Link between the ability to detect and manage emotional disorders: a study of general practitioner trainees

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SUMMARY. Independent ratings were made of videotaped consultations involving six general practice vocational trainees, of whom three were poor identifiers and three were able identifiers of emotional illness. Taped consultations were selected so that each trainee was rated interviewing five patients with low general health questionnaire scores, and five patients with high scores. It was found that able identifiers of emotional illness were more likely than poor identifiers to offer patients information, advice and treatment relevant to their illness, and that they did so in a manner likely to maximize patient satisfaction and cooperation. This was true for both distressed and non-distressed patients.

It is argued that both the ability to identify emotional disturbance and the ability to manage emotional illness are characteristics of a generally superior interview style. This may reflect a common variable: the possession of good communication skills.

Introduction

THERE are wide variations between family doctors in the way in which they interview their patients[1] and in their ability to make accurate assessments of emotional distress.[2] The ability to detect probable cases of emotional disorder has been termed the 'identification index' of a particular doctor, and early research has concentrated on the determinants of this ability. Doctors with a high identification index were rated by an independent observer as having more interest and concern for the patient, having a greater interest in psychiatry, and were more likely to be settled in their practice and to possess higher qualifications. More detailed analysis showed that such doctors behaved differently during the interview, in that they were better at clarifying the patient's complaint, were better at picking up cues relating to emotional distress, were better able to deal with interruptions and with over-talkative patients, and asked more questions with a psychosocial content.[3]

It has been shown that doctors who were better able to identify emotional illness made things easier for themselves by allowing the patients to emit more cues relating to emotional distress.[4,5] More recent research has shown that they make more eye contact with the patient throughout the interview, interrupt the patients less and make more facilitating noises, and do not look in the notes while speaking (Goldberg DP, *et al*, unpublished results).[6] All the research reported has been focused upon the processes of detection. The purpose of this research was to investigate possible relationships between the ability to detect emotional disorder and the ability to give information, advice and management to the patient.

Undiagnosed and untreated illness has negative consequences not only for the patient and his family, but also for the doctor in terms of the added burden on primary care services of such illness.[7] It has been demonstrated that there is a wide variation between general practitioners in the extent to which they offer relevant treatment to patients with psychological illness.[8] It is not enough simply to demonstrate that a doctor is capable of recognizing and labelling psychological disorder and offering relevant treatment; one should also ask how well treatment is given.[9] It is suggested that by making the patient aware of the relevant information and by encouraging his or her participation in clinical decision making, the doctor will positively influence the outcome of the consultation.[10]

Method

Materials

A collection of videotaped consultations between 19 general practice vocational trainees and their patients had been gathered during an earlier study in 1987.[11] These doctors were all from the Rochdale scheme, and were thought to be representative of local trainees. Consecutive patients attending surgeries were approached and asked to complete the 28 item version of the general health questionnaire (GHQ-28)[12] and for permission to record their consultation on videotape. This process yielded approximately 300 videotaped consultations and 950 completed questionnaires. The discrepancy between these numbers was because a run of at least 50 general health questionnaires was necessary to calculate the identification index for each doctor. The videotaping could be discontinued once interviews between each doctor and five patients with high general health questionnaire scores had been collected, thus minimizing the intrusiveness of this part of the project.

All patients who completed a general health questionnaire were assessed by the trainees for emotional disturbance using a six-point scale. A score of two or more indicated that they believed the patient to be suffering from a clinically significant degree of psychiatric morbidity. Using a general health questionnaire threshold score of five, patients were divided into high scorers and low scorers. The assessments were then compared to produce estimates of each trainee's identification index.[2] The three trainees with the lowest identification index and the three with the highest identification index were selected for further study. Videotapes of a random selection of five high scorers and five low scorers on the general health questionnaire were chosen for each doctor.

Measures

Ratings were made using a rating scale designed to measure the content and extent of the information and advice offered and various stylistic aspects of the trainees' behaviour. Each item on the scale was rated once for each interview. Each interview was viewed once from start to finish and then sections were reviewed as required by the rater (T M) to make the ratings. The

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ratings were operationally defined and were rated as absent (0) or present (1).

The rater was looking for presence of the following behaviours:

- giving psychosocial information
- giving psychosocial advice
- prescribing a psychotropic drug
- explaining the link between symptoms and diagnosis
- giving information clearly
- giving information in a negotiatory style
- checking that information has been understood
- giving specific advice about the patient's main concerns
- giving advice and treatment clearly
- giving advice in a negotiatory (rather than a didactic) style
- checking that advice and treatment have been understood
- telling the patient what has been prescribed
- explaining the correct dosage
- explaining the duration of treatment
- explaining the main effects of medication
- explaining the side effects of medication

For example, a doctor who said 'These may make your mouth feel a little dry for a couple of weeks' when handing the patient a prescription would be rated as having explained side effects of medication.

Data analysis

For each rating, the data were initially analysed in 2 × 4 frequency tables using the chi square test of association, since this test may be applied to 2 × C tables where all expected frequencies are greater than one.[13] When the initial analysis indicated a significant association, the 2 × 4 table was collapsed into a 2 × 2 table by combining the general health questionnaire categories so that doctors with a high and low identification index could be compared using a significance level of $P<0.05$. For two items, 'Does the trainee give psychosocial information?' and 'Does the trainee give psychosocial advice?', the 2 × 4 table was partitioned using the process described by Brunden[14] and tested against a more stringent significance level of $P=0.008$ to allow the comparison of the behaviour of the two groups of general practitioners in interviews with high scoring patients; and of the behaviour of the able interviewers in their interviews with high versus low scoring patients.

Results

Table 1 shows the results of the ratings. Only 'explain the correct dosage' and 'explain the main effects' failed to reach significance with the initial chi square test. The significance levels shown are for the collapsed 2 × 2 tables in which low identification index doctors are compared with high identification index doctors.

As might be expected, the significant differences for the three ratings dealing with psychosocial aspects of care were mainly confined to those patients with high general health questionnaire scores. However, of the remaining ratings nine reached significance when the columns were collapsed to examine the effects of identification index, the only exceptions being 'give specific advice', and 'explain duration of the treatment'. For four ratings — 'give information clearly', 'check that information is understood', 'check that advice and treatment are understood' and 'tell the patient what is being prescribed' — the effects are as striking among patients with low general health questionnaire scores as they are among those with high scores.

Table 1. Results of the ratings and significance levels for high and low identification index (II) doctors using collapsed 2 × 2 tables.

Does trainee ...?		Number of patients: Low GHQ score, Low II doctors	Low GHQ score, High II doctors	High GHQ score, Low II doctors	High GHQ score, High II doctors	Significance level
Psychosocial aspects						
Give psychosocial information	Yes	0	0	0	10	$P<0.05$[a]
	No	15	15	15	5	
Give psychosocial advice	Yes	0	0	0	10	$P<0.05$[a]
	No	15	15	15	5	
Prescribe psychotropic medication	Yes	0	1	0	6	$P<0.05$[b]
	No	15	14	15	9	
Information						
Give explanatory information	Yes	1	3	0	6	$P<0.05$
	No	14	12	15	9	
Give information clearly	Yes	4	15	5	14	$P<0.05$
	No	11	0	10	1	
Give information in a negotiatory style	Yes	2	8	1	10	$P<0.05$
	No	13	7	14	5	
Check that information is understood	Yes	2	11	0	8	$P<0.05$
	No	13	4	15	7	
Advice						
Give specific advice	Yes	1	1	4	6	NS[b]
	No	14	14	11	9	
Give advice and treatment clearly	Yes	10	15	11	14	$P<0.05$
	No	5	0	4	1	
Give advice and treatment in a negotiatory style	Yes	2	7	3	9	$P<0.05$
	No	13	8	12	6	
Check that advice and treatment are understood	Yes	1	14	1	11	$P<0.05$
	No	14	1	14	4	
Prescribing drugs						
Tell the patient what is being prescribed	Yes	7	13	6	10	$P<0.05$
	No	6	1	9	3	
Explain the correct dosage	Yes	11	14	10	12	NS[c]
	No	2	0	5	1	
Explain the duration of treatment	Yes	6	14	6	4	NS
	No	7	0	9	9	
Explain the main effects	Yes	7	10	9	7	NS[c]
	No	6	4	6	6	
Explain the side effects	Yes	1	3	1	6	$P<0.05$
	No	12	11	14	7	

NS = not significant. [a]Test with high general health questionnaire (GHQ) scorers only. [b]Fisher's exact test. [c]Significance at initial chi square test.

Discussion

The results indicate that those who are better able to detect emotional disorder are also very much better at giving patients information and advice about their treatment. Doctors who are confident about managing disorders are also prepared to detect them, while those who are less confident may have a blind spot about detecting them. An example from a research video shows this: an elderly woman with multiple somatic symptoms burst into tears during her physical examination and told her doctor that her husband was prone to fits of temper during which he threw things at her, and that this was frightening her. The doctor

responded to this by providing her with a tissue, but continued his physical examination and made no comment to her about what he had heard. Her distress was not explored, so that any emotional disorder would have been missed.

The willingness to explain and negotiate and to mention the possible drawbacks of treatment in terms of side effects of medication are perhaps a reflection of a more patient-centred style, which may actually contribute to a greater capacity to detect psychiatric morbidity. By demonstrating such behaviours it is to be hoped that these doctors will increase the patient's understanding of his or her illness. Their tendency to explain clearly, to give specific advice and to check the patient's understanding is likely to contribute to this process.

However, the results are not confined to interviews with patients with high general health questionnaire scores. Doctors with high identification indices are more likely to display desirable behaviours with non-distressed patients, and this result fits with our more recent studies of 'detection' behaviours (Goldberg D P, *et al*, unpublished results).[6] It is therefore possible that both the ability to detect emotional disorder and the ability to give information and advice are each reflecting a common variable, the possession of good communication skills. Our results underline the importance of providing training in communication skills for doctors working in general medical settings, and reinforces the efforts of those who are providing training courses in these skills.[11,15,16]

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