LETTERS FROM MAINE

Closure … Now or Later?

One of our newer physicians asked recently if I had any suggestions for increasing his efficiency. It's getting closer to the day his income will be based solely on productivity, and the handwriting on the wall is coming into clearer focus.

BY WILLIAM G. WILKOFF, M.D.

Never being bashful about pontificating, I began by suggesting that he move efficiency up his priority list to the same level as quality care and professional enjoyment. I continued by urging him to arrive early enough to make his call-backs and see his first patient on time. Playing catch-up isn't fun, and it certainly isn't efficient.

Then I said, "I've noticed that you do a lot of double-dipping." His puzzled expression prompted me to explain that every time a physician leaves and returns to the examination room to see the same patient he must invest valuable time reestablishing the dialogue and the continuity of the visit. These return trips can be as costly as a full office visit, but of course the insurance companies don't reimburse for them.

A typical example involves a visit for a sore throat at which one does a rapid strep test. Before leaving the room with swab in hand, the efficient physician will have already discussed Plan A (test is positive) *and* Plan B (test is negative) with the patient and will have written a prescription for his choice of antibiotic so that his assistant can finish the visit. The experienced physician will have anticipated all of the usual questions and touched on them before exiting the room.

My student-for-the-moment said, "I can see what you mean, and I've been trying to get it all done with one trip into the exam room when I can. But, communication is important to me and I want to take advantage of every opportunity to achieve closure."

Contorting my face into what I hoped was my wisest expression, I said, "Ah, closure—now there's a troubling concept." Most training programs are in large metropolitan areas and serve outpatient populations that are often transient and economically disadvantaged. This fact, combined with the reality that house officers rotate and graduate, makes the establishment of a medical home model extremely difficult. I know that some programs work very hard to create continuity, but still most outpatient encounters exist in a vacuum. The physician-in-training and the patient understandably assume that they may never see or hear from each other again. In this dynamic, the physician's concern about achieving closure may squeeze common sense out of the picture.

Lab work is ordered to make sure that all the stones have been turned. Treatments of dubious value may be recommended and anxiety-provoking options are discussed unnecessarily because the practitioner is worried that he only has one chance to cover all his bases.

Many patients arrive at the physician's office in the early stages of an illness that is likely to be self-limited. Even the best diagnostician can't predict exactly where the process will go. Attempts at achieving closure in this fluid state are fruitless, time consuming, and potentially dangerous.

I urged my young associate to take full advantage of the fact that we live in a stable community of reasonably educated people. I suggested that he tell the patients that he is sure what they don't have, but that it is too early to be sure exactly what they do have or to expect the illness to have run its course.

I said, "Remind them that you and your partners are truly available by phone around the clock. Promise that you will call them the next day to see how things are going and then *keep your promise*. If you detect in your follow-up call even a hint of uncertainty, don't hesitate to have the patient return for another visit. That kind of double-dipping can teach you something, and you'll get paid to boot."

As I rose to see my first patient of the afternoon 5 minutes late, I reminded my young associate that, "In a well-organized and compassionate outpatient setting, closure will come naturally. You won't have to waste time forcing it before it's ready to happen." ■

DR. WILKOFF *practices general pediatrics in a multispecialty group practice in Brunswick, Maine. Write to Dr. Wilkoff at our editorial offices (pdnews@elsevier.com).*

GUEST EDITORIAL

Are Warnings on Antidepressants Backfiring?

Our ability to recognize and effectively treat mental health conditions has improved over the last 20 years. As a result, suicide rates across all age groups had been on a steady decline since the early 1990s. But recent data show a disturbing reversal of this progress among our youth.

BY DAVID SHERN, PH.D.

Findings published earlier this year indicate that although overall youth death rates did not change significantly between 2003 and 2004, suicide rates increased significantly in this period (Pediatrics 2007;119:345-60). Specifically, the data show that for youth aged 15-19 years, the suicide rate increased during that period by 11%, from 7.3 per 100,000 to 8.2 per 100,000. Similarly, for youth aged 10-14 years, the rate increased by 8%, from to 1.2 to 1.3 per 100,000.

Clearly, we are not in a strong position to draw unambiguous conclusions about the causes of these increases. But they could be related to changes in prescribing practices in the wake of media coverage related to the Food and Drug Administration's warnings about suicidal thoughts and the use of selective serotonin reuptake inhibitors (SSRIs).

In 2004, the FDA mandated labeling for SSRIs after reviewing research that indicated a small increase in suicidal thinking—not actions—among young people who were taking the medications. This sparked sensational media coverage that may have frightened clinicians from prescribing—and families from using—the SSRIs, which can be a life-saving treatment.

As we know, significant decreases in the numbers of SSRI prescriptions for children, adolescents, and other age groups followed the agency's warnings. Because other research has indicated a relationship between the increased use of SSRIs and decreasing suicide rates, the drop in the number of prescriptions is consistent with an increase in suicide rates.

This disturbing increase in the rate of suicide and its relationship to decreasing SSRI prescriptions highlight the tension between effectively informing patients and families about the potential risks of treatment relative to the risks of untreated illness.

In this case, the rate of suicidal thinking for adolescents who were depressed increased by about 2% (from 2% to 4%), indicating that 96% of those treated did not report suicidal thinking. However, the headlines—along with anecdotal reports of adverse drug reactions—spurred a dramatic decline in drug use.

Suicide claims the lives of 30,000 Americans each year, and depression is the leading cause, although it is the most treatable of all mental disorders. Unfortunately, the recognition and treatment rates of depression in primary care, although improved during the last several years, are still too low. A recently released 10-year retrospective study by Mental Health America shows that the percentage of Americans who believe depression to be a serious health problem has nearly doubled, from 38% in 1996 to 72% in 2006. Yet with an estimated 19 million Americans suffering from depression in any given year, and half of all Americans with mental health conditions not seeking treatment, the danger of untreated depression far outweighs any danger associated with antidepressants.

Patients and their families need better education about the dangers of untreated depression, and balanced information to help them understand and make decisions about treatment. It is critical that the FDA craft and test its messages so that they are optimally designed to support decision making by both clinicians and consumers. The goal should be fully informed decision making, including a risk/benefit analysis that addresses the risks of nontreatment.

In addition, nonpharmacologic treatment alternatives should be included, so that consumers and clinicians can achieve an optimal match of patient preferences and available therapies. Not all children and adolescents living with depression need or want an antidepressant, but for many, these treatments can be an effective and even life-saving component of their treatment plan.

Adverse drug reactions can occur with any treatment and have been dramatically reported in the FDA hearings. As with any medication, the use of antidepressants must be carefully monitored. It is therefore essential that patients who are prescribed a medication for heart disease, diabetes, or any serious medical or psychiatric condition be closely followed.

More research is needed to fully understand the underlying causes of the increase in the youth suicide rate, as well as to fully understand the effect of the black box warning on prescribing patterns. However, the increasing rate of adolescent suicide just may be a sobering signal about the importance of carefully communicating the full range of costs, risks, and benefits for antidepressants. ■

DR. SHERN *is president and chief executive officer of Mental Health America, Alexandria, Va.*