

# How general practitioners manage depressive illness: developing a method of audit

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**SUMMARY.** A model of process is necessary if it is to be audited. A model derived by a group of general practitioners for an audit of their management of depressive illness is described, together with the recording form used and the results of the audit. It is suggested that other general practitioners could test the validity of the model by using the recording form to audit their own management of depressive illness.

**G**ENERAL practitioners vary in the accuracy with which they diagnose psychiatric disorder (Marks *et al.*, 1979; Zintl-Wiegand and Cooper, 1979), and some are more likely than others to identify psychiatric disorder (Goldberg and Huxley, 1980). These variations make it difficult to assess the usefulness of antidepressant medication prescribed in general practice, although the majority of patients with a depressive experience will never see a specialist (Fahy, 1974). The 1970-1971 National Morbidity survey (OPCS, 1974) showed 35.5/1,000 patients consulting general practitioners at least once a year for depression. In contrast, the Chichester and Salisbury study found a referral rate to psychiatrists of about 3/1,000 (Grad de Alarcón *et al.*, 1975). Johnson (1973) studied patients notified to him by general practitioners with a new episode of depressive illness—that is, those who had been free from symptoms and had had no treatment for a year. He concluded that “patients with depressive illness do not receive the best treatment in general practice”.

The care of depressive illness in general practice seems a suitable subject for audit of both process and outcome. The conduct of such an audit requires a model, agreed by the participants, of the processes by which general practitioners reach a diagnosis of depression.

## Methods

### *Producing a model*

During a course on clinical care conducted by the General Practice Unit of St George's Hospital Medical School in 1977 (Freeling and Burton, 1982), a group of local doctors decided to audit their management of depression and set out to produce a recording form acceptable to them all. The group began by recapitulating some of the symptoms of depression such as sleep disturbance, disturbance of appetite and weight, feelings of tiredness and loss of energy and loss of enjoyment of life. They had begun to discuss their search for suicidal tendencies before they realized that they only looked for items in this catalogue in response to a cue or cues from the patient. It took three more meetings, each lasting up to two hours and involving a number of case discussions, to produce a list of the cues. These were:

1. A patient's statement of mood, such as “I feel depressed”.
2. Presentation of one or more items from the classical catalogue of symptoms of depression.
3. A constellation of physical symptoms which the doctor could not readily identify as representing an organic syndrome.
4. Recurrent presentation of children with neither obvious organic illness, nor overt behaviour problems.
5. The doctor's feeling depressed during a consultation or at the prospect of further contact.
6. Clinical acumen: the doctor forms an impression that the patient is depressed, probably from a complex of para-verbal and non-verbal messages.

Further discussion revealed that members responded to these cues, or to combinations of them, not only by checking the depression catalogue, but also by questions aimed at uncovering recent life events (Paykel *et al.*,

DEPRESSION AUDIT					
Name:		NHS No:			
GP		DOB:			
Cues: "I am depressed" <input type="checkbox"/> Symptom(s) associated with depression <input type="checkbox"/> Physical symptoms without physical cause <input type="checkbox"/> Recurrent presentation of children <input type="checkbox"/> Doctor feels depressed <input type="checkbox"/> Doctor feels patient is depressed <input type="checkbox"/>					
ASSESSMENT (see Protocol)				Date:	
	Very much	Considerable	Moderate	Somewhat	Not at all
Verbal report					
Behaviour					
Secondary symptoms					
Life events					
0 _____ 10					
Depressive tendency					
0 _____ 10					
Contributing physical conditions:					
Drug(s)					
Dosage schedule:				Quantity prescribed	

*A recording form.*

1976). They also considered items such as past or family history of depression or having had adverse life experiences which had a depressive tendency.

Members wished to use a severity scale for the depressive episodes they recognized. A consultant psychiatrist drew their attention to a validated five-point scale (Raskin *et al.*, 1970) which moves from "very severe" (4) to "Not at all" (0), for three composite items. The first item, the verbal report, includes the following: says he/she feels unhappy; talks of feelings of worthlessness, helplessness or hopelessness; complains of loss of interest; may wish he/she were dead; reports crying spells. The second item, behaviour, includes: looks sad; cries easily; speaks in a sad voice; appears slowed down; and lacking in energy. The third item, secondary symptoms of depression, includes: insomnia; gastro-intestinal complaints; dry mouth; recent suicide attempt; lack of appetite; and difficulty in concentrating or remembering. The group adopted this scale enthusiastically.

*The model and management predictions*

The group continued to discuss cases in the light of the model they were devising. They thought it probable that two categories (recent life events and depressive tendency) could be used to delineate four broad types of

patient (Table 2), and they predicted they would adopt a different management approach for each. They thought that a depressive tendency required drugs and that life events required counselling. The predicted management categories were as follows: patients with high scores in both categories would receive both support and antidepressant drugs; high scores for recent life events but low for depressive tendency meant support but no drugs; where depressive tendency scored high and recent life events low, drugs would be prescribed with a little sympathy; and low scores in both categories should mean a review of the diagnosis. Personality disorder could be considered as a possible alternative and the evidence for an organic disorder could be reviewed. It was felt that antidepressant drugs would not be prescribed for this last group. All members of the course accepted the model and its management predictions. The model was translated into a recording sheet (see Figure) which fitted into a standard medical record envelope. A sub-group of members produced, with some difficulty, a protocol for using the record sheet.

*The protocol*

The group decided to include in the audit:

1. Any patient in whom a diagnosis of depression was a

major possibility for the first time in the presenting episode.

2. Any patient in whom a diagnosis of depression had already been made in the presenting episode, and for whom an antidepressant drug was prescribed.

Members had freedom of choice over the drug prescribed.

A life event was defined as recent if it had taken place within one year; otherwise it became part of a depressive tendency. This decision was imposed by the course organizer/group leader after lengthy discussion had failed to produce a consensus.

We originally thought that the same recording form could be used to monitor progress as well as to record the basis of diagnosis. The group realized, however, that the recording doctor would be biased by seeing the original assessment when they were recording progress. So the group opted for a system in which completed diagnosis forms were sent to the secretary of the General Practice Unit at St George's Hospital and a blank form was left in the patient's medical record envelope. It was used to note prescriptions which had not been given at an initial diagnosis and any changes in prescription or dosage. At the end of three months the secretary notified the doctor, who recalled the patient, completed a recording form and returned it to the Unit.

**Results**

Seven doctors notified 61 patients to the audit; one doctor accounted for just over half of the total. Ninety per cent of the patients were women. All were prescribed antidepressant drugs. Follow-up reports were received for half of the patients. There were no notifications of change of treatment.

*Cues*

For four patients the section on cues was not completed. Table 1 shows the frequency with which the cues were noted. For eight patients one cue only was listed; for 24 there were two cues; for 17 patients there were three; for six patients, four; and for two patients five cues were listed.

*Predictions and management*

All the patients received drugs. Table 2 shows the numbers and percentages allocated to each of the four predicted management categories. Thirty-nine patients (64 per cent) who had been prescribed drugs fell into the group for whom drug management had been predicted. The scores on the Raskin scale tended to be higher for those patients with low ratings for depressive tendency than for those with high ratings.

At recall after three months all the patients on whom the doctors reported (50 per cent) seemed to have improved to much the same extent.

**Discussion**

The fact that members of the group made predictions about management, rather than attempting to adhere to external criteria, may have accounted for their willingness to audit their work. Nevertheless, follow-ups were received for only 50 per cent of patients.

It has been reported already (Freeling and Burton, 1982) that members of this audit group consistently proved reluctant to return to recording an item of care months after they had left the topic. There is an alternative explanation possible for follow-up being obtained on only half of the cases entered into the audit, namely that, like the general practitioner patients re-

**Table 1.** Cues and their frequency.

Cue	Number (per cent)	Number with only one cue
'Feeling depressed'	33 (58)	0
Symptoms associated with depression	47 (82)	4
Physical symptoms without physical cause	25 (44)	3
Recurrent presentation of children	0	-
Doctor feels depressed	4 (7)	0
Doctor feels patient is depressed	30 (53)	1
Section not completed	4 (7)	-

**Table 2.** Distribution of audit patients by 'predicted management' categories.

Recent life events	Depressive tendency	Predicted management	Number (per cent) of patients prescribed antidepressants
None or few	High	Antidepressant drugs and a little counselling	23 (38)
Many	High	Antidepressant drugs, support and counselling later	16 (26)
Many	Low	Counselling. Antidepressant drugs rarely	17 (28)
None or few	Low	Question diagnosis. Consider possibility of 'personality disorder'. Certainly not antidepressants	5 (8)
Total			61 (100)

ported by Johnson (1973), half of those entered had, without informing the doctor, stopped taking their medication.

That all but four of the original notifications were complete suggests that the model (represented on the recording form) was a true reflection of the way these doctors reached their decisions about the diagnosis and management of depression. It is worth noting that no patient was notified to the audit who had not been prescribed an antidepressant drug, although the protocol made specific provision for this. There are a number of possible explanations; Howie (1976) has demonstrated that general practitioners tend to make their management decision first and their diagnoses later. Others (Browne and Freeling, 1976) have pointed out that general practitioners tend to justify their investigations by their diagnoses, in contrast to specialists who tend to justify their diagnoses by their investigations. Watson and Barber (1981) reported 101 patients with new episodes of depressive illness notified by nine general practice tutors in a three-month period. Twenty per cent of their patients were male, all but eight received medication and 77 per cent received an antidepressant. The notification rate varied between the nine doctors about as widely as it did for members of the audit reported here.

There is an indication that members of the audit group recognized that the depression seen in general practice can be severe, even if it is self-limiting, because when members' prescribing behaviour was different from their predicted prescribing behaviour (Table 2), they had usually rated their patients as markedly depressed. In any case, there was no validation of the diagnoses made by members of the audit group.

As has been reported elsewhere (Freeling and Burton, 1982), members were not willing to re-audit their prescribing of antidepressants after an interval. It is not possible to determine, therefore, whether or not their behaviour in diagnosing and treating depression was altered by the results of their audit. There is considerable anecdotal evidence of change. The doctor who had notified most patients to the audit replied to the request for re-audit, "I am not now diagnosing patients as having a disease called 'depression' for which I may prescribe antidepressants." The audit raises many questions about the nature and natural history of depressive illness in general practice, questions which cannot be answered unless the diagnoses are validated, the cluster of symptoms are described, and the number of overlooked cases are determined. It seems unlikely that the variations in notification rates can stem only from the characteristics of the different populations served by each of the general practitioners.

### Conclusions

Audit of process requires a model of process. The model created by the doctors who took part in this audit may

be useful to others, and replicating the audit may be valuable. The subject of the audit is particularly important, if only because the nature of depression treated in general practice can be determined only with the co-operation of general practitioners and their patients.

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### Words our patients use

- 'Lozzack'—to be completely relaxed in a chair (Lancashire).
- 'Oo is badly'—she is not well (Lancashire).
- 'Links'—a sore throat that aches and throbs (Lancashire).
- 'Fricken t' death'—frightened to death (Lancashire).
- 'Haw and hucker'—stammer. "He dew haw and hucker soo" (East Anglia).
- 'Sapy'—pale and sickly (East Anglia).
- 'Poddy'—pot belly, derived from 'ped', a pannier basket (East Anglia).
- 'Megrim's'—migraine (East Anglia).