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 cooperation 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).
'Megrims'—migraine (East Anglia).