Unrecognized psychiatric illness in general practice

THE care of people with mental health problems has long been an important component of the daily work of the general practitioner (GP). The clinical content of this work was well described by Watts & Watts[1] as early as 1952. From three surveys, each of 1000 consecutive cases seen in routine work, they estimated the proportion of psychiatric to other forms of illness to be approximately 13%. The size of this workload carried by GPs was not generally recognized till many years later on the publication, in 1966, of the research by Michael Shepherd and his colleagues at the General Practice Research Unit of the Institute of Psychiatry.[2] Study of a much larger population from London general practices showed that, in any one year, 14% of patients consulted at least once for an illness judged to be largely or entirely psychiatric in nature. Recent diagnosis rates[3] are strikingly similar to this early work.

However, general practice diagnosis rates do not match the much higher estimates of illness from community surveys. Even though many emotionally ill people do not choose to consult a doctor, the consistent shortfall can be explained only by a substantial minority of ill patients being unrecognized by doctors. Comparing GPs' diagnosis and awareness with psychiatric interviews before and after consultation, Freeling *et al*[4] confirmed this underdiagnosis in relation to depression, the commonest serious mental illness seen by GPs. In these London practices, GPs missed about half of all the patients with depression, particularly those with significant chronic physical disease.

Independent assessments made by research psychiatrists provide valuable information, but both their general approach to classification and the circumstances of the interview differ greatly from the working environment of general practice. General practitioners are the diagnosticians of the front line of the health service. They are often faced with several presenting problems and must decide quickly among a wide range of possibilities including potentially life-threatening diseases.

Short consultation times in general practice make classical mental state examination impracticable: the usual clinical approach has to be problem solving rather than formal analysis. General practice does have some advantages in the recognition and management of psychological problems. Except in the inner cities, most GPs live in the same community as their patients, knowing first hand about local issues affecting patients and often caring for families over three generations.[5] Ritchie has shown that as many as 42% of patients are continuously registered with their GPs for over 20 years or since birth.[6] About 10% of all contacts with practices take place at home. Patients over the age of 75 years, an at-risk group for psychiatric illness, have seven contacts per year on average with half taking place in the home.[7] Thus, the GP can have the longitudinal perspective possible for specialists only after a long period of observation. As family doctor, the GP can know the background against which the patient lives, and often knows patients before they are ill, so that unspoken and subtle change in patient attitude, motivation and outlook can be sensed by the alert doctor.

Of course, doctors vary in their ability to recognize mental illness and patients vary in the ways they present their symptoms. Doctor factors in recognition include their previous training in consultation skills,[8] their behaviour during consultations,[9] their accuracy as clinicians and their personal attitude to patients with psychological complaints.[10] Not all of those found to be psychiatric case in research surveys may want their GP to regard them as mentally ill. Even when it is offered, some patients will not wish to have treatment for symptoms such as anxiety or panic attacks which they may rightly regard as related to transient environmental factors. Others many wish the doctor simply to exclude serious physical causes for the physical symptoms which they present.

Observing consultations in general practice by patients with new illnesses, Bridges & Goldberg[11] estimated that almost one-third had a mental disorder. It has been pointed out,[12] that patients with diagnosable psychiatric disorders most commonly consult general practitioners for physical symptoms. Bridges & Goldberg[11] have produced and operational definition of illnesses in which there is a psychiatric disorder present, but the patient is seeking help for somatic symptoms ('somatization'). Somatization is common[13] and may explain much of the underdiagnosis of psychiatric disorder. This is especially so for patients who also have significant chronic physical illness.[14] General practitioners have to be sensitive to both the physical and emotional problems presented by their patients

In addition to a painful shortage of time, GPs have thus to face the tendency of many patients to present the physical rather than the emotional symptoms of their psychological distress. For example, common somatic symptoms reported by depressed patients are headache, backache, persistent tiredness, sweating, palpitations, nausea and generalized body aches. Most of the 'hidden psychiatric disorders' (those that are present but are undetected by the doctor) are either instances of somatization or are illnesses that are in fact unrelated to the disorder for which help is being sought.[12]

Though the issue is more complex than 'missing' illness diagnosable by a research psychiatrist, there is clearly a real problem of non-recognition which will deprive some patients of the help they need. Gask and colleagues[15] have shown that interviewing skills can be improved using video techniques and that these skills can be maintained over time. While such interventions are effective, the need for highly skilled psychiatric input limits general applicability.

Various educational packages for the detection and management of depression have been developed in relation to the *Defeat Depression* campaign.[16] It is important to know whether such packages are really effective in achieving their aim. In this issue of the *Journal,* Hannaford and colleagues[17] report their evaluation of a commercially sponsored educational package for the detection and management of depression by all members of the primary health care team. General practitioners working in 13 practices in North West England or Trent Regional Health Authorities took part. When all practices were considered together, the GPs missed a depressive illness in 24.1% of patients before the Take Care intervention, and 17.1% afterwards, a useful decrease of 7%.

What can GPs do themselves to improve their skills? We will publish a controlled trial in the next issue[18] which shows that GPs can improve their own ability to detect psychological distress in their patients utilizing a self-directed educational approach. This package was designed to be used by individual GPs without outside support, and is based on principles of reflection on GP

performance and consultation skill work. The trial GPs improved their detection rate significantly, both compared to their performance at baseline and compared to the control group.

Everyday consulting requires GPs to switch their attention quickly from perhaps an elderly arthritic patient, a patient with diabetes, a feverish child, and someone with headache, backache or persistent tiredness which may be caused by physical disease or be a sign of underlying psychological distress. Longer consultations would help, but it is probably just as important to make the best use of the time that is available and to organize the practice so that there is continuity of contact between the patient and a specific GP. It has been shown that the presence of a personal list system in practices is associated with increased patient satisfaction with accessibility, availability, continuity of care and medical care.[19] Strategies are available to improve the ability of GPs to detect mental health problems and these can be supplemented by the judicious use of patient-completed questionnaires. Several different workers[20-22] have shown that detected disorders have a better outlook than those that remain undetected so helping GPs sharpen their recognition or management skills will directly benefit patient care.

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Vocational training: The end or the beginning?

VOCATIONAL training has had a good innings. It was seen as one of the success stories of the 1970s and 1980s.[1] How things have changed! Recruitment is at an all-time low and it is fashionable to blame this on the health care reforms. While the latter have been a contributory factor, there are opportunities to try and think ahead to the type of service which will exist in the next decade and beyond. If the late 1960s and early 1970s were the so-called 'golden era' for creative developments in postgraduate education, we are now in a period when the original structures of vocational training need radical review.

The 'corridor talk' that I overhear includes comments such as: 'Young doctors don't want to work hard'; 'There isn't the commitment there used to be'; and 'Dedication doesn't exist anymore'. Is this a form of transference of inner beliefs related to low morale rather than a true reflection of what keen young doctors are really like? We have to be honest enough to find out if there is a widening gulf between the values and attitudes of established practitioners and those in training. Registrars are also less willing to accept paternalism, voicing concerns about rigid training schemes, the perceived tyranny of assessment and inflexible partnership arrangements.

The differential between the salary of a registrar and an equivalent training post in hospital can present dilemmas for those contemplating how best to proceed in their careers. After vocational training, when faced with the prospect of entering full-time practice, many young doctors are reluctant to 'sign up' for a long-term commitment offering little room for manoeuvre later in life. Current working patterns and financial disincentives will have to be overcome if general practice is to become an attractive option once again.

If we are to heed the evidence of Allen's studies of *Doctors and their Careers,*[2] then there are major implications for policy makers and those in leadership positions in education establishments. From Allen's rigorous scrutiny of young doctors' needs, some key issues emerged: