember bristling that these PRs thought they were doing a great job of conning us, and then I realised, no, these PRs believed just as strongly in what they were promoting, otherwise they probably couldn't live with themselves. And the patient organisations which get support from drug companies and fervently recommend their drugs, they believe it too.

Anyway, you got out, but you made it your mission to share what you had learned. The

Cochrane Collaboration had a worldwide reputation for being trustworthy. Do you think it can be trusted now?

GØTZSCHE: I am perhaps not the best person to ask, as I was expelled, but let me say that, over 12 years ago, one of the chairs of the Cochrane governing board wrote to the then CEO to say that he had not treated me well and that he should know that I was a symbol for Cochrane of honesty, integrity and science at a very high level. He wrote that, "In many ways, Peter is the 'conscience' of the Collaboration. We may find him irritating at times, but we should never ever be dismissive of him". I am the only Dane who has published more than 100 papers in the so-called big five scientific journals – that is the *BMJ*, *The Lancet*, *Journal of the American Medical Association*, *Annals of Internal Medicine* and *New England Journal of Medicine*. Very few others in the world have done that. So I know how to do good science, and people around the world in evidence-based circles repeatedly told me that they had lost confidence in Cochrane, because the organisation couldn't tolerate that I criticised Cochrane reviews when they were not good enough.

You must be aware that the NHS has stripped all funding to the Cochrane groups in the UK, which is a sign that they are not happy with them any longer. So you don't need my opinion. This is a fact.

WINN: For years, we have covered in this journal so many reasons why the outcomes of randomised controlled trials, the so-called gold standard for evidence-based research, are likely to be unreliable – unconscious bias on the part of the researchers, allegiance to what is being studied, nepotism, cronyism, corruption, and all the other reasons that Stanford professor John Ioannidis cited in his famous paper, entitled "Why most published research findings are false".[4] So, do you actually believe that it is ever possible to draw meaningful conclusions from meta-analyses of studies of medical interventions?

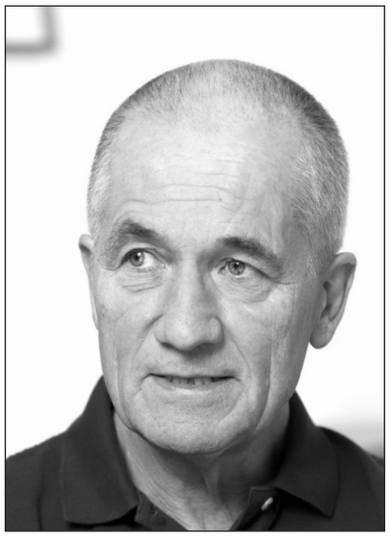
GØTZSCHE: It depends. I think my own greatest contribution to public health was when I managed to get the archives at the European Medicines Agency opened, after complaining to the European Ombudsman that we had been denied access to clinical study reports on two slimming pills, on the grounds of protection of commercial interests. I complained that there were no commercial interests in the study reports to protect. It took three years for the ombudsman's investigation to be completed but he agreed with me. So the European Medicines Agency had to give us access to the reports. It was 2010 and the first time in the world that anybody had got access to these confidential study reports that can run into thousands of pages for a single trial.

What you can read there is far more reliable than what the drug industry publishes in medical journals, and my research group at the Nordic Cochrane Centre published some very important articles about psychiatric drugs, which we based on such clinical study reports. It often still took a lot of work to get hold of them. Fluoxetine was approved in the UK for children, and the European Medicines Agency didn't have the reports, but the Medicines and Healthcare Products Regulatory Agency in London wouldn't give them to me. So I wrote to them, reminding them that Britain was a member of the European Union (as then, it was), therefore it could hardly take a different stance from the European Medicines Agency. They then felt obliged to cave in and I got the reports. Our studies of these reports showed many very interesting things. For example, we saw that, when children were given depression drugs, they could become very hostile. For instance, the serious adverse events on sertraline included homicidal threat, homicidal ideation, assault, sexual molestation, and a threat to take a gun to school.[5] You will never see things like that mentioned in the reports published by the drug companies.

These drugs likely decrease quality of life. We found that 12 per cent more patients dropped out on drugs than on placebo. The patients weigh any perceived benefit from the pills against their harms when they decide if they want to continue in a study till the planned end, and drop-out for any reason is therefore a highly relevant outcome. The patients prefer to be treated with a placebo![6]

WINN: So Cochrane reviews routinely rely on such detailed reports?

GØTZSCHE: Alas, no. I argued that Cochrane should support our getting access to these clinical study reports, otherwise Cochrane's 'independent' reviews of drugs are built on published trial reports of something the industry has manipulated. But the Cochrane Collaboration was under new leadership by then, and it didn't happen. Cochrane reviews of drugs are, thus, generally unreliable and, at the same time, Cochrane is proud of its logo, which is "Trusted evidence". How can it be trusted evidence when you have built your castle on a house of cards? The Cochrane leadership was very much against accessing and working with clinical study reports



Peter Gøtzsche *graduated as a Master of Science in biology and chemistry in 1974 and as a physician in 1984. He is a specialist in internal medicine and worked with clinical trials and regulatory affairs in the drug industry between 1975 and 1983, and at hospitals in Copenhagen between 1984 and 1995. He co-founded the Cochrane Collaboration (the founder is Sir Iain Chalmers), and established the Nordic Cochrane Centre in 1993. He became professor of clinical research design and analysis in 2010 at the University of Copenhagen and has been a member of the Cochrane governing board twice. He co-founded the Council for Evidence-based Psychiatry in the UK in 2014 and the International Institute for Psychiatric Drug Withdrawal in Sweden in 2016. In 2019, he founded the Institute for Scientific Freedom and was visiting professor at the University of Newcastle from 2019 to 2022. Peter currently works as a researcher, lecturer, author and independent consultant, including in lawsuits. He is author of hundreds of papers and several books.*

because it would mean more work for the Cochrane researchers, of course. But it would have been very, very good for the patients and their relatives.

So, to go back to your original question, no, we can't trust the evidence from drug trials or from systematic reviews of them. John Ioannidis, whom I am going to visit next month at Stanford, is absolutely right that by far most of what gets published, particularly about drug trials, is unreliable. In my first book about organised crime and the drug industry, I wrote, as you pointed out, that prescribed drugs are the third leading cause of death after heart disease and cancer. This tells you a mouthful! I recently tweeted about why the whole world panicked about covid-19, which killed seven million, when our drugs kill far more people every year, and no one raises an eyebrow.

WINN: It is very disheartening, to put it mildly. One of the things I learned recently was that adjusting for 'confounders', which you read about all the time in papers, sounds impressive but may actually make research more unreliable. Adjusting for confounders means that researchers 'adjust' for the fact that people in two groups being tested are different from each other, eg in terms of age, sex, income, socioeconomic status, smoking habits, etc, etc. I had thought that was a good thing and that it made the findings *more* reliable, whereas, in fact, it is more usually the opposite.

GØTZSCHE: Yes. Let's take a typical case: age difference. If people are older in one group than in another group that you are testing, statistically you would adjust for the 'confounding' age difference, so the research comes out as if people in the two groups have the same average age. I wrote in my *Critical Psychiatry Textbook*, which people can download for free on my website,[7] about an ingenious study, in which a statistician used raw data from two randomised multicentre trials as the basis for observational studies that could have been carried out. These showed that the more variables that are included in a logistic regression [a method of estimating the odds of an event occurring], the further we are likely to get from the truth. He also found that comparisons may sometimes be *more* biased when the groups appear comparable than when they do not; that adjustment methods rarely adjust adequately for difference in case mix; and that all adjustment methods can on occasion increase systematic bias. He warned that no empirical studies have ever shown that adjustment, on average, reduces bias.[8]

His study may be the most important one that I have come across in my whole career. But I have not met a single researcher who was aware of his highly important results, unless they knew him personally.

WINN: And what researchers should be doing, presumably, is randomising their participants properly. This journal has covered a great many of the shocking untruths that have been told about psychiatric medications, so I would like to home in on facts that might still be new to readers. For instance, you have suggested that the increase in depression isn't down to unprecedented modern-day challenges and stresses – but is partly a result of screening! The test recommended by the World Health Organization is so poor, you say, that 36,000 people out of every 100,000 healthy people will get a false positive diagnosis of depression. Indeed, I believe some of your colleagues have failed the online tests for depression, too.

GØTZSCHE: I have done such tests for depression when I have given lectures to lay audiences, and ordinary people who consider themselves healthy have often tested positive for depression, ADHD, mania and so on, and some tested positive for more than one diagnosis. The criteria for making a diagnosis of depression have been continually lowered during the last 50 years. The drug industry pushes very hard for that in order to sell more drugs. They have the help of a lot of psychiatrists, particularly American psychiatrists who are deeply corrupt because they receive loads of dollars from the industry, so they won't bite the hand that feeds them.[9] The fact is that depression has not become more common. Serious cases of depression have not increased. What have increased are the mild cases.

Currently, we have many other false epidemics from psychiatric diagnosis – for instance the number of cases of ADHD, bipolar in children and autism have skyrocketed. When I use the ADHD test for adults when I lecture, it never fails that between one-quarter and half of the audience test positive! This is so insane that I invented a test for Adult Symptom Deficiency Disorder for those who *don't* have any symptoms of a psychiatric disorder.[10]

> *"I invented a test for people who don't have any symptoms of a psychiatric disorder."*

WINN: The Danish National Board of Health recommends routine screening of pregnant women for depression and treating the 'depressed' ones with antidepressants. Fortunately for us, Public Health England's UK National Screening Committee does not recommend such screening, but certainly mothers-to-be already diagnosed with depression are likely to be offered antidepressants. Yet there are a lot of risks to SSRIs during pregnancy, aren't there?

GØTZSCHE: I have pointed to evidence for connection with spontaneous abortion, decrease in birth weight, likely increase in birth defects, neonatal complications, risk of pulmonary hypertension, which can be fatal – there are lots of things that have been associated with these drugs during pregnancy. Some researchers have even speculated that autism might be associated. The anti-vaxxers believe the measles vaccine causes autism, which is totally wrong – this belief arose as a result of the Andrew Wakefield fraud – but perhaps depression drugs might cause autism. Some researchers, including psychiatrist David Healy, have concluded from empirical data that these drugs are responsible for many cases.[11]

WINN:: I see that others, too, have concluded that a direct correlation can no longer be ignored.[12] I note you say depression drugs, not antidepressants.

GØTZSCHE: Psychiatric drugs work more or less in the same way, either by suppressing emotional reactions, so that people get numbed and pay less attention to significant disruptions in their lives, or by stimulating them. I therefore avoid the conventional nomenclature for drugs. It is misleading to call pills used for depression antidepressants and pills used for psychosis antipsychotics. These drugs are not 'anti' some disease. The 'anti' also creates an association with antibiotics, which save lives, but psychiatric drugs do not save lives; they *take* many lives and, unlike antibiotics, do not have disease-specific properties.

Taking a depression drug influences neurotransmitters that not only exist in the brain but are also very important throughout the whole body, even in earthworms; they have serotonin, you know. We really have no idea what happens when women take these drugs during pregnancy but common sense would tell us that it might actually be pretty risky, because serotonin is so important for so many functions in the body. This has not been researched sufficiently.

WINN: Being able to put diagnoses on people confers an awful lot of power. I was amazed by your account, in *Deadly Psychiatry*, of a court trial at which American child psychiatrist Joseph Biederman, inventor of juvenile bipolar disorder, as you put it, and keen advocate of treating it with antipsychotics, was giving evidence. When asked what ranked above his own rank of 'full professor' at Harvard Medical School, he replied, "God"!

GØTZSCHE: A large number of patients and their relatives have told me that, unfortunately, very many psychiatrists do not listen sufficiently and, even when patients complain that they are experiencing side effects that might be outright dangerous for them, their concerns get dismissed. The psychiatrist says, "It's your disease. It isn't the drug." I come across this all the time. One of the side effects of psychotropic drugs that is very dangerous is akathisia, indescribably intense restlessness which predisposes to suicide, violence and even homicide. It has been documented that psychiatrists usually overlook it but, if you send the same patients to a neurologist, many more would get diagnosed with akathisia. I must say that many psychiatrists become arrogant because of the power imbalance in psychiatry. You need to work actively *not* to become arrogant because you have so much power.

WINN: I was very amused by the diagnosis you invented, in *Deadly Psychiatry*, to cover what you think arrogant psychiatrists suffer from. [See box below.] You have said that the big increase we have seen in diagnosis of bipolar disorder was mainly caused by SSRIs and ADHD drugs?

Diagnosing arrogance in psychiatrists

"Isn't this behaviour so bizarre, abnormal, socially dysfunctional and harmful towards others that, in accordance with the psychiatrists' own way of thinking, it would be legitimate to invent a diagnosis for it? An appropriate name could be obsessive compulsive disease-mongering disorder (OCDMD). The diagnostic criteria could be a disturbance of at least six months during which at least five of the following are present:

1. Has been on industry payroll within the last three years.
2. Is willing to put his or her name on ghost-written manuscripts.
3. Believes that getting a diagnosis cannot hurt.
4. Believes that screening cannot hurt, as drugs have no side effects.
5. Believes that people with psychiatric disoders have a chemical imbalance in the brain.
6. Tells patients that psychiatric drugs are like insulin for diabetes.
7. Believes that depression and schizophrenia destroy the brain and that drugs prevent this.
8. Believes that antidepressants protect children against suicide.
9. Believes information from drug companies is useful.

I have come across psychiatrists who have a full house, ie for whom all nine criteria apply. I am against forced treatment but I am in favour of forced retirement for doctors who suffer from OCDMD in order to protect other people from harm."

From *Deadly Psychiatry and Organised Denial.*

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GØTZSCHE: Yes. These drugs can cause symptoms like euphoria, hypomania and mania, which may be misinterpreted as symptoms of bipolar.

The adverse effects of ADHD drugs are very much the same symptoms that psychiatrists use to diagnose that you are bipolar. When these symptoms overlap, you cannot possibly know if the poor child diagnosed with ADHD is also bipolar. You can find out only if you stop the drug slowly and then, after a period of time, you can see if there are any symptoms left that are compatible with bipolar. Biederman, whom you just mentioned, made a diagnosis of bipolar in about a quarter of children when they were in treatment with him on an ADHD drug. Before Biederman and ADHD drugs, bipolar didn't really exist in children. So Biederman invented the name juvenile bipolar disorder. This is very much a drug harm, and Biederman's influence on American children has been devastating for them.

> *"We cannot say ADHD causes this and that, because it is just a social construct."*

WINN: And is that connection between ADHD drug side effects and bipolar diagnosis being picked up now?

GØTZSCHE: No.

WINN: That is terrifying. While we are touching on ADHD and inventions, can you say more about what you call the invention of ADHD, and how America's National Institute of Mental Health (NIMH) wrongly called it a brain disorder. NIMH is the lead federal agency for research on mental disorders and one of the 27 institutes and centres that make up the National Institutes of Health, which, in turn, are part of the US government's health department.

GØTZSCHE: In order for something to be called a brain disorder, I believe that you have to show that something is wrong in the brain. If people have a broken leg, you can see it. But it has never been possible to demonstrate that anything is different in those children who get an ADHD diagnosis and those who don't. Therefore it must be wrong to call it a brain disorder. ADHD is nothing but a name attached to a group of symptoms that some people have. It is not something that exists in nature. But people forget about logic when they say, "Brian behaves like that because he has ADHD". No. This is circular evidence. Brian behaves like that *and* we call it ADHD. We cannot say ADHD causes this and that, because it is just a social construct.

WINN: A very contentious area, of course. You say a great deal of worrying things about antipsychotics, which you always call neuroleptics – for instance, that it is so well known that neuroleptics kill nerve cells that their use against brain tumours has been explored! Has this information not been given to psychiatrists?

GØTZSCHE: I am pretty sure that most psychiatrists have no idea about this. Joanna Moncrieff, professor of critical and social psychiatry at University College London and one of the co-founders of the Critical Psychiatry Network, wrote about it in her book *The Bitterest Pill*.

WINN: I am interested in what you have to say about using benzodiazepine drugs rather than neuroleptics.

GØTZSCHE: This is very interesting. A Cochrane review compared the outcome of trials of benzodiazepines versus neuroleptics in acute psychosis. Some psychiatrists have complained that the studies were not of a high quality but, if so, why don't the psychiatrists do better studies? It is not so difficult. Anyhow, there were 14 studies and the Cochrane review showed that benzodiazepines were actually somewhat better than neuroleptics. The desired sedation occurred significantly more often on benzodiazepines. In essence, this is a dosing question. You can make zombies out of people very quickly whether you use a large dose of a neuroleptic or a large dose of a benzodiazepine. But what is interesting is that neuroleptics are some of the most toxic drugs ever invented, apart from chemotherapy for cancer. Benzodiazepines are not nice drugs either but they are not *that* toxic and dangerous. They have a huge addictive potential, which we know about, but if you have an acute situation, the idea is not that you should go on using the drug months in and months out. The patients might want to be calmed down, because they are very disturbed by their acute psychosis. They need some rest and some sleep. For that, benzodiazepines are clearly what we should use.

When I have lectured for patients and relatives and other members of the public, I have often asked them what they would prefer and I have never had any patients telling me that the next time they have an acute psychosis, they would prefer a neuroleptic. The reason that they don't get the less toxic drug is purely financial. This has to do with the psychiatric guild, self-perception and all the money that passes between the industry and leading psychiatrists. Neuroleptics are in all the guidelines for acute psychosis, but really they should use benzodiazepines.

WINN: Just for a week, say?

GØTZSCHE: Not even that long is necessary. If you calm the patient down and they get some sleep, many of them will be better in just a few days.

WINN: Do you have any comments on Joanna Moncrieff's antipsychotic dose reduction trial, which, disappointingly, found a higher risk of relapse if antipsychotics – or neuroleptics, as

you would say – were discontinued, even very slowly, than if people were kept on maintenance doses. She and a team carried out a trial which showed that there was no evidence to support their hypothesis that gradual reduction of antipsychotics would improve social functioning, and they also found that, although most people did not relapse, a quarter of people in the gradual reduction groups did relapse severely and more quickly than those staying on the drugs –13 per cent of whom relapsed.[13]

GØTZSCHE: The brain changes that these drugs accomplish can take a very long time to go back to normal, if you stop the drug. Some patients need not months but years to withdraw very slowly from a neuroleptic. It is the same with depression drugs – some people need months, even years, and some never succeed. This might be partly because of irreversible brain damage. So it was wonderful that Joanna did this study and she herself said that, if they had tapered the drugs even more slowly still, they might have been more successful. I haven't studied it in detail but the symptoms of relapse are very much the same as withdrawal symptoms. Even if you withdraw very slowly you can get withdrawal symptoms.

WINN: Yes, I have known of a number of people who, once they had gone under what is termed the 'therapeutic threshold' for the drug during withdrawal (ie below a level where it may be doing anything at all in terms of alleviating symptoms), they immediately have something unpleasant start to happen.

GØTZSCHE: The binding of a drug to brain receptors is not a straight line but a hyperbola. When doses are low, the curve is very steep. This means that even a minor dose reduction could result in far fewer receptors in the brain being occupied than with the previous dose. Very few doctors know this. They have forgotten what they learned in clinical pharmacology at university and get surprised when the patients experience withdrawal symptoms after a minor dose reduction from a dose that is already very low.

> *"You break your tongue on these strange generic drug names, whereas the commercial ones are catchy."*

WINN: So that is why many people get so stuck. I would like to move on to talk about dementia. The UK's Alzheimer's Society is calling for diagnosis rates to be restored to pre-pandemic levels, saying on its website that, from January 2020 to March 2023, dementia diagnosis rates in England dropped from nearly 68 per cent to 63 per cent, equating to a reduction of over 30,000 diagnoses, and this prevents affected people from accessing support and symptomatic treatments.[14] You have written about how dementia criteria have been broadened, so more people fall into its net, and that a lot of dementia is likely caused by psychiatric drugs.

GØTZSCHE: *The Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) calls dementia an umbrella term now and categorises dementia as a neurocognitive disorder, which is further divided into major and minor varieties, based on evidence of cognitive decline from previous higher functioning in one or more cognitive domains. I think everyone above 50 would qualify, with those criteria!

It is likely that all psychotropic drugs can cause chronic brain damage, which may be permanent, and the hallmark is impaired cognitive function. So I believe that a lot of the dementia we see today is iatrogenic. In *Deadly Psychiatry*, I give references for a 17-year follow up of the Framingham Heart Study, which found that depression drug use increased the risk of developing dementia by 50 per cent. Benzodiazepines also seem to double the risk of dementia.

But the drugs for dementia are totally useless. There isn't a single drug in the world that works for dementia, and of course not. How would a drug work for dementia? We still don't know exactly what dementia is, and top neurologists have for many years discounted the hypothesis that it has to do with plaques in the brain. When you have a new, very expensive anti-dementia drug and it removes a little of these plaques, so it gets approved by the Food and Drug Administration, the US regulatory body, without any evidence that it helps the patient, this is very poor drug regulation indeed.

The small subjective effects registered in drug trials are likely spurious, as they can easily have been caused by unblinding bias, because of the drugs' conspicuous adverse effects. The most common harms of donepezil are nausea, diarrhoea, insomnia, vomiting, muscle cramps, fatigue, and anorexia. This is not what we would want for an old person who might already have problems with bad sleep, feeling tired, and eating too little.

WINN: Is it still the case that drug companies may charge independent investigators fortunes for placebos, to stop independent trials? Quoting from your book, *Deadly Medicines and Organised Crime*, "Drug companies may try to avoid being seen as uncooperative by demanding ludicrous sums for placebos, although the cost for producing them is close to zero, knowing that academic researchers would not be supported by a public funder for such excesses. On one occasion, the largest drug company in the world said that

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the placebos would cost about €40,000, which was enough to block an otherwise well-motivated trial." In another case, refusal by another drug company to provide placebos obliged the researcher to go ahead without a placebo arm to his study, which was then criticised as a great weakness when the study was published.

GØTZSCHE: Drug companies use any tricks they have to prevent studies being performed that are not in their interest.

WINN: Were you tongue in cheek when you said that one reason the generic names for new drugs, which are decided on by the drug companies, are so long and unpronounceable is so that doctors will use the brand names instead and be less likely to prescribe the generic version when its patent expires?

GØTZSCHE: No, it is true. You break your tongue on these strange names and you can't remember them, whereas the commercial ones are catchy. There is an anti-epileptic drug called Lyrica. Lyrica, for goodness sake! These drugs are pretty harmful – nothing lyrical there.

WINN: As you have said, you were always renowned for your scientific integrity. Richard Smith, previous editor-in-chief of the *BMJ*, said as much in the foreword to *Deadly Medicines*: "There must be plenty of people who shudder when they hear that Peter Gøtzsche will be speaking at a meeting or see his name on the contents list of a journal. He is like the young boy who not only could see that the emperor had no clothes but also said so. Most of us either cannot see that the emperor is naked or will not announce it when we see his nakedness, which is why we badly need people like Peter." Post-Cochrane, you have set up the Institute for Scientific Freedom (www.scientificfreedom.dk), currently work as a researcher, lecturer, author, and independent consultant and have been an expert witness in lawsuits in many countries. So do you still have your reputation, despite all apparent efforts to destroy it?

> ***"It is now difficult to publish anything which goes against the political interests of psychiatrists or the drug industry."***

GØTZSCHE: They *killed* Socrates, and he still has a great reputation. Many people have asked me why I don't have a logo for the Institute for Scientific Freedom, and then I got the idea – it must be Socrates! So I put a bust of Socrates on our home page this summer. I write that we are indebted to Socrates and that, even today, people are executed for asking questions.

WINN: But *you* don't go down! As psychologist John Read, whom you know well, said when I interviewed him for our last journal, "Peter is undefeatable."

GØTZSCHE: My reputation has not suffered at all from what Cochrane did to me. If anything, people are so angry about it that I have been strengthened. Cochrane's leadership kicked me out after a secret show trial, without having any good arguments for their action. Even when asked by Cochrane members about it, they either kept quiet or lied, which I have documented in my two books about the Cochrane downfall. At the annual general meeting I told the audience that "I shall survive, but I'm worried about Cochrane".

WINN: So you and others are still doing an incredible amount of work to bring the truth about psychiatry and the pharmaceutical industry into public awareness, and you have written quite a few explosive books, and still not enough is changing quick enough, is it?

GØTZSCHE: It is now more and more difficult to publish anything which goes against the political interests of psychiatrists or the drug industry. The biggest journals that have the most prestige are beholden to the drug industry, because the industry advertises in them and supports them in other ways.

WINN: Then, leaving the psychiatric professionals aside, what realistically do you think can be done, by individuals, to help shift things further? Can you pick out a few top things?

GØTZSCHE: If I had known how powerful film is, I would have left Cochrane much earlier. I now work with one of the best Danish documentary filmmakers. We have together launched the podcast Broken Medical Science (https://brokenmedics.com/) and already the first four episodes have generated an enormous amount of positive response. Now he is making small trailers for X (formerly Twitter), just one or two minutes long, where we refer to our podcasts. We started this a couple of weeks ago [at the time of speaking] and far beyond half a million people have seen these trailers. It is a powerful way to tell the truth to people. What's more, we have relevant references on the website, in contrast to other podcasts. We try to tell people that what we say in these podcasts is true and, if you want to check us, here are some sources you might want to look into. I believe what we are doing with our films and podcasts could be helpful for a lot of people in psychiatry and elsewhere in healthcare

WINN: So you mean that psychiatrists might listen as well?

GØTZSCHE: Oh yes, but psychiatrists are usually beyond repair. What I am counting on is that patients and their relatives take notice and think, "Why don't I take back responsibility for my life, because I gave it to my psychiatrist? I want to get rid of these damn drugs!" ■

12 *G Mundy, J (2007). Paxil, birth defects and autism. Lawyers and settlements online. https://www.lawyersandsettlements.com/article / paxil_birth_defects/ paxil-autism-00868.html*

13 *Moncrieff, J, Crellin, N E, Stansfeld, J et al (2023). Antipsychotic dose reduction and discontinuation versus maintenance treatment in people with schizophrenia and other recurrent psychotic disorders in England (the RADAR trial): an open, parallel-group, randomised controlled trial.* Lancet Psychiatry, *doi:10.1016/ S2215-0366(23)00258-4.*

14 *https://www.alzheimers.org.uk/about-us/policy-and-influencing/our-position-key-dementia-challenges/diagnosis Accessed 25 October 2023.*