Using Prudence When Prescribing

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INTRODUCTION

Over the last decade, the number of Americans who took a single prescription drug increased by 10 percent, while the use of multiple prescription drugs increased by 20 percent. According to the Centers for Disease Control and Prevention (CDC) almost half of the United States population uses prescription drugs. The most commonly prescribed drugs were those used to manage high blood pressure and heart disease for patients 60 and older. Additionally, the most commonly prescribed drugs for ages 20-59 were antidepressants.[1]

ANALYSIS

The increase in prescription drug use comes at a high price. In the past decade, the national pharmaceutical bill has more than doubled to a hefty $234 billion dollars. This cost is expected to increase with the rise in population, increase in acute and chronic conditions, and the growing cost of new pharmaceuticals.

When examining the increasing cost, one must ask, "Is this worth it?" This question is not meant demean the efficacy of pharmaceutical intervention, but rather, to examine whether clinicians are being prudent in their decisions regarding patient care.

The mental health field is one area where this question should be posed. Medical Expenditure Panel Surveys conducted by the Federal Agency for Healthcare Research and Quality found that more than 57 percent of patients now receive medication without psychotherapy. Additionally, the portion of patients that received both psycho-therapeutic and pharmacological therapy has dropped from 40 to 32 percent.[2]

This statistic conflicts with the current research in the field. It has been shown that medication and psychotherapy have comparable short-term benefits, and certain psychotherapies have outperformed current medications. As antidepressants are one of the most prescribed medications nationally, it is vital to scrutinize whether they are necessary as a method of treatment. Current meta-analyses of the efficacy of psychotherapy (particularly cognitive behavioral therapy) versus medications conclude that the longer-term effects outperformed newer antidepressants.[3] The combined effects of psychotherapy and medications indicate faster recovery rates, decreased rate of relapse, improved compliance and satisfaction, and lower long-term health costs.[4]

Extended conversations and therapeutic interventions may necessitate spending more time with patients, resulting in clinicians being able to see fewer patients overall. Psychiatrists and general physicians generally complain of too little time and too many patients. While less time with patients may result in more care for the overall patient population, the quality of care must be taken into account. Efficacy must not be substituted for efficiency. In terms of mental healthcare, behavioral intervention may offer a decreased rate of relapse[5] and lower long-term health and social service costs[6] which has the potential to cease a patient's need for chronic medication.

The point is not that behavioral interventions will significantly impacts all patients, however it may be in the patient's best interest to attempt behavioral health interventions before pursuing medication. Furthermore, this approach does not necessarily preclude pharmacological interventions, but rather encourages consideration of behavioral intervention for all clinicians prior to any other approaches.

Behavioral interventions can be prescribed in other areas aside from the mental health field. Implementing proper interventions that focus on nutrition and exercise can also help to trim down the patient's medical bill. The reasoning here is the same, to discourage "giving fish, and instead teaching one how to fish."

The clinician has a fiduciary relationship to the patient, one that relies on trust and confidence. The clinician's focus should not be solely on what will be efficacious in the short-term, but also the long-term effects chronic medication may have on the patient. Clinicians should not put their patients on an anti-depressant when behavioral therapy may be just as, or more, efficacious, and result in less longitudinal cost. Every clinician has a responsibility to determine and use the most effective interventions for their patients, basing their judgment on that patient's individual case.

A clinician must also consider alternative prescriptions to medications. Modern healthcare emphasizes the role of healthcare workers to fix a problem rather than prevent a problem. Preventative care has been shown to be extremely efficacious in improving public health and thereby reducing the need for bandaging issues

rather than averting them. Prescriptions could be written for thirty minutes of cardiovascular exercise a day, or even two additional servings of fruits and vegetables a day. Organizations such as Health Leads connect low-income patients with basic health-related resources. Clinicians participating with Health Leads can prescribe food, fuel assistance, housing and more.[7]

Some may decry this approach as paternalism and assert that a clinician should not have such authority over the patient's life. This approach does not mandate that the patient must agree to all behavioral interventions, but instead simply encourages the patient to do so. Autonomy is not restricted as the mechanism of prescription leaves the final choice (to obtain and use medications) up to the patient.

CONCLUSION

With the rise in prescription drug use, it is imperative for clinicians to consider viable alternatives, which may be more efficacious and less costly. This process starts with spending additional time with the patient, getting to know their lifestyle, where they come from, and how they feel about their own condition. The extra time the clinician spends with the patient may make a difference for a lifetime.

[1] http://www.cdc.gov/nchs/data/databriefs/db42.htm#frequently

[2] http://www.apa.org/monitor/2011/09/psychotherapy.aspx

[3] Spielmans GI et al, *J Nerv Ment Dis* 2011;199:142–149

[4] http://www.psychiatrictimes.com/articles/combining-drug-therapy-and-psychotherapy-depression

[5] Teasdale, J. D., Segal, Z. V., Williams, J. M. G., Ridgeway, V. A., Soulsby, J. M., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68(4), 615.

[6] Browne, G., Steiner, M., Roberts, J., Gafni, A., Byrne, C., Dunn, E., ... & Kraemer, J. (2002). Sertraline and/or interpersonal psychotherapy for patients with dysthymic disorder in primary care: 6-month comparison with longitudinal 2-year follow-up of effectiveness and costs. *Journal of Affective Disorders*, 68(2), 317-330.

[7] https://healthleadsusa.org/