

our is of any benefit to the patients. It is widely acknowledged that up to half of all cases of depression are not diagnosed in primary care, but depression in primary care is known in general to be mild¹ and, as a result, the significance of undiagnosed depression as a public health problem has been questioned by Coyne.² He contends that most cases of missed depression in primary care are so mild that they result in little disturbance of social functioning, and can be categorized with those types of depression that have not been demonstrated to respond to treatment. Moreover, he suggests that these cases would no longer qualify as major depression under the DSM IV criteria, which incorporate impairment criteria into the diagnosis. The use of the Hospital Anxiety and Depression (HAD) threshold score of eight, while having satisfactory sensitivity, is regarded by the originators as a borderline score and is bound to capture patients with the mildest degrees of depression.

While there is some evidence that improving detection rates among general practitioners has a beneficial effect on outcome of depression, other studies have failed to replicate this. In his study, Dowrick suggested that one of the explanations for the negative outcome was a failure to initiate adequate treatment despite a knowledge of recommended dosage schedules.³ Donoghue reports that up to 88% of depressed patients treated in primary care with tricyclic antidepressants may be underdosed.⁴ Patients who are readily recognized by GPs as suffering from depression are likely to have a greater severity of illness, and are therefore more likely to benefit from appropriate treatment. It is probably more important to direct educational campaigns to ensure confident diagnosis of moderate to severe depression and to improve effective dose and duration of treatment.

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Continuing medical education (CME) in mental illness: a paradox for GPs

Sir,

From the perspective of a CME tutor and GP academic, Singleton's and Tylee's revealing article (June *Journal*) was both thought-provoking and disturbing. I would support their conclusion that encouraging learner-centred education in primary care presented various paradoxes: central to this debate is the truism that encouraging learners to define their own learning needs means that they will *only* take up a planned educational package if it is perceived as meeting their requirements. This is a potential source of frustration to those who may feel they have an important message to deliver, be they local cardiologists, AIDs awareness facilitators, or Health Commission managers.

The issue of 'access' in the data given does not address the position of CME tutors who themselves are committed to an andragogic approach, but it may be for this reason that providers of education (in this case, the RCGP Mental Health Fellows) cannot expect CME tutors to be able to guarantee delivery of any programme to their autonomous peers. In addition, I perceive the following factors to be relevant:

- Apparent 'non-cooperation' by CME tutors may have been a consequence of the barriers to implementing innovative educational programmes at a local level: the authors do not present data on this
- There is as yet no coherent approach to CME on a national basis, and CME tutors may vary in their preference for pedagogic or andragogic approaches
- Creating a new network with a declared educational brief, such as the Regional Fellows, is inevitably going to be seen as 'outside' the CME tutor system
- The market research among CME tutors prior to setting up this initiative, which might have allowed more ownership and less 'resistance', seems to have been lacking
- CME tutors may form judgements about educational initiatives based more on origin than content
- Some difficulty may have arisen from local 'competent and enthusiastic teachers' feeling excluded from the Mental Health initiative because their experi-

ence was not drawn on or recognized in providing for the programme

- Barriers to taking responsibility for one's own learning go very deep, and personal facilitation may need to precede the uptake of educational packages which require a GP to engage at a self-critical and active level.

It may be that resourcing generic programmes of educational facilitation which are truly learner-centred (portfolio learning, team-based multidisciplinary education) would prove more fruitful than content-oriented campaigns (pedagogy masquerading as andragogy?), and working through local providers and educators may prove a key factor in the success of future educational initiatives.

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Improving the detection of mental illness in general practice

Sir,

Alastair Wright (June *Journal*) summarizes the substantial problem of unrecognized mental illness in general practice and makes a number of suggestions for improving detection rates.¹ One strategy which he does not consider, however, is a greater involvement of other primary care staff. In the district of Epsom an education package designed to improve mental illness detection rates has been provided to both general practitioners and other primary care staff involved in the care of patients. Prior to the introduction of the package we carried out a survey to compare the detection rates of anxiety and depression by general practitioners with those of other primary care staff. More than 2500 patients from 10 practices took part. Each participant was required to rate the patient on a scale of 1-3, with 1 representing no anxiety/depression, 2, mild to moderate anxiety/depression, and 3, severe anxiety/depression requiring treatment. This was compared with the score from a patient self-administered Hospital Anxiety and Depression (HAD) questionnaire.

General practitioners were slightly more likely to make a correct diagnosis of severe anxiety and severe depression, but at the expense of diagnosing anxiety and depression where there was none accord-

ing to the HAD questionnaire. Primary care staff were more likely to make a correct diagnosis of mild to moderate anxiety. This is perhaps not surprising given the greater time available to other members of the primary care team to explore health problems with patients. Preliminary results, however, suggest that overall there were no significant differences in the total detection rates of anxiety and depression between general practitioners and other primary care staff.

These results highlight the potential role for other members of the primary care team in the diagnosis and treatment of mental illness and the importance of directing efforts to improve the detection of mental illness in primary care, not just at general practitioners, but at the whole primary care team.

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Avoiding infection after splenectomy

Sir,

The risk of serious infection following splenectomy has received increasing attention.¹ Nationally based guidelines recently published highlight the importance of preventive measures after surgery.² An active management programme for asplenic individuals within our district led to high immunization uptake, but general practitioner (GP) uncertainty over antibiotic prophylaxis remained.³

Because potentially life-threatening sepsis occurs suddenly, prior appropriate education of both patients and medical staff is essential. To assess patients' knowledge of their condition, a questionnaire was sent to 245 asplenic individuals on our district register; 222 replies were received. Only 11% were unaware of their increased sepsis risk. Patients had discovered the increased risk from various sources, with GPs responsible in 46% and hospital doctors in 35% of cases. Almost 20% had obtained information from the media. In

response to who should counsel patients, 49% nominated their GP, 27% the hospital doctor, and 24% a combination of both. Only 38% considered their current knowledge of asplenia satisfactory. The importance of immunizations was recognized by 90%, but the role of prophylactic antibiotics had been discussed with only 27% of patients. In those holding antibiotic courses at home, only 50% had an arrangement to renew an expired prescription.

When asked for further comments, nearly 50% of positive replies suggested information leaflets and a national body to be available for advice. Controversy over the role of antibiotics and how to recognize potentially serious infections was also emphasized. Over 15% specifically questioned whether an unnecessary medical fuss was being made over the issue.

A survey from the USA revealed that only 16% of asplenic were aware of potential health problems.⁴ Although it was gratifying to find 89% of our group aware of sepsis risks, 62% still considered their overall knowledge of asplenia poor. This may reflect the time of splenectomy, as 60% had undergone surgery at least 10 years ago when routine counselling was less likely.

Most patients believed their GP should be the primary source of information. However, GPs themselves need improved guidance, as illustrated by comments on the controversial role of chemoprophylaxis. The finding that 20% had relied on the media for education reflects the current inadequacies of medical counselling and emphasizes the need for multisource but consistent information. Comments questioning the necessity for an active immunization/antibiotic/education programme highlight the difficulty in raising patients' awareness without causing undue anxiety.

An information leaflet was produced from this district survey, and distributed to both patients and GPs. We support recommendations that written and verbal information regarding potential health problems should be given to all asplenic individuals,⁵ with GPs actively involved.

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Why are even fewer people dying at home in Belfast?

Sir,

We report a decrease in the number of deaths occurring at home over a 15-year period, with an apparent shift from home to nursing home or other residential accommodation for the final period of care. Hospital deaths have fallen slightly over the same period.

In 1981, Reilly¹ reported on the place of death for people dying within Greater Belfast over a 16-week period (September to December 1979). He found that 56% of people died in hospital with 36% dying at home. The intervening years have seen many changes in the delivery of health care both locally and nationally, with an emerging emphasis on community care and a primary care-led *Health and Personal Social Services*. Fifteen years later, in 1994, we replicated Reilly's work by undertaking a manual search of registered death certificates over the same 16-week period (September to December).

During the 16-week period there were 1064 deaths in a population of 279 237. Of these, 828 deaths (78%) were registered by death certificate and 236 (22%) were recorded by the coroner. To enable comparisons with Reilly's data of 1979, only

Table 1. Place of death in Greater Belfast area by location in 1979 and 1994 for deaths recorded by death certificate.

Place of death	1979 (%)	1994 (%)
Hospital	56	51
Home	36	24
Various institutions	8	25