The Evidence Against Primary Care Physicians Providing Behavioral Healthcare

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Absent from the discussion about patient care is the relationship of science, population demographics and epidemiology to the healthcare system. Field-tested providers have been locked out of any substantive opportunities to express their views about coverage, effective best practices and cost controls. Going forward, NAPPP will advance some very bold and, for some, controversial statements. Given the crisis that confronts the healthcare system, timidity is not an option.

NAPPP believes that the public needs to hear from very experienced healthcare providers who have made the long journey through a broken and co-opted healthcare system that is being driven further into the hands of the Primary Care Medicine and the marketing system that uses physicians, primary care and specialists as vehicles for unproven and costly treatment regimens. The result has been a system that largely is unresponsive to reform and a healthcare system that, in fact, promotes illness, habituation to analgesics and addiction to other drugs**,** large expenditures for ineffective care and a drain on the economies of local, state and federal governments. Businesses, both large and small, are diverting funds into healthcare expenditures that could very well provide greater benefits if directed to the appropriate providers and if physicians were required to adhere to the standards of care for behavioral conditions. As a result of this medical mismanagement, healthcare reform has little to do with health but more to do with:

1. Organized medicine's unwillingness to admit its shortcomings and desire to maintain physicians as the "masters" of all healthcare.

2. Political contributions to politicians who, naively or otherwise, fail to pass legislation that provides any real regulatory oversight over healthcare stakeholders.

3. The misplaced trust in the stated mission of the overall healthcare system.

4**.** Continued corporate control of health care.

Many studies have chronicled reports from consumer groups, government reports, and research that indicates the American healthcare system is substandard, ineffective and inefficient when it comes to the evaluation and treatment of individuals with substance abuse and mental health problems.[4-6] These problems emanate from an outdated health care belief that "primary care physicians can lead and manage the healthcare system". This belief holds that because the primary care physician is available and accessible in most communities, they will "screen" and "link" patients to the appropriate specialists for needed care. The system has several flaws and simply does not work this way for the following reasons.

First- Financial incentives are powerful primary reinforcers that have been scientifically proven to rapidly shape and maintain new behaviors. Unfortunately for patients and the public, these reinforcers have become perverse economic incentives. Physicians, however, have been financially rewarded for keeping mentally ill and chemically dependent patients in treatment and under their care rather than seeking an appropriate specialist assessment, much less transferring them to specialist treatment.

The primary care industry developed partial, inadequate, and even unproven treatments with no real rational, scientific, or amplitude of effect on mental illness and substance abuse.[4,7,8] Physicians devised short and marginally valid "screening instruments" that have a huge misidentification ratio and developed assessment protocols that are used in the absence of a well-done psychosocial history, mental status examination, collateral family interviews and family assessment, and psychological testing when indicated. These unproven and unreliable procedures miss most behavioral illness and chemical dependency identification in primary care centers and hospitals. They are so bioreductionistic that they focus only on the sequalae physical problems or diagnose "feelings and behaviors" such as "anxiety, depression, anger or marital problem, sleep disturbance, etc." rather than an appropriate diagnosis. Patients are then prescribed antidepressants or benzodiazapines with no rational to support these treatments. These treatments have been proven incomplete, inadequate, and ineffective.[9-11.]

Despite this, primary care physicians and the primary care industry continue these inadequate treatments despite the evidence about their inadequacy, widespread articles exposing the problems with the approach and long-term costs and waste of human potential associated with it.[12] Patients and the public have every reason to suspect that a major cause of escalating healthcare costs is economically motivated.

Second- The healthcare industry composed of physician groups, insurers, large contract providers, medical device companies, and the pharmaceutical industry has achieved total control of the healthcare system that routinely misleads and colludes with government regulators. Regulators frequently put primary care physicians in control of nearly all of the system (community hospitals, state and federal clinics, primary care clinics, third party payer systems, and healthcare law and standards development). Yet, there are no psychologists or psychiatrists staffing requirements before primary care centers can qualify to be certified for reimbursement from Medicare and Medicaid. Similarly, there are no such requirements enforced by hospital, nursing facility, or residential care facilities. Primary care physicians are simply "trusted" and "given the option" concerning when to staff these centers with such specialists, when to call them in on cases, and whether or not realistic treatment protocols beyond a tranquilizer, antidepressant or antipsychotic is used.

When we look at the effect and outcome of this approach, we find it has been an abysmal failure with catastrophic results. Patients are partially treated with weak or ineffective medications, their mental illness or substance ***abuse*** is rarely identified or it is ignored. Worse yet, they are given naive medical practitioner advice or "talks" masquerading as a much more complex process, referred to as "counseling". Many patients have been seriously harmed, injured or killed by these approaches. Others have had years of their lives wasted or damaged. People have lost marriages, children, jobs, productivity and income, and have lived in ongoing and unnecessary stress that has undermined their physical health and longevity. Even when these things become widely described in the literature, the control of the primary care industry is maintained as "necessary" and as "the best way".

Third- The healthcare industry has embraced the myth that a behavioral disorder is a medical problem and implies that it is either genetically caused or neurohormonally caused and, typically, lifelong. This myth maintains the medicine's control of revenue streams and patients as chattel within the healthcare system. Even though the scientific literature shows that there are no genetically determined mental disorders, and that even the most genetically loaded mental disorders (a minority of mental disorders) have a small percent that can be ascribed to or explained by a genetic component, the medical establishment perpetuates the insinuation that the mentally ill are suffering from "defective protoplasm" or genetic disorders.

Every parent raising young children knows there is a complex interplay between genetics, neurohormones and the environment and very slow autoplasticity of the central nervous system. They understand that hundreds of focused and intense hours are needed to grow the neural connectors and autoreceptor breaks to gain the coordinated and appropriate self regulation necessary to create complex awareness and behavior such as potty training, bedtime skills, table manners, impulse control and judgment processes such as learning not to dash into the street.

Relying on the unproven genetic based theory, each generation of patients is repeatedly, cyclically, and incessantly provided with ineffective and costly treatments based on "new" neurohormonal hypotheses for their behavioral conditions, even though top scientists have long since concluded these are “only theoretical” as one hypothesis after another is proven false. Even with the growing scientific evidence about the brain-changing effects of the environment and experience, and the autoplacity of the central nervous system, the primary care system perpetuates its myth.[13-15]

Highly trained psychologists, psychiatrists and brain research scientists with many years of experience with mental illness have been raising the alarm about biologically based theories of behavioral disorders for decades.[16-18] The public also has been warned by other experts in mental illness [19, 20] and by research authors in the legal arena[21] that medicines as the only and first-line treatment in a treatment plan is a dangerous and ill thought-out approach to treatment, with significant, highly probable and predictable costs. Consequently, patients and the public have been left at the mercy of the primary care industry for their explanations of available science and health education.[22, 23]

Renowned researchers have been writing voluminously for the need to require protocols that include psychosocial and behavioral treatments with medications [24, 25] and in some cases in place of medications[6]. With such data, one would think that the government and certification and quality assurance organizations would require that primary care centers, hospitals, nursing homes, and residential care centers have staff psychologists or psychiatrists available. Although such a practice would be in the interest of the patient and would make good economic sense in the long run, one rarely sees psychologists routinely staffed and used in these situations. In fact, when such specialists attempt to get staff privileges and rules in place that allow them to be easily accessed by patients without going through the primary physician, they must go through the executive committee of the medical staff

(primary care physicians). The committee rarely approves such access in spite of many statutes that requires it to place psychologists on medical staffs.

Thus, in primary care and health facilities in America, the primary care physician acts as a “gatekeeper." But, more often than not, they screen out the possibility that a patient will get effective care or receive the standard of care mandated by guidelines rather than provide symptom screening and automatic referral and linkage with such specialists when behavioral health symptoms are encountered. Whatever the rationale and whatever the intent, it is wrong and patients and the public are paying a high price for this negligence.

Fourth- Another myth that permeates the primary care system is how identifying a feeling or surface symptom, such as sleep problems or aggression, can determine a diagnosis and thus trigger the appropriate protocol to treat the patient. Anxiety manifests itself, for instance, in many behavioral disorders and is simply misdiagnosed by physicians as hypomania or a stress response. Other emotions, such as feeling "down" or "blue," anger, or fear are similarly not definitive of which mental disorder may be present. Yet, primary care physicians in clinics, nursing homes, and hospitals frequently treat these feelings and behavior disruptions as if they are a “diagnosis” and subsequently prescribe the wrong medications and unrealistic behavioral regimens that often make the condition worse. Presently, the over-prescription of pain medications and sedatives has resulted in visits to emergency rooms for abuse related to these drugs being equal or exceed visits for illegal drugs.[25a]

This often is seen when physicians prescribe to drug-addicted individuals, whose lives are splintering and creating great concern and anxiety, benzodiazapine medications. These medications increase depression and sleep problems, increase already noteworthy memory problems, and exacerbate the aging process already driven by the addiction and related nutrition deficits, lifestyle effects, and vitamin depletion. Moreover, one of the critical issue with practicing in nursing homes is the disturbing policy of patients being chemically restrained and addicted.[26-29]

Insurers and managed care companies reimburse for this approach since they understand that a patient does not need to be provided treatment that might cost more in the short run when they can be prescribed a few antidepressants or tranquilizers, which are very inexpensive. In such cases, which are all too common, the primary care physician and the managed care company are providing ineffective and dangerous treatment by using medications instead of using an integrated approach that is both

beneficial and cost-effective.

Organized medicine has contributed to a virtual “War on Behavioral Treatment” with the overmedicalization of behavioral illness and by not using psychologists in all health facilities.[30] Hospital administrators, legislators and government officials, and even state and government employed psychologists, have gone along with this out of fear of retaliation of the health care industry and primary care physicians. This is understandable, since primary care physicians and insurers have effectively captured the American healthcare system, including facilities and third party reimbursers, who are in a position to withhold medical treatments, revenue, and cooperation and collaboration if challenged or exposed.

Often patients do not come to a healthcare provider for change or long-term health interests. Many patients simply want comfort and symptom control. The primary care system has built its industry on this awareness and has used the "right of the consumer" to remain silent and capitalize on a broken system for which they are rewarded. This mercantile vision and awareness is an economic and not a healthcare leadership role. It recognizes that many patients want short-term, passive, and palliative care and may be uneducated, uninvested, or simply don’t believe in the possibility of change without a drug. Such patients want a very specific product-comfort/ Medications that offer minor or major tranquilization (increased tranquility), a little more pep, or interfere with normal membrane or cell functioning to inhibit impulsiveness or mood volatility are all they focus on. However, do physicians have a responsibility to act in the patient's interest or assent to a patient's request knowing that it is wrong? We think they do. No psychologist would treat a patient for depression knowing or suspecting that they might have a brain tumor that is responsible for the symptoms, no matter how much the patient is in denial or wants to avoid a consult with a specialist. Should physicians not be held to the same standard?

Summary

Moving more services and responsibility into primary care centers and breaking down the silos in the health and mental health systems is a long-held goal. It requires not just a change in where services are geographically located, but change from the bioreductionistic philosophy and hierarchy of decision making that is deeply embedded in the culture and traditions of the primary care and medical services industry. We will not achieve improvements in the quality and costs of care if we do not improve the

leadership, traditions, and the broad application of science in these systems. Physicians and nurses are not trained or philosophically equipped to do this alone. There will have to be strong and enforced systemic and accreditation and reimbursement systems that require a broader staffing and presence of psychologists and other healthcare providers at all levels of the primary care and hospital system. The limits of medical care in decision-making, designing care plans, creating opportunities to deliver long-term care rather than palliative interventions, and with regard to limiting costly and debilitating side effects of care has been well established. The system has simply not been redesigned to accommodate this knowledge and science.

Real healthcare requires real change rather than minor changes in failing philosophies and systems. The public and patients are right to demand that the government demonstrate the will and intelligence and power to check the considerable influence of the medical, pharmaceutical, and hospital corporation establishment and truly redesign and maintain a vastly different system. The anxiety and fear of these powerful dominating forces in the current failed healthcare system is realistic. However, the needed changes to this system may not be expensive and ineffective as the industry will have us believe. What is required is a change in attitude and philosophy that physicians do not and should not be expected to know everything about illness. They alone have the power to significantly change the healthcare outcomes for patients. They alone can be instrumental in changing a system that makes a profit on non-beneficial and ineffective treatment. They alone are in a position to make healthcare cost effective. It will mean, however, that they must first acknowledge that a license to practice medicine should not be construed as a license to collude with insurance companies, pharmaceutical companies, and medical device companies to exercise undue influence and power over healthcare.