Of quantity and (perceived) quality

It's a much-debated question: Will the United States soon face a serious shortage of physicians? Or not . . .

In a new study, researchers at the Dartmouth Institute for Health Policy and Clinical Practice (TDI) tackled this question from a different perspective, by examining whether there's a relationship between the supply of physicians in a given region and the perceptions patients in that region have of their health care. "It is really one of the very rare studies that has actually asked patients what they think," says TDI researcher David Goodman, M.D.

Groups: The researchers surveyed 4,000 Medicare beneficiaries between March and October 2005; 2,515 responded. The survey asked beneficiaries 12 questions about their access to care and their satisfaction with the care they received. The results were divided into five groups based on the number of physicians per capita where patients lived, from very low supply to very high.

Physician supply varied greatly across the country. Regions in the lowest-supply group had a median of 146 physicians per 100,000 beneficiaries. The median in the highest-supply regions was 245 per 100,000—almost 70% higher.

But there was little difference in patients' perceptions of their care. In high-supply areas, patients believed that their communities received more care, but, the researchers found, they were no more or less likely—compared to patients in the low-supply areas—to "have a personal physician, to feel that they had visited the right number of specialists, or to say that they wanted tests or treatments they had not received." The results were the same when it came to how patients felt about the quality of their own health care and whether they felt that their physicians spent enough time with them.

Patients were no more or less likely to have a personal physician.

Access: So, at least for the Medicare population, the authors concluded, training more physicians "is unlikely to lead to improved access to care, higher satisfaction, or greater assurance of having a personal physician who spends enough time with the patient."

"Even apart from supply, what makes more difference is what physicians do, not how many there are in a region," says Goodman. "So a few physicians providing excellent care are worth a whole lot more than a whole gaggle of physicians in a disorganized system where the care is of mediocre quality."

But he offers a caution. Training more physicians in primary care may sound like a good idea, but Goodman believes that many medical school graduates who train in primary care are increasingly apt to "become hospitalists or emergency room doctors, and they're primary care in name only." The answer, conclude the study authors, may be "encouraging primary-care physicians to practice in regions with a lower supply of such providers."

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Berman found psychotherapy and medication equally beneficial against depression.

A finding to feel good about

For people who are depressed, there is no right—or wrong—answer when it comes to choosing between psychotherapy and medication. That's the primary finding of a new paper coauthored by Margit Berman, Ph.D., a Dartmouth psychologist.

Meds: "I always remind my patients that they are not average," Berman says, "that there is no average person." Certain individuals may prefer therapy or medication. But, in general, she says, "there is no research to suggest that either antidepressant medication or psychotherapy or the combination of meds and therapy is better."

To reach this conclusion, Berman and her coauthors at Minnesota's Metropolitan State University analyzed 15 already published studies, an approach known as a meta-analysis. Their analysis was the first to include only research that compared psychotherapy to second-generation antidepressants—without muddying the waters with older drugs that are now rarely used. Second-generation antidepressants include selective serotonin reuptake inhibitors like Prozac and serotonin and norepinephrine reuptake inhibitors like Cymbalta.

Berman's study, which was published in the *Journal of Nervous and Mental Disease*, also distinguished what she calls "bona fide psychotherapy" from psychotherapy lacking a clear evidence base or a skilled practitioner. To be considered bona fide, the therapist had to have at least a master's degree or be in graduate school in a relevant field; the therapy had to be delivered face-to-face and be individualized to the patient; and the therapy had to be evidence-based.

Many doctors believe that only specialized therapies, such as cognitive behavioral therapy, are as effective as medications, she explains, but practitioners of those therapies can be hard to find in many communities. "Actually, any good therapy helps," she says, noting that patients don't need to seek out a particular type of therapist.

Depression: Psychiatrists have great faith in antidepressants, "just as I have great faith in psychotherapy," she adds. "We all like what we do." And now patients with depression—and their doctors—can feel good about trying either approach.

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