over those treated in the general medical sector stems from specialists' "more extensive training and expertise in treating mental health problems" (1, p. 112). Twice the number of patients treated by specialists as patients treated in the general medical sector had treatment in accordance with Agency for Health Care Policy and Research guidelines (2, 3). However, only 48% of the patients treated by specialists had treatment that followed those guidelines. Because the authors did not provide the details of their analysis, we cannot reach a conclusion regarding the meaning of this finding. Which of the guidelines were not followed? What was the use of certain medications, the dosing, the length of treatment, and the like? If 52% of the specialists were not in compliance with the guidelines because they use antidepressants other than those recommended by the Agency for Health Care Policy and Research, the meaning of the authors' finding would be very different from what it would be if the specialists' noncompliance were based on their failure to make patients' drug levels reach accepted therapeutic doses. This is equally true for the 79% of the physicians in the general medical sector who were not in compliance with the guidelines. When training psychiatrists and nonpsychiatrists about the treatment of depression, knowing what they do and do not do would guide the educational endeavor.

REFERENCES

1. Zhang M, Rost KM, Fortney JC: Earnings changes for depressed individuals treated by mental health specialists. Am J Psychiatry 1999; 156:108–114
2. Depression Guideline Panel: Depression in Primary Care, vol 1: Detection and Diagnosis: Clinical Practice Guideline #5: Agency for Health Care Policy and Research Publication 93-0550. Rockville, Md, US Department of Health and Human Services, Public Health Service, AHCPR, 1993
3. Depression Guideline Panel: Depression in Primary Care, vol 2: Detection and Diagnosis: Clinical Practice Guideline #5: Agency for Health Care Policy and Research Publication 93-0550. Rockville, Md, US Department of Health and Human Services, Public Health Service, AHCPR, 1993, pp 1–175

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Dr. Rost and Colleagues Reply

TO THE EDITOR: In our article, we reported greater cost savings for patients treated by psychiatric specialists than for those treated in the general medical sector. One explanation for this is that 48% of the community residents treated for depression in the specialty care sector received guideline-concordant care in contrast to 21% of the community residents treated for depression in the primary care setting. In his letter, Dr. Muskin requested further information to identify where the deviations from guideline-concordant care occurred in both sectors. We are happy to provide a further breakdown without extensive statistical comparisons. Specialty care patients were more likely than primary care patients to get any antidepressant medication (64.3% and 53.0%, respectively). Among those who received antidepressant medication, specialty care patients were more likely than primary care patients to be prescribed a guideline-concordant dose (52.8% and 39.4%) and were somewhat more likely to take the medication for a minimum of 8 weeks (75.0% and 70.5%). The remaining difference in guideline-concordant treatment rates was explained by the greater likelihood for specialty care patients to report that they received eight or more counseling visits for depression. The 1992 medication patterns do not adequately represent current primary care medication prescribing patterns, particularly the greater use of newer-generation antidepressants whose limited side effects allow physicians to prescribe therapeutic doses more readily. However, if specialty care's achievement of better outcomes is in part attributable to providing psychotherapy (in combination with medication or independently), we might continue to observe these outcome differences if the study were to be replicated in the current health care environment.

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Clinical Trials and Effectiveness Research

TO THE EDITOR: Kenneth B. Wells, M.D., M.P.H, has made an important contribution with his article (1). It may be helpful to keep the following considerations in mind in interpreting both efficacy and effectiveness studies for both clinical and policy decision making.

Outcomes are most often defined in terms of easy-to-measure markers. Features such as autonomy or authenticity are rarely considered and are also never measured in either type of study. Yet they are most relevant in terms of the utility of given outcomes to individuals, as well as our culture and our society (2–4). More easily measurable outcomes continue to dominate the studies reported even in this *Journal*. Should all outcome studies carry at least an explanation of why the particular outcomes were chosen and why meaningful outcomes were not considered?

REFERENCES

1. Wells KB: Treatment research at the crossroads: the scientific interface of clinical trials and effectiveness research. Am J Psychiatry 1999; 156:5–10
2. Bursztajn HJ: Efficacy research and psychodynamic psychiatry (letter). Am J Psychiatry 1991; 148:817–818
3. Bursztajn HJ, Hamm RM: The clinical utility of utility assessment. Med Decis Making 1982; 2:162–165
4. Bursztajn HJ, Feinbloom RI, Hamm RM, Brodsky A: Medical Choices, Medical Chances: How Patients, Families, and Physicians Can Cope With Uncertainty. New York, Routledge, Chapman & Hall, 1990

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Dr. Wells Replies

TO THE EDITOR: Dr. Bursztajn raises the question of whether the authors of treatment-outcome studies should justify their outcome selection within a broader scheme that includes effects relevant to practice and policy that are difficult to measure. The simple answer is "yes," but this is not a simple question.

Practice and policy decisions involve tradeoffs among treatments and their expected outcomes under conditions of constrained resources, uncertainty, and personal distress. The information required to inform those decisions ideally includes all expected benefits and costs, including respect for individual autonomy and societal implications, of the alternative actions. In addition, one would desire a validated pro-