Preface

Primary Psychiatry—At the Crossroads

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In the past, the treatment of mental illness was considered the sole responsibility of psychiatrists. The current environment has, however, changed dramatically. While the concept of primary care within psychiatry is receiving increased attention, some primary care physicians diagnose and treat depression to an extent that allows many to be considered primary psychiatrists. Factors that have contributed to this shift include the increased number of patients presenting with depression, the stigma of seeing a psychiatrist for treatment, the recognition that a majority of patients with psychiatric illness are already being cared for at the primary care level, and the realization that primary care physicians are the only physicians who are in a position to screen the general population for this disorder.

For the same reasons that we must screen for hypertension, diabetes, and breast cancer, primary care physicians must also accept the responsibility of screening for depression. Clinical studies have established that the majority of depressed patients present initially to the primary care physician and that they utilize healthcare resources more frequently than other patients. In fact, as many as 25% of the patients we see on a daily basis have psychiatric disorders. Therefore, primary care physicians, their educators, and their psychiatric colleagues must become convinced of the importance of diagnosing and treating depression at the primary care level so that the practice of primary psychiatry can be advanced. Moreover, clinical outcome studies of depression treatment in the primary care setting are urgently needed.

Fortunately, significant progress is already being made as depression is one of the most common disorders that we see, the ability to recognize and treat it is steadily being tailored to the family practice setting. The emergence of easy-to-use, time-efficient screening tools along with the development of psychotropic agents that are well tolerated, simple to use, and have a broad spectrum of efficacy have all facilitated the treatment of depression by primary care physicians.

Conversely, including patients with depression in our practice does not come without challenges. Medicare, Medicaid, and other insurance companies either do not fully support reimbursement or suggest that primary care physicians are not qualified to treat depression. In addition, formularies attempt to restrict the drugs we prescribe, as well as the specialists we use as consultants. Further, as with many other illnesses, issues of reimbursement are based more on business interests than on scientific rationale. All these obstacles must be confronted or this trend may continue and family physicians will find themselves "locked out" as primary providers for these patients.

The purpose of this five-part supplement is to move forward and meet these challenges by advancing the understanding of the practice of primary psychiatry. In that light, a group of primary care physicians with expertise in psychiatry convened to contribute papers and participate in discussions about special patient populations that may present with depression in a primary care setting. Russel J. Kuzel, MD (Dakota Clinic at West Acres, Fargo, North Dakota), David M. McCoy, MD (Baptist Health Care Group, Nashville, Tennessee), Frederick Richardson, Jr, MD (Richardson's Family Practice, Oak Park, Illinois), Gary E. Ruoff, MD (Director, Clinical Research, Westside Family Medical Center, Kalamazoo, Michigan), Jeffrey L. Susman, MD (Assistant Dean, Primary Care, University of Nebraska Medical Center College of Medicine, Omaha, Nebraska), and Jeffrey N. De Wester, MD (American Health Network, Indianapolis, Indiana) were participants in this group.

Depressed patients often present to their family physician not with classic symptoms of depression, but with physical complaints that mimic other medical diseases. Thus, in my paper, recommendations are provided on ways to distinguish between symptoms that are representative of a newly developing medical illness versus symptoms of depression and the nuances of treating patients with prominent somatic presentations. The next presentation turns to a discussion on physical and emotional demands that result from the role and occupational changes associated with pregnancy and childbirth which

often lead to mental health disorders. Jeffrey L. Susman, MD, provides a thorough overview of the risks and benefits that should be factored into the decision of instituting pharmacotherapy to the pregnant woman or new mother.

Further, depression may also be masked or complicated by comorbid conditions. Failure to recognize and properly treat depression in the presence of other medical conditions can have a negative impact on the prognosis and prolong the time to recovery. Therefore, David M. McCoy, MD, provides some insight on how to accurately diagnose depression when it occurs concomitantly with other medical illnesses, and he offers some guidelines on the use of antidepressants that do not exacerbate the underlying medical condition. Next, because of the high incidence of comorbidity (as high as 50%), the paper by Gary E. Ruoff, MD, is devoted to the management of depression in patients with chronic pain. Finally, clinical experience has also led to the realization that anxiety is often a component of depressive illness and that when these conditions coexist, more psychological, physical, and social impairment results. Russel J. Kuzel, MD, discusses several coexisting permutations of these conditions; in addition, he provides treatment guidelines that facilitate compliance while providing symptomatic relief for both the anxious and depressive components of the disease.

The practical information provided in this supplement should increase our ability and confidence to practice as primary psychiatrists. With the tools provided, primary care physicians can overcome the challenges cast upon us at the current crossroads and secure our role in the treatment of depression in the primary care setting.