A Glimpse at Physician Attitudes About Care of Patients Who Suffer from Depression

Allen J. Dietrich, MD
Hanover, New Hampshire

In this issue of the Journal, Shao and colleagues offer us a glimpse at some key issues relevant to our care for patients with depression (*Shao W-A, Williams JW Jr, Lee S, Badgett RG, Aaronson B, Cornell JE. Knowledge and attitudes about depression among non-generalists and generalists. J Fam Pract 1997; 44:161-8*). Before I reflect on these issues in the context of today's health care environment, I want to offer a confession. With "primary care bashing" currently in fashion, especially in regard to the mental health services we provide, any mental health/primary care study that does not bash I tend to like. That is not to say that we should not try to improve the care we give, but more on that later.

The article by Shao and associates does not bash, but it has two limitations that also should be noted: the clinician sample was drawn from just two academic medical centers, presumably selected for convenience; and 63% of the respondents, and even higher percentages of the generalist and non-generalist groups, were residents in training. For these reasons and the self-report nature of this study, it can give only a glimpse of what is really going on in American primary care, but a provocative glimpse it is.

Overall, knowledge scores about depression and its management were better than I expected. Generalist and non-generalists (73% and 64% of whom, respectively, were residents) scored only slightly less well than psychiatrists (most of whom were faculty) regarding the recommended duration of treatment with medication. It was no surprise that compared with psychiatrists, fewer generalists and non-generalists could name five or more symptoms of depression as defined by *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (DSM-III-R), but I was surprised that 11% of psychiatrists could not come up with at least five symptoms, since DSM is central to psychiatric practice in the 1990s.

From the Department of Family and Community Medicine, Dartmouth Medical School, Hanover, New Hampshire. Requests for reprints should be addressed to Allen J. Dietrich, MD, Department of Family and Community Medicine, Dartmouth Medical School, Hanover, NH 03756.

The comparisons of generalists with non-generalists are more intriguing, especially since non-generalists are coded to include obstetrician-gynecologists. Patients suffering from depression and seeking primary care from a non-generalist should prepare to be sent elsewhere for this primary care service! If the depression is recognized (and confidence in this ability is not assessed), patients can count on a referral to a psychiatrist: 79% of non-generalists indicated that this was their preferred management strategy. For generalists, 58% indicated that they would prefer to refer. Here I regret not knowing more about faculty as compared with resident status and about how family physicians differ from general internists. Of the family physicians I know, the great majority would be comfortable and happy to manage most patients suffering from depression.

More disturbing to advocates of primary care by non-generalists should be the findings that only 39% of non-generalists find treating depression to be rewarding and only 25% feel comfortable prescribing antidepressants. Advocates of primary care by generalists can take some comfort that these numbers are reversed for generalists; the great majority find it rewarding and comfortable to prescribe the drugs; but now I am starting to bash non-generalists!

To give equal time, some findings about generalists worry me. Over 40% of generalist respondents indicated that "the typical depressed patient causes the illness to persist" and that "the typical depressed patient exaggerates the symptoms." This sounds like moralism from another era. I hope that these respondents are early in training and that their faculty still have time to help them.

I am also uncomfortable with the finding that 58% of generalist respondents indicated that their "priority is to treat medical problems first, then investigate psychological/psychosocial problems." The mind–body dualism of Descartes is apparently still with us, but I agree that the question is tough. I too would try to treat the acutely blocked coronary artery in a patient with an evolving myocardial infarction (MI) with more urgency than I would treat the patient's acute anxiety about the MI diagnosis, although I would try to attend to both. It is to be hoped that this

priority of the "medical" over the psychological and psychosocial does not apply to the depressed, perhaps suicidal patient who presents with a complaint of fatigue or headache and a blood pressure of 160/100 mm Hg.

Some findings about the generalists make me just curious. Sixty percent of generalist respondents indicated that "most of their patients are receptive to the diagnosis of depression" and 76% indicated that "most . . . are receptive to taking antidepressant medication." Would it were so! I still find considerable resistance among my New Hampshire and Vermont patients to the diagnosis of depression. Even with all the popular media attention to the wonders of SSRIs such as Prozac, the majority of my patients are reluctant to accept a trial of medication, especially as first-line therapy. More often the response is, "I just wanted to be sure that this headache and lack of energy wasn't a brain tumor. If it's depression, I'll deal with it myself."

In the opening paragraph, I indicated that the study by Shao and associates offers us a glimpse at some of the key issues concerning management of mental health problems in primary care. A number of studies are currently in the field that will provide a detailed look, not just a glimpse, at the recognition and management of depression in primary care.

Through sponsorship of the MacArthur Foundation Initiative on the Recognition and Management of Depression in Primary Care, a national random sample of over 3000 family physicians, general internists, and obstetrician-gynecologists received survey questionnaires recently inquiring about their specific management of the most recent patient they have seen who suffered from one of a variety of depression presentations. Results should be available by year end and should provide a new analysis, not just a glimpse, of what primary care physicians do, what barriers compromise optimal patient care, and in what ways these physicians perceive that the care environment could be improved. In a related study sponsored by the MacArthur Foundation, 150 family physicians and general internists consented to unannounced visits from actors offering various depression presentations for the purpose of exploring in detail the physicians' approach to recognition and management while controlling for case mix.

These descriptive studies are part of a multi-year commitment by the MacArthur Foundation to work with primary care physicians to assure that patients suffering from depression receive the best possible care. Other studies in the MacArthur Foundation Initiative explore, through randomized trials, ways to enhance our interviewing skills for recognizing depression and assessing the effectiveness of various treatments for minor depression and dysthymia, conditions that are common in our offices, cause significant dysfunction, and yet for which the best treatment strategies are unknown.

Joining the MacArthur Foundation in sponsoring related studies are the Hartford Foundation and the Commonwealth Fund. The aim of these efforts is to have a national impact on the well-being of patients with depression by working with and supporting the work of primary care physicians. These foundations have moved beyond primary care bashing in forging a partnership with primary care for the benefit of our patients. In this partnership, the only losers will be the bashers. Rather than seeking a new bashing target, they would be well advised to focus on their own patient care and how to improve it.