less than three weeks.

Not everyone agrees completely with Dr. Kline. "I, for one, am not convinced that family physicians are equipped to treat depression as readily as Dr. Kline says they can," remarks psychiatrist Daniel X. Freedman of the Pritzker School of Medicine, University of Chicago.

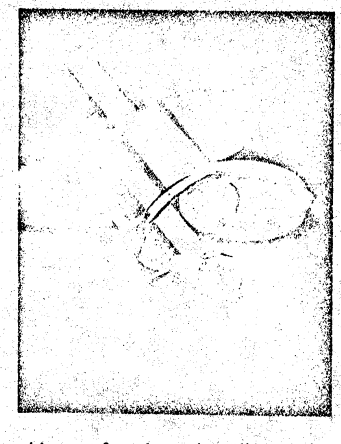
"It's a complicated matter, and most nonpsychiatrists need more training and readily available psychiatric consultation to cope with these cases." But Dr. Freedman agrees that antidepressants are sometimes misused by family physicians.

"Hospital studies have shown that physicians tend not to monitor treatment closely enough, and that they don't tailor a drug regimen to the patient's needs. Drug therapy seems to be aimed at the average patient, rather than the individual. The drugs are usually used when they're indicated, these studies show, but they're not used with enough careful thought. And some patients are undermedicated."

Hypertension, of course, is the classic undermedicated condition, but physicians seem to be improving their performance with it, according to Dr. Richard S. Ross, president of the American Heart Association.

He thinks physicians increasingly are treating mild and moderate cases, rather than waiting until the diastolic hits 115. Treatment ought to start at diastolic 105, according to the National Heart and Lung Institute, but Dr. Ross says that he and other physicians regularly initiate treatment at 90 to 100 for some patients, depending on such factors as age, family history, target organ damage, and cholesterol level.

"In the last five years we've learned that there's no such thing as 'benign' essential hypertension," says Dr. Ross. "We know that treatment of mild cases can reduce the incidence of stroke and cardiovascular-related mortality in later life."



It's possible, though, says Dr. Ross, that physicians using information eight or ten years old are still treating only severe cases. It may also be that some physicians are discouraged from taking on the extra burden because treatment, as Dr. Ross puts it, "is a nuisance. You've got to do a lot of talking to convince a patient to take a drug that may make him feel worse to prevent something hypothetical from happening. That's a difficult idea for some people to grasp."

Of course, much hypertension goes untreated simply because people don't know they have it. But of the known hypertensives, according to the National Heart and Lung Institute, only one-fourth are getting adequate treatment. Doctors may be changing that, as Dr. Ross says, but clearly there is plenty of room for improvement in this area.

Antibiotics

Even with that class of drugs that physicians are accused so often of *over*prescribing—antibiotics—there are occasions when they undermedicate. "It's rare," says Dr. James J. Rahal Jr., chief of the infectious disease division at the New York (Manhattan) VA Hospital, "but it does happen—particularly with Group A streptococcal infections. Everyone knows that streptococcal pharyngitis will usually respond to 125 to 250 mg of penicillin four times a day. So many physicians, when they see a strep infection like cellulitis, for example, think it will respond to the same small amount of penicillin. When it doesn't, they ask, 'What does this patient have? It can't be strep.' I used to do the same thing myself until I got burned a few times.

"Now, with really severe cases of streptococcus cellulitis, I sometimes have to give penicillin intravenously or intramuscularly, perhaps a half million to a million units every four hours, and sometimes more," Dr. Rahal observes.

These experts agree, then, that our supposedly overmedicated society is sometimes undermedicated. They're also in agreement about the remedy: Be confident of your diagnoses, know what the available medications can do (and package inserts aren't *always* a reliable guide), and tailor each prescription to the individual patient's needs. In so doing, you'll avoid the ranks of those irrational prescribers who are not cavalier, but too cautious. □

Undermedicated society: Additional prescribing information

For more information on therapeutic agents discussed in this article, see Physicians' Desk Reference, 1975 edition.

	PDR page
Nortriptyline	
Aventyl (Lilly)	912
Phenobarbital	
Eskabarb (Smith Kline & French)	1383
Luminal (Winthrop)	1604
Solfoton (Poythress)	1193
Prednisone	
Delta-Dome (Dome)	741
Deltasone (Upjohn)	1515
Meticorten (Schering)	1331
Orasone (Rowell)	1291