EDITORIAL

In This Issue

Kurt C. Stange, MD, PhD, Editor

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Five research articles and an editorial in this issue address the diagnosis and treatment of depression in primary care. Together, this research takes us through the diagnostic process in primary care[1] to factors associated with depressed patients' intent to accept the diagnosis,[2] to factors affecting adherence to treatment.[3] Depression research in this issue identifies the need to tailor interventions to subgroups of patients with primarily psychological or physical symptoms,[4] and shows the cost-effectiveness of enhanced primary care management of depression.[5] The editorialist presents a framework for interpreting these studies.[6] Moreover, he draws a larger cautionary lesson about forces that are disintegrating primary care practice through efforts to control the cost and quality of mental health and chronic disease, to the possible detriment of the patients with those conditions.

In research that contradicts common perceptions, Vinson and colleagues[7] discover that injuries requiring emergency department visits are associated more with an occasion of drinking than with alcohol dependence.

Concerns that physician values may be shifting are supported empirically by Beach and colleagues,[8] in a study of physicians in 11 managed care organizations. These researchers find that a strong sense of physician responsibility to individual patients is less common among younger physicians and physicians who practice in staff-model health maintenance organizations. Interestingly, a sense of responsibility to individual patients is associated with physician satisfaction with practice.

Evidence of the epidemic of diabetes is provided by Koopman and colleagues, using nationally representative data.[9] They find that between the 1988-1994 and 1999-2000 National Health and Nutrition Examination Survey studies, the age of diagnosis of type 2 diabetes has decreased from 52 to 46 years. These data most likely show the combined effect of earlier onset of disease, changing diagnostic criteria, and increasing recognition of diabetes, and they portend growing challenges for the health care system.

Meadows and colleagues use qualitative methods to develop a typology of women's perceptions of future risk for fractures after having suffered a low-impact fracture.[10] The authors identify 3 belief systems among women in this study, which seem to call for different clinical approaches to individualizing care.

The study of a community advisory board provides powerful lessons for engaging the community voice in participatory research.[11] This brief article summarizes important lessons, and the more detailed online appendix[12] brings these lessons to life by showing the lives from which these lessons emerge.

A methodological study by Glasgow and colleagues represents an important springboard for research to advance the science of health behavior change.[13] These authors identify approaches to measuring health behavior change that are practical to implement in primary care and practice-based research. The online appendixes[14] show the actual instruments for those who wish to use them.

Finally, a distinguished ethicist and practicing family physician shows that from the perspectives of professional integrity and time management, physicians should refuse to see pharmaceutical sales representatives.[15] This careful analysis shows that arguments for developing relationships with reps are hollow rationalizations and that these relationships are at odds with our patients' interests. If we are listening, this is a call to action.

We look forward to a thoughtful and lively online discussion of these studies at http://www.annfammed.org.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/cgi/content/full/3/1/2.

References

1. Baik S, Bowers BJ, Oakley LD, Susman JL. The recognition of depression: the primary care provider's perspective. *Ann Fam Med.* 2005;3:31-37.
2. Van Voorhees BW, Fogel J, Houston TK, Cooper LA, Nae-Yuh W. Beliefs and attitudes associated with the intention to not accept the diagnosis of depression among young adults. *Ann Fam Med.* 2005;3:38-46.
3. Aikens JE, Nease DE, Nau DP, Klinkman MS, Schwenk TL. Adherence to maintenance-phase antidepressant medication as a function of beliefs about medication. *Ann Fam Med.* 2005;3:23-30.
4. Dickinson LM, Rost K, Nutting PA, Elliott CE, Keeley RD, Pincus H. Care manager for major depression in primary care: costs of outpatient care over two years comparing patients with physical versus psychological symptoms. *Ann Fam Med.* 2005;3:15-22.

5. Rost K, Pyne JM, Dickinson LM, Elliott CE, deGruy F. The cost effectiveness of enhancing primary care depression management on an ongoing basis. *Ann Fam Med.* 2005;3:7-14.

6. deGruy F. Depression care: progress and prospects. *Ann Fam Med.* 2005;3:3-6.

7. Spurling MC, Vinson DC. Alcohol-related injuries: evidence for the prevention paradox. *Ann Fam Med.* 2004;2:47-52.

8. Rost K, Pyne JM, Dickinson LM, et al. Physician conceptions of responsibility to individual patients and distributive justice in healthcare. *Ann Fam Med.* 2005;3:53-59.

9. Koopman RJ, Mainous AG, Diaz VA, Geesey ME. Changes in age at diagnosis of type 2 diabetes in the United States, 1988-2000. *Ann Fam Med.* 2005;3:60-63.

10. Meadows LM, Mrkonjic L, Lagendyk L. Women's perceptions of future risk after low energy fractures at midlife. *Ann Fam Med.* 2005;3:64-69.

11. Chené R, García L, Goldstrom M, et al. Mental health research in primary care: mandates from a community advisory board. *Ann Fam Med.* 2005;3:70-72.

12. Chené R, García L, Goldstrom M, et al. Mental health research in primary care: mandates from a community advisory board. Appendix. Available at: http://www.annfammed.org/cgi/content/full/3/1/70/DC1.

13. Glasgow RE, Ory MG, Klesges LM, Cifuentes M, Fernald DH, Green LA. Practical and relevant self-report measures of health behavior for primary care settings. *Ann Fam Med.* 2005;3:73-81.

14. Glasgow RE, Ory MG, Klesges LM, Cifuentes M, Fernald DH, Green LA. Practical and relevant self-report measures of health behavior for primary care settings. Appendix. Available at: http://www.annfammed.org/cgi/content/full/3/1/73/DC1.

15. Brody H. The company we keep: why physicians should refuse to see pharmaceutical representatives. *Ann Fam Med.* 2005;3:82-85.

EDITORIAL

Depression Research in Primary Care: Pushing the Field Forward

Frank de Gruy III, MD

University of Colorado, Aurora, Colo

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This issue of the *Annals* contains a suite of studies dealing with mental health care, particularly the care we render to depressed patients in the primary care setting. I hope every reader reads these articles, because they are solid, scientifically sophisticated studies that advance the field—that lead us toward better care of our depressed patients. And they are more than that. In just a moment we will look specifically at where some of these discoveries are leading us, but first a few general thoughts.

For some of us, the early 1990s were when the lessons from the foray of this nation into managed care began to really sink in. In primary care one of those forays was the creation of hard-partition mental health carveouts, and one lesson was that this so-called solution to the problem of expensive mental health care itself created even larger problems. We faced the difficulty of practicing integrated, comprehensive primary care within a disintegrative structure. Not only were carveouts difficult to work with, but no one asked us whether we wanted them—this structure was delivered to us as a fait accompli, the prescribed, received world in which we practiced. So we published polemics about the necessity of rendering mental health care in the primary care setting.[1] We took on (and sometimes became) health plan managers, looking for ways to break down, work around, or work within this onerous barrier. We sought solutions among our cousins in cognate fields that might map to our problems (we have borrowed freely, for example, from the literature on chronic disease management[2] and imported the structures and resources necessary for our success).

Look at this field today! We're not talking about *whether* we should manage depression in our practices, but *how*. That is progress. It didn't come by killing carveouts (as if that were possible). It came by work-

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CORRESPONDING AUTHOR

Frank de Gruy III, MD
Department of Family Medicine
UCHSC at Fitzsimons
PO Box 6508 - Mail Stop F496
Aurora, CO 80045-0508
frank.degruy@uchsc.edu