

Letters

The *BJGP* welcomes letters of no more than 400 words, particularly when responding to material we have published. Send them via email to jhowlett@rcgp.org.uk, and include your postal address and job title, or if that's impossible, by post. We cannot publish all the letters we receive, and long ones are likely to be cut. Authors should declare competing interests.

Ever been HAD?

Dougal Jeffries suggests that the inclusion in the QOF of payments for using the Hospital Anxiety and Depression Scale (HAD), or other measures of severity, will encourage antidepressant prescribing,¹ but I think he's wrong.

I can give Dougal evidence that the introduction of these measures is likely to help to rationalise antidepressant prescribing. Anticipating their introduction by 6 months, Southampton City Primary Care Trust agreed to reward practices for measuring the severity of depression, through the Trust's prescribing audit incentive scheme. Participating practices used the HADS depression sub-scale (HAD-D), with all patients they were considering for possible treatment for depression, between December 2005 and April 2006.

The GPs were advised that active intervention should not usually be offered to patients scoring less than 8 out of 21 on the HAD-D (indicating major depressive disorder is unlikely), while patients scoring 8 to 10 out of 21 (indicating possible major depressive disorder) should be followed up, to see if their depression worsened. They were

further advised that patients scoring 11 or more (indicating probable major depressive disorder) would be likely to benefit from antidepressants, or referral for counselling or psychological treatment, if this was preferred by doctor or patient. Anonymous data on the number of patients assessed using the HAD-D and the subsequent care provided by participating practitioners were collected from the practices' computer records systems at the end of the 5-month study period by the Trust's pharmaceutical advisors.

Table 1 shows that the likelihood of being prescribed an antidepressant increased significantly with severity on the HAD-D ($\chi^2 = 17.3$, degrees of freedom [df] = 2, $P < 0.0001$). A sizeable minority of patients were referred for psychological treatments in each severity category, with no significant differences between categories ($\chi^2 = 3.73$, df = 2, $P = 0.155$). Note that around 20% of those with probable major depressive disorder were not prescribed antidepressants, while more than 40% of those scoring below the threshold for possible major depressive disorder were treated. Therefore the practitioners did not always follow published guidance, which is not to offer treatment to patients with mild depression.

However, this may have been for a number of reasons. Only the depression sub-scale of the HADS was used in the study, so there was no measure of anxiety symptoms. It is possible that those with lower scores on the HAD-D were prescribed antidepressants for anxiety symptoms, for which they are also licensed. It is also possible that patients with a past history of more severe depression were offered active treatment to prevent recurrence in spite of a currently low severity score. It is also highly likely, given the high level of intervention overall among these patients, that the GPs only measured severity in those patients for whom they were already actively considering treatment, and not for most of those they perceived to be mild cases.

Overall, of 134 new courses of antidepressants recorded in this study, only 18 (13.4%) were for patients with scores below the threshold for possible major depressive disorder, indicating good targeting of antidepressant treatment within this group, in line with guidelines. This may be compared with a previous observational study of practitioner treatment of depression in Southampton, which showed that antidepressants were poorly targeted to

Table 1. Differences between the care of men and women.

Severity of depression on HAD-D questionnaire	Antidepressant prescribed		Referred for psychological or psychiatric treatment		Any active intervention with antidepressants or referral, or both		Total <i>n</i>
	No <i>n</i> (%)	Yes <i>n</i> (%)	No <i>n</i> (%)	Yes <i>n</i> (%)	No <i>n</i> (%)	Yes <i>n</i> (%)	
HAD-D 7 or less (major depression unlikely)	23 (56.1)	18 (43.9) ^a	27 (65.9)	14 (34.1)	18 (43.9)	23 (56.1) ^b	41
HAD-D 8-10 (possible major depression)	24 (39.3)	37 (60.7) ^a	31 (50.8)	30 (49.2)	12 (19.7)	49 (80.3) ^b	61
HAD-D 11 or greater (probable major depression)	21 (21.0)	79 (79.0) ^a	65 (65.0)	35 (35.0)	16 (16.0)	84 (84.0) ^b	100
Total	68 (33.7)	134 (66.3)	123 (60.9)	79 (39.1)	46 (22.8)	146 (77.2)	202

HAD-D = depression sub-scale of the Hospital Anxiety and Depression Scale. ^aStatistically significant differences between severity levels ($P < 0.0001$).

^bStatistically significant differences between severity levels ($P = 0.001$).

those with more severe depression, due to the inaccuracy of practitioner clinical assessment of severity when compared to the HAD-D.² In the previous study more than 40% of antidepressants were offered to patients with sub-threshold scores compared to around 13% in this study. Measuring severity therefore does seem to improve the targeting of GP antidepressant treatment, which is the aim of the quality indicator.

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2. Kendrick T, King F, Albertella L, Smith P. GP treatment decisions for patients with depression: an observational study. *Br J Gen Pract* 2005; **55**: 280–286.

Competing interests

TK has received fees for speaking at educational events from Pfizer, Lilly, Wyeth and Lundbeck pharmaceuticals. He was a member of the expert advisory group on the mental health indicators for the 2005 Quality and Outcome Framework. He is Chief Investigator on a successful application for pharmaceutical company funding for a larger study of changes in the treatment of depression following the introduction of the severity indicators.

Privatising primary care

At last an article¹ in the *BJGP* reflecting the concerns of a large number of GPs. How can we stop the current politics? How can we move away from the needs for points towards the needs of patients? How can we spend more time in patient care and less in practice-based commissioning? Thanks again for publishing this leading article. Lets hope it is read by PCT chiefs, politicians and a pang of conscience is raised in the pro-marketeters.

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Should I go or should I stay?

Having been an NHS GP for 16 years, nowadays two things go through my mind every day I am in my practice:

- How to take the line of least resistance to get to the end of the day;
- How do I continue to engineer my career to reduce my frontline GP work (having already succeeded in reducing it to half time over the last few years, while being able to pay the mortgage).

It has been said that GPs become GPs rather than specialists because of their independence of spirit. This tendency has become an increasing problem as we move further and further towards being micromanaged to the point of absurdity. The control freakery, lurking in the background for some years, has reached new heights with the new contract.

The tipping point for me has been intrusive interference in that central facet of general practice, which is the consultation. This is largely due to the QOF requirements. Still, the pragmatic GP tries to make it work, trusting the no doubt wholly admirable intentions of those who come up with the formulae for 'good practise'. But making it work is often in the form of a 'work around' a system that is too complex and intrusive. Hands up those who have entered a systolic measured at 152 as 148 in the patient record, and then entered the code for the absurd 'Mental Health Review' while they are at it (it is unlikely anyone will actually check, isn't it?). Most of us just get on with it, because it pays the mortgage and we want to have a life rather than spend our lives at focus group meetings or conferences, or giving constant feedback to anybody who demands it.

Surely the time has come for us, the 'ordinary GPs' to demand a re-evaluation of the principles underlying the QOF, unless of course all the potential non-compliant doctors have already left the NHS? Is QOF likely to actually improve the quality of overall holistic care of patients, or just the quality of electronic coding to further its abilities as a

management control tool, with annual incremental tightening of the screws?

Like most things in general practice one needs to try and get a feel for the potential benefits versus harms of the new contract. I don't see how the quality of the consultation is not being harmed by the present set up, but this is a lot more difficult to measure than checking for the right codes. In my view we need to find a way of trusting GPs with the freedom to do their job without constant interference, particularly if a robust system for individual revalidation is introduced. I won't mind if some computer nerd taps into my system as often as he wants and does all the interrogation he needs to do in order to test out the quality credentials of my work. Let these people do what they have to do, but please stop interfering with the area of my expertise.

I still have one foot in general practice, I am not sure that it will still be there in 10 years time. All I can say for now is thank goodness for the patients, and the observations and vitality of medical students and registrars who still have some room to think, and can see that there are always novel and alternative solutions to any problem. But I feel sorry for young GPs who will have no chance to work in an environment that allows for 'discovery', because everything is prescribed. For my generation of GPs I believe the zenith for general practice was reached when we were able to create novel solutions with fundholding and the out-of-hours revolution. It has now all gone sour.

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Euthanasia abroad

Rhona Knight¹ forms an interesting hypothesis in her letter and I think her opening point answers the question in her final paragraph. I would like to further the perspectives on this debate, the arguments about which do not seem to have progressed for decades. The point being that this country already condones assisted suicide. In that it allows patients