Between Research and Practice in Family Medicine: The Gulf Resolution

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It has been well documented that family physicians play an important part in mental health treatment in the United States, and that patients will often begin the process of mental health referral or care with their primary care provider. In addition, some studies have shown that primary care providers underdiagnose and therefore undertreat mental illness in their practices. For years, it seems, we have been told that legions of depressed patients are going untreated in the primary care setting.[1,2]

The work by Robinson et al[3] in this issue of the *Journal* takes an approach different from that of previous work by focusing on the diagnostic nature of depression in primary care as well as its treatment. This common-sense tactic, ie, using the physician's categorizations of depression, is an elegantly practical approach to this important primary care problem. Legions of depressed patients appear *not* to be ignored, at least in Puget Sound. The study by Robinson and co-workers reveals that family physicians were actually willing to categorize 58% of this sample as patients with "minor depression," to move them to treatment. "Minor depression" represented an amalgam of DSM-III-R *(Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised)* adjustment disorders, remission from previous depression, and subclinical major depression. The physicians made the diagnostic tools work for them, even when the fit was less than perfect.

The diagnostic revelation above is but one contributory feature of this family medicine–relevant study. To begin with, this study was well designed, executed, and analyzed. But a more important aspect is that it is one of but a small handful of studies that couple patient-physician interaction with patient education. It has been a constant source of puzzlement to me why the literature on patient-physician interaction and the literature on patient education evolved separately, as they have. What could be more important to patient education than the nature of interaction with your physician? What could be more important to the nature of your interaction with your physician than the information you receive? Nothing, but unfortunately, these two literatures have grown separately, and are rarely cross-cited by one another. Family medicine research and its literature provide one place to unite such traditionally and illogically divorced concepts.

"The Education of Depressed Primary Care Patients" bridges this literature gap by examining the treatment of depression *as an educational patient-physician interaction.* While such a description is not clinically revolutionary, it is a welcome step in the research world. The union of the two areas serves to enhance the relevance of the present study's findings. Good family physicians will tell you that separating patient education from patient interaction is folly. It is only in our drive to compartmentalize our research that we have done so.

It is worth noting the kind of contribution this study makes. For years, family medicine has agonized over the nature of its scholarly work: content, impact, relevance, and the like. We have worried about whether the content of our research was significant, or if anyone had done it before; we have worried about the impact that our results would have on the practicing physicians who might use them; and we have worried that in our efforts to be faithful to the mission of the field, others might perceive our efforts as simply mundane. Having ruminated over these important issues, we may have lost some of the essence that could be captured by truly looking at what family physicians do, rather than contributing to others' pre-existing literature. This is not to discount the value of others' contributions, but to call for a literature of our own that truly says something about the processes of care that family physicians engage in. Examining the process by which family physicians render care may yield a uniqueness to the field that is not subject to the criticisms of duplication, redundancy, or banality from other fields. There is a seeming gulf between the philosophical underpinnings of family medical care and family medicine research. They sometimes seem

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antithetical to one another, certainly in disposition, if not conduct. "The Education of Depressed Primary Care Patients" begins to resolve the gulf by answering some clinically important and theoretically useful questions simultaneously. It tells more about what physicians do in practice, and what they should do more of.

Why is family medicine research so often removed from the practice of family medicine? There are numerous reasons that have been discussed in great depth before, and I will not rehash them here. Suffice it to say that there are tremendous difficulties in mounting a research agenda subsequent to the maturation of an already successful clinical discipline; moreover, generalist disciplines are notoriously hard to define by their very nature. Why define the inherently undefinable? We persist, despite the difficulty of the challenge in defining this broad generalist field.

Efforts to define often miss the point, in my view. Processes of care, management of patients, continuity, and comprehensiveness need not be content-bound. Family physicians are not. What intrigues me about the study by Robinson and colleagues is that it does capture some of the essence of family medicine and primary care. It codifies a process by which physicians may diagnose, define, manage, treat, and maintain continuity on one category of diagnoses. It follows the process of education, a process that includes the patient-physician dyad. We need not obsess over whether someone in another field has "done this study already," because it is not based on any preconceived notions of what anyone other than a primary care physician believes that the care of depression *ought* to be, including involvement of consulting psychiatrists in the treatment plan.

To take the approach outlined above, that is, to capture a process, design an intervention, and follow it through, requires more than scientific knowledge. It requires confidence. Confidence is something that has been sorely lacking in the scholarly arena of family medicine. Until we acquire it, we will continue to adopt means of scientific definitions that do not fit for our field and contribute to the gulf between research and practice. Rather than behaving as if we need to ask others' permission to contribute to a different literature, we should instead step forward to claim our own agenda, an agenda that captures what we instinctively know to be unique about family medicine and its process of care.

At the end of the movie *Bull Durham*, the veteran catcher "Crash" is coaching "Nuke" on how to pitch once he gets to the big leagues. "They're going to light you up like a pinball machine out there," he says, "but you can't let it bother you. You have to play this game with a combination of fear and arrogance." "Fear and ignorance?" says Nuke. "No! Fear and *arrogance!*" is the exasperated reply. "I know," Nuke counters. "I just like to see you get worked up."

I, for one, would like to see *us* get worked up and play with "fear and arrogance." Most family medicine people I talk to reject the notion of arrogance, but in my opinion, it is not always a bad thing. We may just have something to contribute, and we owe it to our colleagues throughout medicine to let them know. But first, *we* must believe in the value of our work. And that will not be misguided arrogance; it will be a step toward establishing the importance of our work to our ultimate audience: the patients we serve.

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