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The acid test is whether clinicians are so impressed by these findings that they are not prepared to deliver radical therapies without access to magnetic resonance imaging. To truly show an improvement in wellbeing, such therapies require access to magnetic resonance imaging. Herein lies the problem for evidence based diagnostic radiology. Such trials rarely occur early in the evaluation process of an imaging technique.

Radiologists will have gone through a learning phase in evaluating its diagnostic performance; clinicians will have had a chance to refine their case selection. Even when ethics committees are convinced of the justification for such research, recruitment and randomisation may be so slow that by the time the trial reports, the imaging test is already considered routine in clinical practice. Furthermore, the pace of technological development in magnetic resonance imaging is such that by the time large randomised studies are completed the technology used may have been superseded.

Perhaps it is asking for too much of an evidence base for pelvic magnetic resonance imaging to expect data from randomised clinical trials to underpin its every application. Business cases for expansion in new imaging technologies have traditionally been more concerned with financial than with diagnostic and clinical impact.

Yet the messages are becoming clear for those formulating guidelines for the use of imaging as well as for purchasers of health care. They argue strongly for integration of magnetic resonance imaging in the pathway of care for several pelvic malignancies and complex benign pelvic conditions. To deny patients access to magnetic resonance imaging is likely to result in suboptimal clinical and cost effectiveness.

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Distinguishing mental illness in primary care
We need to separate proper syndromes from generalised distress

Two studies in the BMJ last year make challenging reading set alongside one another. Kessler et al reported that over half the patients attending general practice surgeries are depressed, and the Norwegian naturalistic treatment study of depression in general practice concluded that the best treatment for depression in primary care is a combination of antidepressant medication and counselling. Read uncritically, these findings imply that half of all general practice patients should be taking antidepressants and undergoing counselling. Clearly few people would agree with this, but the apparent folly does draw attention to a gap in our understanding of mental ill health in primary care. Uncertainties about the best way to provide for such patients, and indeed questions about the propriety of doing so at all in the NHS, have a long history. These uncertainties largely revolve around differences between medical and sociological approaches to psychological distress. The medical approach argues that such distress reflects an underlying illness which merits treatment. The sociological perspective argues that it is the consequence of a failure to respond adaptively to social challenge. The former focuses on diagnosis and the provision of treatment, the latter on understanding and clarifying patients’ dilemmas.

Established psychiatric diagnostic schemes such as the International Classification of Diseases and the...
Diagnostic and Statistical Manual were developed to classify the psychological and behavioural disease found among psychiatric inpatients. Although their scope has broadened with successive revisions, they remain more applicable to the 2% of the population who are seen by psychiatrists than to the much larger proportion who are considered to have mental health problems by their general practitioner. General practitioners have long argued that the process enshrined in psychiatric diagnostic systems helps in managing only a tiny proportion of the psychiatric problems they encounter.

The 1995 Office of Population Censuses and Surveys’ household survey confirmed widespread psychological symptoms in the general population—a prevalence of 23%. This figure is not substantially different from the 26-31.5% of psychiatric “cases” found in the general population using the general health questionnaire or the 50% of those attending general practice. However, a substantial proportion of these people do not necessarily display definitive signs of a formally defined mental illness.

In the household survey nearly a third were described as suffering from mixed anxiety and depressive disorder, a condition defined by the absence of signs and symptoms that might fulfill criteria for either an anxiety disorder or a depressive illness; and a significant minority (nearly 15%) were classified as suffering “subthreshold” mental disorders—conditions that are certain subjective threshold. Signs but simply on the basis of a level of distress above a certain subjective threshold. Twenty nine per cent were suffering from problems with alcohol or drug abuse, conditions specifically proscribed from definitions of illness used by the 1983 Mental Health Act.

Distress is not always due to mental illness

Thus, only about 1 in 4 of those identified by the household survey can be expected to be suffering from a definite psychotic disorder, depressive illness, or anxiety disorder that undeniably falls into conventional conceptions of “illness.” Most of the rest may be distressed and may construe their distress as the result of mental illness, but it is not always accurate and sometimes harmful to assume that this is the case.

This is important because we would gain much from clarifying this area. Patients with ill defined psychiatric problems can have a poor prognosis. The Warwickshire study documented significant long term disability among 100 such patients followed up after 11 years.

It is unclear how representative this cohort was, but there is little other research evidence available. In the case of patients disabled by the psychological consequences of adversity, a relatively brief period of legitimate social space may well facilitate the resolution of problems, which might otherwise have resulted in the breakdown of family or work relationships. This is an important role for the primary care counsellor.

On the other hand, there is increasing evidence that many of the clearly defined neurotic syndromes—panic attacks, social phobia, obsessional compulsive disorder, and agoraphobia—are best construed as discrete disorders and treated accordingly, with appropriate medication or cognitive behavioural psychotherapy. This can happen only if the neurotic syndrome is identified as a primary cause of distress and disability, rather than as a consequence of adversity and personal difficulties. These are patients in whom the trouble taken to identify specific psycho-pathology—panic attacks, avoidance behaviour, obsessional rituals, early morning waking—will be rewarded.

Conversely, people with personal and social difficulties who might benefit from counselling are ill served if they are misunderstood and encouraged to view their difficulties as disease meriting treatment. Ill directed treatment is a potent cause of costly and disabling abnormal illness behaviour and may contribute to long term morbidity.

Medical approaches for specific disorders should be available when most effective

If the many “mentally ill” people in primary care are to be best served, a philosophy that argues that their needs can be adequately met by the non-specific application of antidepressants and counselling has to go. There is a need to consider their problems in greater detail and to identify specific disorders where they exist, and where they do not respect the roles of social, economic, occupational, and physical health problems in determining and shaping psychological disability. Only then can empathy, social support, and understanding be provided when they are appropriate and a more medical approach, whether drug treatment or psychological therapy, be made available where it might be most effective.

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