

# Can GPs audit their ability to detect psychological distress? One approach and some unresolved issues

AMANDA HOWE

## SUMMARY

**Background.** General practitioners (GPs) should be able to detect psychological distress in their patients. However, there is much evidence of underperformance in this area. The principle of clinical audit is the identification of underperformance and amelioration of its causes, but there appear to be few evaluated models of audit in this area of clinical practice.

**Aim.** To evaluate the feasibility of auditing GPs' performance as detectors of psychological distress. Specific objectives were to test a model of the audit cycle in the detection of psychological distress by GPs; to research GP perceptions of prior audit activity in this area and the validity of the instruments used to measure GP performance; and to research GP perceptions of the value of this specific approach to the audit of their performance and the particular value of different aspects of the model in terms of its impact on clinician behaviour.

**Method.** Prospective controlled study of an audit cycle of GP detection of psychological distress. Nineteen GP principals used a self-directed educational intervention involving measurement of their performance, followed by data feedback and review of selected videotaped consultations. Qualitative data on GP views of audit in this area of clinical activity were collected before and after the quantitative data collection.

**Results.** The study shows that the GP cohort had not previously considered auditing their performance as detectors of psychological distress. They found the instruments of measurement and the model of audit acceptable. However, they also suggested modifications that might be educationally more effective and make the audit more practical. These included smaller patient numbers and more peer contact. The implications of the study for a definitive model of audit in this area are discussed.

**Conclusion.** Effective audit of GP performance in detection of psychological distress is possible using validated instruments, and GP performance can be improved by educational intervention. GPs in this study appear more motivated by individual case studies and reflection through video analysis on undiagnosed patients than by quantitative data feedback on their performance. This study therefore supports other evidence that clinical audit has most impact when quantitative data is coupled with clinical examples derived from patient review.

**Keywords:** audit, psychological morbidity; general practitioners.

A Howe, MBBS, MD, FRCGP, senior lecturer, general practice CME tutor, Department of General Practice, Community Sciences Centre, Northern General Hospital, Sheffield.  
Submitted: 8 October 1996; accepted: 11 July 1997.

© British Journal of General Practice, 1998, 48, 899-902.

## Introduction

The accepted criteria for a successful audit<sup>1</sup> are that:

- the subject should be common and important clinically,
- an improved performance should be of clear benefit clinically,
- the standards to be achieved should be clear, realistic, and acceptable,
- change in performance should be possible,
- the actual performance of the practitioner should be measured with simple reliable instruments, and
- these measures should be repeated after changes have been implemented to demonstrate an improved performance.

Looking at the detection of psychological distress, the literature suggests that the following criteria apply:

1. General practitioners (GPs) fail to recognize a considerable proportion of patients who are significantly distressed when they consult.<sup>2-4</sup>
2. The likelihood that undetected distress may lead to recurrent consultations,<sup>5</sup> chronicity and suffering,<sup>6</sup> and inappropriate management or referral<sup>7</sup> makes this a problem of considerable concern.
3. Change in clinician behaviour in this field has been shown to be possible, mainly through training packages focusing on consultation skills, which have been proven to improve GP performance related to the accurate detection and management of psychological distress.<sup>8-11</sup> There is some evidence that making doctors aware that a patient is unexpectedly psychologically distressed may alter their care<sup>6</sup> and also improve patient satisfaction.<sup>12</sup>
4. Questionnaires have been developed and extensively validated for measuring the psychological state of the patient at consultation.<sup>13,14</sup> Comparison between these measures and GP opinion gives a measure of the degree of agreement between the two.

These findings suggest that GPs could attempt to measure and improve their performance in this field, thus making it appropriate to consider the feasibility of an audit of GP performance in the detection of psychological distress. Studies of clinician attitudes to audit have shown support for the educational value and impact of monitoring one's own performance,<sup>15</sup> although ambivalence may remain where the purpose of the data-gathering exercise is unclear or the motivation for audit is suspect.<sup>16</sup> Audit is now a routine requirement for GPs,<sup>17</sup> and its role in quality assurance<sup>18</sup> and continuing medical education<sup>19</sup> is frequently cited.

What problems may exist with an audit of this subject? The literature suggests that:

- neither clinician opinion nor questionnaire score can be seen as a 'gold standard', as both are capable of false positives and negatives, and questionnaires have recognized limitations in terms of their reliability,<sup>13</sup>
- the clinical importance of intermediate questionnaire scores for significant consequences has been disputed,<sup>20,21</sup>
- studies in which patient questionnaire score has been fed back to the doctor have shown a contradictory impact on

- clinician behaviour as a result,<sup>22-25</sup>
- there are contradictory opinions on the benefits to patients of improved detection, particularly if management remains unaltered,<sup>26,27</sup> and
- standards of performance have been little discussed, although ranges of performance from previous studies offer some information on the range in this field.<sup>3</sup>

To illustrate some of the rationale behind considering an audit for this clinical area, Table 1 compares a hypothetical audit of GP detection of psychological distress with one of diabetes care. As can be seen, there are extensive areas of similarity (particularly in influencing long-term outcomes), but standard setting is more established in diabetic care.

In the light of these issues, this study took a cohort of GPs through a model of an audit cycle of GP detection of psychological distress, and collected qualitative and quantitative data on the impact of the study. Since the nature of the topic was one that could not be derived from routine data, it was necessarily a prospective exercise.<sup>28</sup> The views of the GPs on the effectiveness and feasibility of this model are presented, modifications suggested, and outstanding issues clarified.

## Method

Nineteen GPs were recruited from a random written approach to one in two list principals in Sheffield in late 1992.<sup>11</sup> The audit cycle comprised:

- Measurement of performance by comparing the opinion of the GP with the patient's General Health Questionnaire (GHQ) score. The GP completed an assessment form, which, like the GHQ, has been used in other studies<sup>29</sup> (Figure 1), for 150 consecutive adult patients immediately after each consultation.
- Undertaking an educational intervention, which comprised quantitative feedback on performance compared with peers, written material and video analysis of consultations showing both detected and undetected patients — all elements likely to be of educational value.
- Repeating the data collection to show whether the intervention had led to improved GP performance in the trial group. The control cohort was allowed to undertake the educational intervention after the second data collection, so the whole GP cohort was able to provide feedback on all aspects of the study.

At the start and end of the study, all GPs were interviewed by the researcher using a semi-structured schedule.<sup>30</sup> The cues pertinent to the issues of audit in the first interview were:

'Have you ever thought of trying to examine this aspect of your work before?'

'If you set a standard for your own performance that you hoped to achieve, about what would that be...?'

In the final interview, the questions were:

'Have you any comments on this study as a way of auditing your performance in this area?'

'Can you suggest any improvements?'

The interviews were audiotaped and transcribed by the researcher. Data were analysed by direct comparison of the transcripts,<sup>31</sup> using a grounded theory approach when more complex themes emerged.<sup>32</sup>

## Results

The quantitative data showed that the detection of psychological distress improved significantly in the trial cohort, and the details of this are written up elsewhere.<sup>11</sup> The qualitative data pertinent to the audit model are summarized below and in Table 2.

**Table 2.** GP views on the audit model for GP detection of psychological distress.

Criterion	GP views
Prior audit activity	None of the GPs had a model for audit of their performance in the detection of psychological distress
Standards	GPs are unfamiliar with likely standards of performance and see any improvement as positive
Instruments	GPs insufficiently familiar with such questionnaires, but find them acceptable in practice
Method of audit	Questionnaires found to be useful for identifying patients in whom GP may not detect psychological distress
Data collection	Statistical validity less important than case identification
Improving performance	GPs feel improved performance depends on the analysis of consultation behaviours rather than on data feedback or written material
Setting	GPs feel peer group work would increase their learning from this audit

**Table 1.** Comparison of audit criteria for diabetes and detection of psychological distress.

Criterion	Diabetes	Psychological distress
Subject common/important	Yes (2-3% population)	Yes ( 30% + attenders )
Objective measures of problem exist	Yes (e.g. glycosylated Hb)	Yes (questionnaire score)
Improved care by doctor results in improved outcome	Possibly — doctor may do right things but many factors influence outcome	Possibly — doctor may do right things but many factors influence outcome
Improved performance is possible	Yes — e.g. by more active monitoring	Yes — by greater awareness and different consulting style
Standards clear, realistic, and acceptable	Known range to aim at	No established standards — wide range of GP performance

Please indicate the degree of psychological disturbance present in your patient today by **circling one** appropriate number

Normal/stable person with or without physical illness	1
Person with subclinical emotional disturbance	2
Person with mild psychological disturbance	3
Person with moderate psychological disturbance	4
Person with severe psychological disturbance	5
Psychological disturbance warrants admission	6

**Box 1.** GP six-point rating scale of psychological distress.

### *Prior audit activity in this area*

None of the 19 GPs had ever thought of auditing this aspect of their work before. One typical comment was: 'Since I don't know who I'm missing, I don't see how I can measure how good I am (at detecting)'. Nevertheless, 12 GPs (12/19) made specific comments about their motivation for participation being related to gaining a measure of their performance. When asked for their ideas on how this might be done, only three suggestions were made: 'following up people you think might be distressed', 'retrospective notes analysis' and 'asking the patients'.

### *Standard setting*

Only 12 out of the 19 GPs were prepared to set standards for the proportion of distressed patients accurately detected: the range was from 50% (three GPs) via 70–80% (seven GPs) to 100% (two GPs). Few were familiar with the literature on the topic, and one comment by a GP declining to set standards was that 'I would want to know how other people do first'.

### *Views on the instruments used to measure performance*

Only one GP in the cohort had previously used the GHQ, and only two others used any mental health measure in their current practice. In the predata collection interviews, only these three GPs made positive comments about such measures, while 16 comments were made expressing concerns such as 'they are too inflexible' or 'are they acceptable to patients?' However, after both data collections were completed, all the GPs perceived the measures as acceptable, putting more emphasis on their own shortcomings (although none of the cohort stated an intent to use the GHQ in routine clinical practice).

### *The value of this specific approach to audit of their performance*

At the final interview, although many GPs were impressed with the educational exercise (13/19 'very positive') and interested in their performance data (13/19 'very interested'), the cohort were almost unanimous in saying that the data collections had 'been too demanding of (our) time'. The workload of collecting data on 150 patients was perceived as outweighing the benefit gained from the data. The overall feeling was that they would willingly sacrifice statistical accuracy for a lower workload, and that smaller patient numbers would have given a sufficient impression of their capabilities for them to see their shortcomings and be motivated to improve — a typical comment being 'I think I'd got the point after fifty!' Some GPs expressed a desire to know the patient questionnaire scores post-consultation and to review those patients about whom GP opinion and GHQ score appeared to conflict ('I would have liked to follow up the ones I missed'). Others wanted to look at management issues in addition to simple detection, and some models for assessing quality of care that have appeared elsewhere may be relevant here.<sup>29</sup>

*The particular value of different aspects of the model in*

### *terms of impact on clinician behaviour*

All aspects of the intervention (written material, data feedback, and video review) were positively evaluated, but the weighting was towards the video work, with only five GPs making spontaneous comment that the data feedback was important: 'I valued having some figures to compare myself with'. In feedback, GPs perceived the video work as contributing more to subsequent behavioural change than the data comparison.

### *Suggestions for modification of the model*

Apart from reducing the size of the data collection, the other major modification that GPs proposed for the whole cycle was increased peer contact (13 comments), which has been found to be an effective source of learning in other settings.<sup>33</sup> They wanted to discuss their data and findings on their own performance with their peers; seeing their data compared on paper with that of others was not felt to be adequate.

### **Discussion**

While the GPs in this cohort appeared willing to accept the model of audit provided (data feedback with an educational intervention), they were clearly most motivated by examining the possible elements in their own behaviour or the patient's, which had led to non-detection of psychological distress. This finding supports evidence from other studies, which shows that change in clinician behaviour is most likely when individual departures from ideal clinical care can be demonstrated.<sup>16</sup> The GPs were not comfortable with standard setting, perhaps because of the novelty of the idea and their unfamiliarity with the literature.

The widespread acceptance of the questionnaire was interesting and lends support to its well-established track record in primary care settings, although its incorporation into routine clinical practice still appears unlikely.<sup>34</sup> GPs would need guidance in the use and scoring of such a questionnaire before they would use it in either an audit or a diagnostic setting. Smaller patient numbers would be adequate for case identification, although risking a misleading picture of overall performance.

There was enthusiasm for the intervention, which proved to be effective in improving GP performance. However, this does not imply that all GPs would be willing to participate in the kind of educational approach that can improve their performance; unlike simply applying a clinical protocol more closely, learning how to improve consultation skills can be costly in time and energy,<sup>8</sup> and improved performance may be undermined by other factors.<sup>35</sup>

### **Implications**

The importance of the clinical issue of accurate detection of psychological distress makes it a potentially worthwhile subject for audit. The instruments exist to measure GP performance in this area, and they are acceptable to GPs, although not often used in practice. Change in GP performance using tested interventions (including that used in this study) is certainly possible, although the benefits of accurate detection of psychological distress remain to be clarified. GPs in this cohort appear to be more motivated by individual case studies and reflection through video analysis on undiagnosed patients than by quantitative data feedback on their performance: this approach would also reduce the workload of the audit. Although wishing to minimize time input, they wanted some peer contact during the audit cycle to share their reflections on the topic under study.

It is clear from this study that the audit of psychological problems presents different challenges from that of other illnesses, and this suggests that clinical audit may have most impact when statistical data are coupled with case review. This finding is sup-

ported by a meta-analysis of other educational interventions, which suggests that audit and data feedback alone are less effective in changing physician behaviour than 'multifaceted' interventions, including case analysis.<sup>36</sup> Combining elements of this model with other work<sup>37</sup> may enable GPs to undertake effective audit of their performance as detectors of psychological distress using proven methods in the near future.

## References

- Baker R, Presley P. *The practice audit plan*. London: RCGP Severn Faculty, 1990.
- Goldberg DP, Blackwell B. Psychiatric illness in general practice. *BMJ* 1970; **2**: 439-443.
- Marks JN, Goldberg DP, Hillier VF. Determinants of the ability of general practitioners to detect psychiatric illness. *Psychol Med* 1979; **9**: 337-353.
- Ormel J, Koeter MW, van den Brink W, et al. Recognition, management, and course of anxiety and depression in general practice. *Arch Gen Psychiat* 1991; **48**: 700-706.
- Wright AF. Psychological distress: outcome and consultation rates in one general practice. *J R Coll Gen Pract* 1988; **38**: 542-545.
- Ormel J, van den Brink W, Koeter MW, et al. Recognition, management, and outcome of psychological disorders in primary care: a naturalistic follow-up study. *Psychol Med* 1990; **20**: 909-923.
- Creed F, Gowrisunkur J, Russell E, et al. General practitioner referral rates to district psychiatry and psychology services. *Br J Gen Pract* 1990; **40**: 450-454.
- Gask L, McGrath G, Goldberg D, Millar T. Improving the psychiatric skills of established general practitioners: evaluation of group teaching. *Med Educ* 1987; **21**: 362-368.
- Gask L, Goldberg D, Lesser AL, Millar T. Improving the psychiatric skills of the general practice trainee: evaluation of a group training course. *Med Educ* 1988; **22**: 132-138.
- Whewell PJ, Gore VA, Leach C. Training GPs to improve their recognition of emotional disturbance in the consultation. *J R Coll Gen Pract* 1988; **38**: 259-262.
- Howe A. Detecting psychological distress: can GPs improve their own performance? *Br J Gen Pract* 1996; **46**: 407-410.
- Hopton JL, Howie JG, Porter AM, et al. The need for another look at the patient in general practice satisfaction surveys. *Fam Pract* 1993; **10**: 82-97.
- Goldberg D, Williams P. *A user's guide to the General Health Questionnaire*. Windsor: NFER-Nelson, 1988.
- Zigmond AS, Snaith RP. The Hospital Anxiety Depression Scale. *Acta Psychiatr Scand* 1983; **67**: 361-370.
- Webb SJ, Dowell AC, Heywood P. Survey of GP audit in Leeds. *BMJ* 1991; **302**: 390-392.
- Black N, Thompson E. Obstacles to medical audit: British doctors speak. *Soc Sci Med* 1993; **36**: 849-856.
- Department of Health and the Welsh Office. *General practice in the NHS: a new contract*. London: HMSO, 1989.
- Grol R. Standard setting for quality in care in general practice: GP attitude and response. *Br J Gen Pract* 1990; **40**: 361-365.
- Al-Sheiri A, Stanley I, Thomas P. Continuing education for general practice 2. Systematic learning from experience. *Br J Gen Pract* 1993; **43**: 249-253.
- Dowrick CF. Care or continuum? Analysing general practitioners' ability to detect depression. *Primary Care Psych* 1995; **1**: 255-257.
- Coyne JC, Schwenk TL, Fechner-Bates S. Nondetection of depression by primary care physicians reconsidered. *Gen Hosp Psych* 1995; **17**: 3-12.
- Johnston A, Goldberg D. Psychiatric screening in general practice: a controlled trial. *Lancet* 1976; **1**: 605-608.
- Brody DS, Lerman CE, Wolfson HG, Caputo GC. Improvement in physicians' counselling of patients with mental health problems. *Arch Int Med* 1990; **150**: 993-998.
- Hoepfer EW, Kessler LG, Nycz GR. The usefulness of screening for mental illness. *Lancet* 1984; **1**: 33-35.
- Rand EH, Badger LW, Coggins D. Towards a resolution of contradictions: utility of feedback from the GHQ. *Gen Hosp Psych* 1988; **10**: 189-196.
- Verhaak PFM, Wennink HJ, Tjihuis MAR. The importance of the GHQ in general practice. *Fam Pract* 1990; **7**: 319-324.
- Dowrick CF, Buchan I. Twelve month outcome of depression in general practice: does detection or disclosure make a difference? *BMJ* 1995; **311**: 1274-1276.
- Shaw CD. Criterion based audit. *BMJ* 1990; **300**: 649-651.
- Crossley D, Myers P, Wilkinson G. Assessment of psychological care in general practice. *BMJ* 1992; **305**: 1333-1336.
- Britten N. Qualitative interviews in medical research. In: Mays N, Pope C (eds). *Qualitative research in health care*. London: BMJ Publishing Group, 1996.
- Patton MQ. *How to use qualitative methods in evaluation*. London: Sage Publications, 1987.
- Lincoln YS, Guba EG. *Naturalistic enquiry*. California: Sage Publications, California Publications, 1989.
- Grol R. Quality improvement by peer review in primary care – a practical guide. *Quality Health Care* 1994; **3**: 147-152.
- Howe A. Testing for depression – a response. [letter.] *Br J Gen Pract* 1994; **44**: 378.
- Howe A. "I know what to do but it's not possible to do it" – general practitioners' perceptions of their ability to detect psychological distress. *Fam Pract* 1996; **13**: 127-131.
- Davis DA, Thomson MA, Oxman A, Haynes B. Changing physician performance – a systematic review of the effect of continuing medical education strategies. *JAMA* 1995; **274**: 700-705.
- Singleton AJ, Smith FR. Developing education in primary care psychiatry management through research based audit. *Med Educ* 1997 (in press).

## Address for correspondence

Dr A Howe, Department of General Practice, Community Sciences Centre, Northern General Hospital, Sheffield S5 7AU.

Early Abortion is a simple medical procedure and we aim to make it as woman-friendly as possible.

# DAYCARE EARLY ABORTION SERVICE

new

Fast appointments, one hour stay  
in a relaxed environment

Contact Julie Douglas **0171 574 7355**

Also Vasectomy and Female Sterilisation

## MARIE STOPES



• CARING CLINICS SINCE 1921 •  
A REG. CHARITY PROVIDING REPRODUCTIVE HEALTH-  
CARE WORLDWIDE

Reg No.  
FS 32585