

Treatment Practices in Primary Care: Setting Directions for Health Outcome Research

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In recent years there has been growing interest in primary care treatment practices for mental disorders.¹⁻³ Commonly this literature has had a critical tone, with questions raised about the degree of recognition of mental disorders in primary care settings and the appropriateness of treatments provided. There are many studies that claim that there is underrecognition of mental disorders in primary care settings, whereas others show a wide variation in treatments given, with some patients who have a recorded mental disorder not receiving any specific treatments, and other patients who do not have a recorded mental disorder receiving specific treatments such as antidepressant medication.^{4,5} At its most provocative, this literature presents the family physician as a good-natured bumbler, providing treatment for mental disorders in an almost random fashion.

Against this background, the research article by Eugene Broadhead and his colleagues in this issue⁶ comes as a breath of fresh air. The authors make use of the National Ambulatory Medical Care Survey (NAMCS) data from 1985 to examine the prescribing habits of various physician groups with respect to tricyclic antidepressants (TCAs). Their approach is noteworthy in that they attempt to subdivide this large data set in a manner appropriate to the questions being asked. They are interested in the appropriateness of the prescribing of TCAs in primary care, and one area where they make such reasonable groupings is the diagnostic categories. Broadhead et al report, as found in earlier studies, that in primary care practices, only 50% of patient visits during which TCAs were prescribed were for documented psychiatric conditions. Based on their review of the clinical literature, they also identify in advance other "nonpsychiatric tricyclic-responsive conditions" such as irritable colon, low back pain, or fibrositis. When these diagnostic groupings were

examined in relation to TCA prescribing, an additional 15% of primary care patients had a documented reason to receive a tricyclic antidepressant. This finding leads the authors to conclude that the "inappropriate" prescribing of TCAs by primary care providers is exaggerated, when in fact 65% of those prescriptions were found to relate to a documented condition for which the medication would be considered appropriate.

In their examination of prescribing patterns, Broadhead and colleagues also subdivided physician respondents into meaningful groups. In addition to the group that was their major focus in this article, a primary care group consisting of family physicians, general practitioners, and internists, they examined three specialty groups—gastroenterologists, neurologists, and rheumatologists—because of the probability that these specialty physicians would see one or more of the "nonpsychiatric TCA-responsive conditions." Thus, they were able to examine the prescribing patterns of primary care providers compared with those of other specialists on conditions likely to be seen by both, such as irritable colon (seen by both primary care providers and gastroenterologists) or fibrositis (seen by both primary care providers and neurologists). When these comparisons were examined, one significant finding was that the primary care providers did not prescribe TCAs indiscriminately, but rather, for the particular diagnostic condition, followed the same general prescribing pattern in the use of these medications as did the corresponding specialist. These results indicated that primary care physicians, to a greater degree than previously documented, do have a recorded reason to use TCAs and that the pattern of such use is not random or indiscriminate but rather mirrors the prescribing practices observed in the various specialty groups who presumably have received more intensive training in the treatment of those conditions.

These findings were indeed encouraging, but along with Broadhead and his colleagues, I found myself particularly interested in the other 35% of patients for

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whom adequate documentation for prescribing a tricyclic had not been given. They suggest that some of this use may reflect the nonrecording of diagnostic data on the charts of patients with chronic and recurring diseases; not an unreasonable explanation since the NAMCS data does overrepresent patients who make frequent visits and who, therefore, are likely to have chronic conditions. Other suggested reasons, outlined earlier in an article by Jencks,⁷ include inadequate evaluation, lack of adequate training in the use of proper terms, poor record keeping, and provider reluctance to write down a psychiatric diagnosis. During the past 10 years I have regularly worked with primary care providers, both on research projects and on developing educational programs for the management of depression. Based on that experience, I would agree that major reasons for not recording psychiatric diagnoses still include provider fear of stigmatizing the patient and the concern that third-party payers will not provide reimbursement, which lead the physician to use other categories, such as chronic fatigue syndrome or insomnia.

Another possibility not emphasized by the authors, however, may relate to the nosology, or rather the lack of it, available to describe psychiatric conditions in primary care. Taking depression as an example, in a recent prevalence study carried out in practices in our area⁸ in which patients presenting for a routine visit to a primary care practice received an independent assessment for the presence of depression, approximately 50% of the patients had a depressive condition that was not captured by the available diagnostic categories of the psychiatric diagnostic system, *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in use at that time.⁹ A mixed anxiety-depression syndrome would be one example; a "masked" somatic presentation would be another. In our experience, just as with the nonpsychiatric TCA-responsive conditions described by Broadhead et al, primary care physicians are sensitive to potentially TCA-responsive psychiatric conditions such as a masked depression or depressions with somatic presentations such as fatigue or insomnia. With these patients they may schedule follow-up visits to clarify the condition, and may prescribe an antidepressant when their clinical acumen suggests that depression is part of the picture, even though classical symptoms were not elicited. In addition to the presence of "nonpsychiatric TCA-responsive conditions," it is likely that there also are TCA-responsive psychiatric conditions for which there is no appropriate diagnostic label to use. Jencks emphasizes a similar issue stating that "primary care physicians recognize and treat a great deal of mental distress that they do not describe in the vocabulary of psychiatry."⁷ He goes on to wonder "whether the problem is in the vocabulary or in the

physician." The vocabulary is clearly one part of the problem, perhaps the major part.

Whether such treatment is effective is another issue raised by these findings, one that emphasizes the need for outcome data on conditions as they present in primary care. Broadhead and his colleagues identify presumed TCA-responsive nonpsychiatric conditions such as peptic ulcer disease, irritable bowel, muscle contraction headaches, or various pain conditions such as chronic low back pain, rheumatic pain, or fibromyalgia syndrome. They indicate that other nonpsychiatric diagnostic conditions described in clinical reports may also be appropriate targets for TCA treatment, but that controlled clinical studies have not yet been done. A similar statement can be made for these depressive conditions not clearly outlined in DSM-III or DSM-III-Revised, such as a somatic presentation of depression, a mixed anxiety depression, or other presentations that comprise nearly 50% of significant depressions seen in primary care. At a conference on the agenda for primary care research in the 1990s, Schulberg emphasized this need: "Research is needed to establish the effectiveness of therapeutic agents within the setting and with the patients where they are to be employed."⁵

This need for further outcome research raises an additional issue also suggested by the article by Broadhead et al: the source of information to guide outcome research. The findings in the article suggest what I personally believe to be true: that primary care physicians use common sense in trying various treatment modalities, and they may discover treatments that "work" before experimental studies have been carried out. In my work with a group of primary care physicians, there was quick consensus about the utility of low-dose antidepressants for certain kinds of insomnia and for various kinds of pain, even though definitive studies documenting this efficacy do not yet exist. The primary care setting is a laboratory of meaningful observation; systematizing these observations into patterns can lead to important areas of focus for outcome research. There is a place for allowing clinical observations to influence the planning for clinical efficacy research rather than waiting for research findings from academic centers to influence clinical practice. Both types of research are needed and useful, but I am highlighting the fact that the primary care setting is one in which a good deal of clinical trial and error, and resulting knowledge, takes place and accumulates, and that it is important to try to systematically tap into this knowledge. After conducting a practitioner survey about who benefits from tricyclic antidepressants, Goldberg et al¹⁰ pointed out that there is a "systematic description of cumulative clinical experience that might serve as a . . . guideline in continuing medical education

and as a stimulus for research." There is a clear need for outcome research to be done in the primary care sector itself, on primary care patients as they present in customary (nonacademic) settings for a wide variety of diagnostic conditions. Suggestive findings from research such as that done by Broadhead et al and other studies of actual clinical practice can guide outcome research in clinically useful directions.

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Doctor-Patient Communication About Resuscitation: 'Have You Signed an Advance Directive?'

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In their recent debate in *The Journal of Family Practice* about routine discussion of advance health care directives, Drs Saultz and Rodriguez agree on one significant point: physicians need to improve their communication with patients regarding this important issue.^{1,2} Unfortunately, little literature exists that reviews specifically how physicians can best discuss these sensitive issues with their patients.

There are two underlying reasons for improving the communicative competence of physicians in discussing resuscitation and life-support measures. First, it is commonly agreed that competent patients have the right to make their own choices about life-sustaining medical

treatment. The 1990 US Supreme Court decision *Cruzan v Director, Missouri Department of Health* implied that people can exert this right early through clearly written advance directives. Congress recently mandated that patients who are members of health maintenance organizations or who are in hospitals or nursing homes should receive information discussing advance directives.⁴ Second, the responsibility for initiating discussions about advance directives and in-hospital resuscitation traditionally has been delegated to physicians, by both ethicists⁵ and patients.⁶

Bioethicists and physicians have concentrated their attention to date on normative ethical principles that they believe should underlie the decision-making process concerning both advance directives and do-not-resuscitate (DNR) orders. These normative guidelines neglect interactional factors present in physician-patient communication, however. Factors such as cultural perceptions of

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