Ketamine is a drug which was originally used in anaesthesia, but which is now more often used in managing pain. It acts upon a range of different neurotransmitter systems in the body and it's not a drug you would expect an average primary care doctor to be very familiar with.

I am therefore heartened at the news that the Australian Health Practitioner Registration Agency (AHPRA) has acted to prevent depressed patients being given ketamine injections to take at home.

This situation illustrates pretty much every eyebrow-raising tactic you can use to hijack promising clinical research for commercial gain. Let's list the ways…

Commercially distributing an unproven treatment

It takes a long time and a lot of research for a treatment, particularly such a novel and seemingly implausible one such as injectable ketamine, to become securely established.

When this happens, every reputable provider of services within that field needs to plan how they will provide that treatment.

Establishing clinics specifically for a single treatment is a well established business model in the hair loss and erectile dysfunction industries. It's not surprising then to discover that some of the same people
were involved in providing ketamine through Aura medical.

Starting the process of commercial distribution when there is only the barest of clinically acceptable evidence available diminishes the academic and professional credibility of that provider.

Allowing unsupervised use of potentially dangerous drugs

I regularly send patients home from my rehabilitation ward performing self injection of a drug to

prevent deep venous thrombosis. We provide education prior to discharge on how to do this safely.

I also provide ketamine infusions for chronic pain of doses in excess of those described in the depression studies. I would never in good conscience permit a patient to use ketamine at home without medical supervision, even in a low-risk dose. The idea of providing several vials of a drug which could be easily fatal in overdose to a depressed patient is straight out bad prescribing.

Despite having supervised hundreds of ketamine treatments for chronic pain with an excellent safety record over the last decade, I would not contemplate providing self-management with it. Providing take-home kits for ketamine injections will inevitably lead to avoidable deaths in my opinion as an experienced prescriber.

Bringing a potentially useful treatment into disrepute

I am fairly sceptical that these ketamine injections will pan out as a real treatment, given that I have seen no evidence of consistent benefit in the large number of depressed pain patients I have treated in the last decade.

However, the mechanism by which ketamine is known to work is peripherally involved in mood regulation, and there are some positive trials that have been performed under reasonable conditions.

Ketamine needs to be more closely studied to see if it has even a niche place in the management of depression, since the public health implications may be huge. If preventable harm comes to patients by providing the treatment in an ill-advised way these trials will never happen.

Treating a chronic condition as if instantly curable

I am especially concerned that patients may have spent thousands of dollars pursuing what is clearly at best a short-term treatment for a long-term problem, and thereby missing out on more effective, established treatments.

A diabetic is not cured by a single injection of insulin, even though it makes all the signs of their diabetes normalise. Getting even a single dose of insulin badly wrong can be fatal. Long-term education and support of the diabetic patient is crucial if the short-term benefits of insulin are to be maximised and the risks managed.

In pain management, we have learnt from bitter experience with injectable and long-acting opioids about the folly of trading longer-term, more challenging gains for easy short-term improvements. Providing a pharmacological treatment with a short half life, no matter how transiently effective, for a medium- or long-term condition with no other support is manifestly bad medicine.

Patients deserve comprehensive care when their needs are complex, and this can never be ethically provided by a single modality clinic.

Going to the media without scientific due diligence

With the greatest of respect to the editors of this fine website, who are exemplary media professionals, it’s very easy to hype poorly done science in a way that will get sensational headlines into print. Medical professionals are rightly disparaging of colleagues who seek to promote potentially exciting new discoveries through the media before the scientific case has been made. Peer review goes on long after papers are published. Promising new avenues of research turn into blind alleys all the time.

There is nothing easier than recruiting desperate patients with serious conditions by making spectacular claims in the media. You can get them to hand over to hand over large amounts of cash which may be borrowed or raised by others.

It doesn’t even matter if you subsequently have to retract your claims as long as your initial publicity splash was a good one. Publicising one’s scientific advances through the media before peer review has got its boots on is becoming a hallmark of the unscrupulous and greedy.

Everything I have said above regarding ketamine injections for depression applies to clinics offering to stem cell treatments, underground cancer “cures” and fad diet treatments.

Scientific medicine became immeasurably safer and more effective when commercial interests were forcibly straitjacketed. This takes the combined efforts of clinicians, scientists and legislators. Patients are harmed when business interests displace the consensus of the scientific and regulatory communities.

It’s painful to have to learn these lessons all over again but we should never be complacent about the processes by which promising new treatments are introduced into clinical practice.

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