Reasons to be cheerful?
Reflections on GPs’ responses to depression

The papers related to depression in this issue of the Journal offer reasons to be cheerful about GPs’ diagnostic abilities and treatment decisions: but they also generate internal debate, and require further reflection.

The perennial question of whether GPs are competent at diagnosing depression receives an affirmative response from the study in the Grampian region of Scotland undertaken by Cameron et al.

This study confirms previous research from Hampshire and elsewhere that GPs are more likely to make a diagnosis of depression as symptom severity increases. The assessment of depression in primary care is increasingly supported by the use of patient self-completion severity rating instruments, but care is needed in how to interpret them. The Swedish study by Hansson et al. corroborates earlier analyses identifying diagnostic discrepancies between the Hospital Anxiety and Depression Scale and the Patient Health Questionnaire (PHQ-9), and shows that the currently recommended threshold score of 10 on the latter is more likely to lead clinicians to diagnose major depression. They support recent research in England, which calls for an increase in PHQ-9 threshold score from 10 to 12 for major depression in order to reduce the risk of over-diagnosis.

We may therefore assume from these studies that GPs’ diagnostic abilities are already in reasonable shape, and could be improved by judicious use of severity rating instruments. However there are important caveats to such an assumption. A focus on symptom counts, which has been encouraged in the UK by the introduction of performance targets for GPs linked to the measurement of depression severity at initiation of treatment, may well be necessary: but it is far from sufficient. As with other conditions where diagnosis is made on the basis of inevitably arbitrary cut-off points on scoring systems (such as anaemia, asthma, and diabetes), we also need to consider the context of symptoms, and understand the complexity of the relationship between psychological, physical, and social problems and their temporal variations.

The updated NICE guidelines on depression note that identification of major depression should be based not only on its severity but also on persistence, the presence of other symptoms, and the degree of functional and social impairment.

Many people with sub-threshold disorders in current classification systems experience significant degrees of disability, while people with severe depressive symptoms may be able to function with a remarkable degree of normality. A tailored assessment of disability, such as the Social Functioning Questionnaire could usefully be linked with routine diagnostic systems within primary care.

To address the gaps in our social and cultural understanding of patients’ problems, we can turn to the International Classification of Primary Care, which provides useful methods for recording details of social context, or to the Cultural Awareness Tool, developed for GPs in Australia. Our awareness of patients’ values may be enhanced, for example, by the seven-item spiritual symptom scale in the awkwardly-named but potentially useful Biopsychosocialspiritual Inventory. Such instruments are likely to be of use to researchers in this field, encouraging us to think more widely about the problems being presented. They may sometimes help the busy clinician, as long as their deployment does not interrupt the flow of the consultation. In any event, we should pay careful attention to our patients’ perspectives on what may be causing their problems, not least because these may be radically different from our own.

Although patients may sometimes have clear and consistent explanatory models, they are more likely — particularly when seeking help for the first time — to hold beliefs about the cause of their mental health problems which are tentative and fluid, sometimes internally contradictory, and characterised by uncertainty. As Williams and Healy put it, they may be working from an exploratory ‘map of possibilities, which provides a framework for the ongoing process of making sense and seeking meaning’.

The mainstays of GPs’ management of depression are prescription of antidepressant medication and referral for psychological therapy. Two papers in this issue indicate that GPs are performing these tasks reasonably well. Cameron et al conclude that GPs in Scotland make circumspect and conservative prescribing decisions, with a tendency to under-use rather than over-prescribe antidepressant medication. In the qualitative enquiry by Stavrou et al, GPs from London gave accounts of their rational decision making about referral for psychological therapy, exercising their ability to take into account patient expectations of and capacity for therapy, and the extent and limitations of their own capacity to help.

Cameron et al’s comments about the under-use of antidepressant medication are part of an ongoing debate within Scotland in response to central guidance that rates of antidepressant prescribing should be reduced. They should be viewed with caution, in the light of mounting evidence of the substantial and increasing placebo effects of antidepressant medication, except perhaps at the very severe end of the symptom spectrum. They also run counter to the views of the Scottish GPs interviewed by Macdonald et al, who raise substantive concerns about the appropriateness of current levels of prescribing, and are troubled by their involvement in the medicalisation of unhappiness, and their pharmacological responses to problems generated by social deprivation and the breakdown of traditional social and family structures. These doctors also disagree with Stavrou et al’s conclusions about rational decision making, seeing themselves as responders to rather than facilitators of change. It is not only GPs who are concerned about their limited and potentially damaging responses to suffering
and distress; patients are also aware of the moral dilemmas created by accepting a diagnosis of depression and a prescription for antidepressant medication, especially the effects on the sense of self as an autonomous agent.19

We need to expand our repertoire of responses. Collaborative models of care, in which practice is restructured to provide adequate follow-up, access to evidence-based expert systems, and strong support for patient self-management have been demonstrably successful in improving patient outcomes.20 This may be because they bring with them a sense of security and purpose, often conspicuously lacking in patients who feel low in mood, hopeless and without motivation, and whose poor self-esteem may lead them to worry about bothering the doctor with their concerns.21

However, there is severe inequity of access to high-quality mental health services that do exist within primary care. Many people with high levels of mental distress are disadvantaged, either because they are unable to access care (for example, people from black and minority ethnic communities), or because the care they receive does not address their needs (for example, many older people, or those with medically unexplained symptoms). It is not clear whether the new cadres of mental health workers entering primary care will help to resolve this problem, or by swapping psychology for pharmacology we will merely serve to entrench prevailing views of depression as a disease which can only be cured with professional intervention. The AMP research group (Improving Access to Mental Health in Primary Care) is testing a new multifaceted model of care designed to improve access, based on three interlinked components: community engagement, primary care development, and sensitised psychosocial interventions.22

In many of the presentations currently labelled as depression, there is sufficient uncertainty about diagnosis and management to allow alternative approaches to be considered. My preference is to move away from the concept of depression as a disease, and to focus instead on the alleviation of suffering23 that is experienced and understood by the patient. I consider that this necessitates a re-vision of patients, not as passive victims of disease or circumstance but as active agents, experts in leading their lives, who occasionally need help, new ways of looking at old ideas, and the encouragement of hope.24 These perspectives derive ultimately from the wisdom traditions,25,26 and are closely related to the emerging constructs of interpretative medicine, which propose that professional knowledge be used ‘to support the creative capacity of individuals in maintaining their daily lives’.27 They invite us to venture from the shelter of diagnoses and interventions of uncertain benefit, and expose ourselves to the raw experience of human suffering, while retaining our belief in patients as persons capable of fulfilling lives.

Christopher Dowrick
Professor of Primary Medical Care, University of Liverpool, School of Community and Behavioural Sciences, Liverpool.

Provenance: Commissioned; peer reviewed.

REFERENCES