

# The first consultation with a depressed patient: A qualitative study of GPs' approaches to diagnosis

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## ABSTRACT

**Background:** The first consultation with a depressed patient is important because many patients do not return for subsequent visits. Therefore, the first consultation provides a unique opportunity for diagnosis (if required) and treatment, but there are risks of both under and over-diagnosis. **Aim:** To understand how general practitioners utilize diagnosis when patients present with a new episode of depression. **Method:** We approached a random selection of twenty-one general practitioners (GPs) in Auckland, New Zealand and asked them to participate in a semi-structured telephone interview. The interviews explored "the first consultation for a depressed/distressed patient" were undertaken to theme saturation. Interviews were hand-written and later transcribed. **Results:** We identified three major themes in GPs' approach to diagnosis. The issue of diagnosis was underpinned by a complex understanding of depression and the GP role. GPs did not always make a formal diagnosis, but the experience of a patient's distress/depression was understood by drawing on a range of factors and resources. These included time, screening tools, clinician experience, and patient affect. GPs were careful about how they communicated a diagnosis, both in their documentation and in their conversations with patients. **Conclusion:** At an initial appointment, the distressed/depressed patient can present to their GP with various symptoms and differing degrees of distress. GPs draw upon a variety of skills and resources to negotiate these complexities. The value of a diagnosis was questioned and issues such as impairment may be more useful concepts for GPs. This is the first study to report the findings of the first visit.

**Keywords:** Diagnosis, depression, general practice, mental health, primary care, psychiatry

## Introduction

Depressive symptoms are common in primary care, accounting for many presentations, yet little is known about how general practitioners (GPs) recognize and manage these patients at the first visit. Our view is that the first visit is crucial as it can determine a lot of subsequent activity. Our medical students visiting a wide range of practices report that antidepressants are often given at

the first visit. This has many later ramifications for patients who may not be able to stop them and may suffer occupational stigma when applying for jobs that require health assessments. Evidence from one study suggests that general practitioners recognize the presence of psychological symptoms in 63.7% of patients but make a diagnosis of depression in 33.8% of their patients who have a major depressive disorder.<sup>[1,2]</sup> At the same time, false positives are not uncommon, with some patients being diagnosed with depression while not meeting the diagnostic criteria.<sup>[3]</sup> In this paper, we use the term distress for what the patient presents with and depression as an output of the consultation.

Managing presentations of distress or depression in a primary care setting is not straightforward, even as this is where most

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mental healthcare is provided. Estimates suggest that 11% of depressed patients do not report any psychological symptoms, and 45%–95% describe physical symptoms.<sup>[4]</sup> Depression is a co-morbid condition of disorders but the diagnosis is often missed.<sup>[5]</sup> Navigation of the mind-body interface requires skilful conversations to elucidate symptoms while minimizing stigma and maintaining the doctor-patient relationship, a skill we feel is vital for all primary care clinicians.

There is some debate about the current diagnostic criteria for depression, which complicates this matter further, particularly in primary care. The criteria in the DSM-5 have been criticized for pathologizing the emotional undulations of ordinary life, representing what Frances and Dowrick have termed a “medical intrusion on personal emotions....”<sup>[6]</sup> For GPs, who are likely to see a more diverse and less uniformly unwell population, these issues are more pronounced.<sup>[6]</sup>

There are currently no data on the approaches used by GPs facing the first consultation with a patient presenting with symptoms suggestive of depression. Therefore, we have conducted a qualitative study of practicing GPs in Auckland, New Zealand, to better understand how clinicians recognize, diagnose, and treat depression. Primary health care in New Zealand is funded by two main sources. A capitation payment to the practice is based on socioeconomic status and ethnicity and patient co-payment and funded by the New Zealand government. Mental health consultations may attract extra public funding to clinicians for extra time spent with the patients and this depends on the geographical locality. The secondary health care system is fully funded by the government and there is a small private secondary health care system that does mainly elective surgery and elective investigations. The majority of medicines are subsidized and patients pay a co-payment of about US\$3 per item for the first 20 items and nothing after that. A diagnosis is not required for any condition and not specifically for mental health consultations. This paper describes the themes relating to the diagnosis of depression in primary care. It sets out the three major themes we identified after analyzing semi-structured interviews with 21 GPs about how they approached the first consultation with a depressed patient. Findings related to treatment are described in a companion paper.

## Method

### Sampling

We randomly sampled 45 GPs in Auckland from a full directory of general practices in the region, publicly available through the Healthpoint website (healthpoint.co.nz). We chose a random sample as our sampling frame to ensure we got a wide range of viewpoints. An initial email was followed by a phone call from the primary investigator (BA) to invite GPs to participate. The sample was confined to the Auckland region to limit study costs; regional telephone calls did not incur an additional charge.

### Data collection methods

Semi-structured telephone interviews were undertaken by an independent interviewer (LB) using question prompts [see Appendix 1]. Two practicing GPs (BA and VM) drafted the questions to resolve questions in earlier research.<sup>[7]</sup> A mix of closed and open-ended questions was used, with participants able to elaborate on key points at the interviewer's discretion. The questioning continued to theme saturation. Interviews were transcribed by hand contemporaneously and later typed out. The responses were generally short and could be captured manually thereby saving us time and cost with transcribing. Respondents were given ≤UK\$35 as thanks for their participation.

### Recruitment

Twenty-one GPs agreed to participate in our study. Participants were eligible if they were currently practicing GPs in the Auckland region. We obtained a random sample of 45 GPs to approximate the spectrum of GPs in practice in Auckland. Recruiting continued until saturation of data.

### Data analysis

We used the general inductive approach for analysis of the questionnaire response transcripts.<sup>[8]</sup> The transcripts were repeatedly read until researchers gained familiarity with their content. We used NVivo 12, a software that facilitates qualitative data analysis, to code the transcripts. Transcript segments that conveyed similar ideas were grouped into emerging codes, and then related codes grouped into categories by researchers (EW, DL, BA). DL used NVivo to do the analysis and this was compared with manual analysis by EW and BA. The final coding was agreed upon after discussion. Overlapping and redundant categories were identified and merged or removed, then the remaining categories were grouped into themes. Collaborators agreed on the final themes and subthemes.

## Results

A random sample of forty-five GPs was obtained, and 21 agreed to be part of the study. Eighteen GPs either declined or did not return calls. Six others were either retired or not doing regular general practice or had moved. This was a 54% (21/39) response rate. The proportion of those who were eligible but declined or said no who were female was 66% (12/18) versus 43% of those who agreed; were graduates of New Zealand Medical School was 56% (10/18) versus 52% (11/21). The average number of years since graduation was 25 years for the declines and 26.7 for those who agreed. The range for number of years since graduation was 5 to 47 years.

We identified three main categories with subcategories as shown in [Table 1]. Quotes from participants are included regarding their duration of GP practice and location of medical training. Location of medical training was included in case that was associated with particular approaches. For example, (female, 13 years, overseas) describes a female GP with 13 years clinical experience since graduation who studied for their first medical

**Table 1: Major themes and subthemes we identified during our analysis**

	Major themes	Subthemes
Understanding depression	Conceptualizing depression The broad range of patient presentations	How respondents tended to think about depression Patients present with a wide array of symptoms
Diagnosing depression	The value of diagnosis Time as a diagnostic tool Severity Screening tools	GPs' perceptions of the importance (or not) of diagnosis How time can aid or thwart the diagnostic process The role of particular symptoms in hastening a diagnosis GPs' views on the utility of screening tools
Communicating the diagnosis	Discussing a diagnosis with the patient Documenting the diagnosis in the clinical record	The language GPs adopt in the consultation with the patient How GPs report they record and/or code their clinical findings and diagnoses

qualification abroad. For graduates of New Zealand medical schools, the abbreviation NZ was used.

## Understanding depression

### Conceptualizing depression

Most respondents seemed to distinguish between different subtypes of depression. GPs described acute stress responses, reactive depression, chronic depression, ongoing depression, and endogenous depression during interviews. Distinctions were most frequently made between reactive and endogenous depression and mild, moderate, and severe depression. There was also some discussion about the difficulty of distinguishing between depression and subclinical stress and sadness:

*“Sadly, I think we have pathologized sadness into depression and there is a very gray zone between the two”* (male, 47 years, NZ).

*“Stress is part of the continuum and a milder form of depression and anxiety is a more severe form of stress”* (male, 13 years, NZ).

### The spectrum of patient presentation

GPs recognized that patients' depressive symptoms could be quite variable. GPs appeared to feel most confident in responding to patients who described themselves as being depressed or anxious. One GP noted, *“If someone says they are depressed, that self-assessment is going to be right”* (female, 35 years, overseas). Nevertheless, some GPs still felt it was essential to clarify what patients meant by these terms because *“... everyone uses the same terms, but they mean different things to different people”* (male, 13 years, NZ).

There was an acknowledgement that depression often had a physical element. Recognizing this presentation was more difficult at the first appointment, even as some GPs seemed to think it was the most common presentation. As one respondent noted:

*“We often see people present with physical symptoms without apparent cause, and it's not always immediately evident. A classic example is fatigue but no diagnosable physical cause, sleep disturbance. It is not always apparent the first time, but often, if these things are persistent, or if there is some other reason to be concerned about their mood, we will think to ask and explore mood more thoroughly”* (male, 31 years, NZ).

Physical symptoms that made GPs more likely to make enquiries about mood included difficulty sleeping, fatigue, lack

of concentration, headaches, and gastrointestinal problems. When patients presented with physical symptoms, there was a tendency to exclude “biological” causes, like thyroid dysfunction, to strengthen a differential diagnosis of depression. For some, this appeared to be a risk-management strategy:

*We need to do due diligence as we don't want to prescribe an SSRI and, in 6 months, find out it was due to a thyroid issue we haven't been treating...* (female, 35 years, overseas)

There was recognition by some GPs that depression might present differently among different ages and ethnicities. There was, however, little consensus about whether Māori patients presented differently to non-Māori patients when this question was posed to respondents. A number of GPs felt unable to comment on this question because they saw few Māori patients. Those who felt that Māori patients did present differently tended to think they presented later, with more severe depression.

### Making a depression diagnosis

Making a formal diagnosis did not appear to be a priority at the first appointment. When GPs were asked if they would make a diagnosis of major depressive disorder at the first appointment, the majority indicated that they would not, or would only do so “incredibly rarely” (male, 47 years) if the patient was acutely unwell. At least one GP was reluctant to make a formal diagnosis altogether, noting that:

*... I would say that, at best, we make a preliminary diagnosis. If someone goes to see a psychologist or psychiatrist, they have a 50-minute appointment one-on-one and they want to see the client the following week to see how they are doing...* (female, 35 years, overseas).

Nevertheless, GPs used some common strategies when consulting with a distressed patient and identifying depression: time, severity, and screening tools, which were frequently invoked by the GPs we interviewed.

### Time as a diagnostic tool

Time was a complicated issue for many respondents. There was an acknowledgement that it was an important diagnostic tool, used both retrospectively and prospectively. Concerns about a lack of time in the GP consult also underscored its clarifying role.

For many, the patient history was central to the diagnosis of depression. As one GP described, *“my experience is that people have usually thought about it for a while before they come to see the GP. If you give them space, then usually they can give you a good background history...”* (male, 13 years, New Zealand). Most of the GPs made enquiries about how long symptoms had persisted over time. In this vein, many GPs felt that offering a diagnosis was more straightforward in cases of depression recurrence: *“I wouldn’t make a diagnosis on a first visit unless there was a past history or very prolonged symptoms”* (female, 13 years, overseas).

Time was also used prospectively as a diagnostic tool to confirm a differential diagnosis of depression. However, it was interesting that GPs drew different inferences from changes in patient demeanor at the second appointment. Some seemed to perceive improvement at the second appointment as confirmation of their initial diagnostic inclinations. In contrast, a few GPs seemed to recognize that improvement might be a quality of the distress itself. As one noted:

*“The first one or two visits, I want to see what is really happening. I would wait to see what happens over time because sometimes you get to the second visit and... you haven’t really done anything, and things are better...”* (male, 16 years, NZ).

Time also emerged as a theme in clinical experience, which was perceived as a diagnostic aid. This sometimes related to the experience of the clinician: *“I have been doing this 40 plus years, so I intuitively work my way through it...”* (male, 47 years, NZ). Or more specifically, the experience of the clinician with the individual patient:

*“A benefit of working in general practice is the relationship you have with patients. Most of them I have known for some twenty years, and the relationships are meaningful, powerful, and helpful...”* (female, 11, overseas).

Finally, the importance of time as a diagnostic tool was also underscored by GPs’ disquiet about their relatively brief consultation times. Some respondents stated that they would try to have a longer consultation with a distressed patient. Others felt that they could not make a diagnosis given their 15-minute consultation windows.

### Severity

Severity was invoked by some GPs on the rare occasions they made a diagnosis of depression at an initial appointment. Several GPs were aware of patient safety, particularly regarding self-harm and suicidality at an initial appointment. With very severe presentations, GPs tended to seek urgent help from psychiatrists and the crisis team. Severity was assessed by examining a variety of factors, including history, but GPs also seemed to be tuned to patient affect, loss of function, and their level of social engagement:

*“I also look at how the patient presents as they don’t tell you truly how they feel, but you can guess by how they look”* (male, 8 years, NZ).

### Screening tools

Nineteen of the twenty-one respondents reported using screening tools like Patient Health questionnaire 9 question for mood (PHQ-9), Kessler, general anxiety disorder questionnaire for anxiety (GAD-7), and Edinburgh Post Natal depression score (EPNDS) [Table 2] at the initial consultation for a distressed patient. In contrast, fewer respondents availed themselves of the DSM criteria for depressive disorders, with only eight respondents indicating they had access to it. One practitioner noted that *“in terms of managing at a GP level, it isn’t particularly helpful to us”* recalling that, with the DSM III criteria, *“basically everyone would have a disorder”* (female, 35 years, overseas).

Practitioners used screening tools for various reasons, including as a diagnostic aid, and as a means to access additional services. Particular screening tools were often selected because of their role as a gate-keeper to funded counselling services:

*“Historically we have needed a certain threshold to reach any funding for ongoing psychology input and those kinds of things...”* (female, 13 years, overseas).

In this way, the diagnostic aspects could be secondary to accessing treatment:

*“If we are enrolling someone [in the PHO’s (Primary Health organization) depression program], we make the assumption they are depressed...”* (male, 13 years, NZ).

For most providers, these resources were perceived as a helpful adjunct to gathering a history and assisted the monitoring of depression severity over time:

*“[The Kessler] is a very useful therapeutic tool to get the patient to reflect on what those symptoms are and the scores”* (male, 31 years, NZ).

Some practitioners were, however, critical of the screening tools. They described how they ate into limited consultation time, disrupted the patient narrative, and impaired rapport.

### Communicating the diagnosis

#### Disclosing a depression diagnosis to the patient

There did not appear to be particularly consistent language when GPs discussed a diagnosis of depression with their patients, although some trends were identifiable.

**Table 2: Screening tools for detecting depression reported by study GPs**

Screening tool	Number of respondents
PHQ-9	12
Kessler	9
DSM V	8
HADS	6
Other tool: EPNDS	6
Other tool: PHQ-2	1

The MIDI (major depression inventory) is not used in New Zealand so not included

When asked directly, none of the respondents indicated they would use the clinical term Major Depressive Disorder, with most electing to say “depression,” or “major depression.” Most respondents appeared to be aware of the stigma of diagnosis, softening their language accordingly. Some respondents were explicitly careful about normalizing the diagnosis, using a variety of strategies to do so:

*“It depends on the level of severity. I would probably use low mood or talk about dysthymia and that it’s normal to be a little low at times...”* (female, 30 years, NZ).

*“I talk about selective serotonin deficiency. Better to say this than say there is something wrong with their mind...”* (male, 29 years, overseas).

*“I would never use the word major as I don’t like the connotations that come with [Major Depressive Disorder] and you don’t want to make it seem worse for the patient”* (male, 47 years, NZ).

At the same time, however, there was an emphasis on using language that was frank and understandable:

*“You can say low mood but when we are classing it as a diagnosis, we have to use depression”* (female, 35 years, overseas).

*“I use the word [depression] because that is the word they understand. I say it is just a label and it doesn’t matter if we put this label or not, the most important this is how we are going to deal with it... I suggest they don’t get hung up on the name...”* (male, 13 years, NZ).

In this vein, some respondents emphasized the importance of tailoring any description to the patient, with one noting that the language was contingent on the “flow of the conversation” (male, 49 years, overseas). Another observed:

*“I think you have to be careful with labels, as for some people it may not give enough of an indication as to what is happening for them, and for others it may give too much emphasis...”* (male, 35 years, overseas).

### Diagnosis in the clinical record

There were a variety of views about how to go about documenting a depression diagnosis.

Most practitioners reported waiting before documenting a diagnosis of depression, even when this was suspected. The reasons given for this delay were various:

*“MDD is not something we should take lightly. Before I put this in writing I am always aware of the consequences”* (male, 49 years, overseas).

*“I often struggle to even write down the words ‘anxiety,’ ‘depression’ because the world is not as black and white as any of that”* (male, 47 years, NZ).

When respondents were asked whether they coded a diagnosis for depression at the first appointment, about half of respondents indicated they would not routinely use a READ classification code.

A majority of practitioners were conscious of the implications of documenting a depression for life insurance when asked about this (i.e., increased premiums if a diagnosis of depression is in the clinical notes). Again, there were a variety of views on its significance. Some felt that the patient’s risks, whose premiums might be increased, were something of a deterrent to a formal diagnosis. Others thought such considerations were not relevant to their record-keeping, noting the importance of having a patient record that reflected the consultation itself, and feeling that any prospective insurers would join the dots:

*“... we have to label in spite of anything. Any patient can later go for insurance. When the clinical criteria fit, we have to write the diagnosis in...”* (female, 35 years, Overseas).

## Discussion

### Summary

Most GPs have a nuanced understanding of depression that informs their approach to diagnosis at the first consultation. GPs also seem to be aware of the variety of symptoms associated with distress and depression, some of which can be harder to recognize than others.

Our study suggests that, for most GPs in this study, establishing a formal diagnosis of depression is not the priority at the first appointment. Instead GPs seem to focus on problem-solving for their patients. This is an unsurprising but important finding: GPs are often required to negotiate undifferentiated problems unlike many hospital-based specialists. Managing diagnostic uncertainty is a crucial skill for GPs.

Symptom duration, severity, and screening tools were significant resources used by GPs to elucidate a patient’s distress and, sometimes, make a formal depression diagnosis. Time was a vital clarifier for GPs, but its value was harder to access at an initial 15-minute appointment. The use of screening tools was interesting because they were frequently invoked, not just as a diagnostic aid, but also as the gate-keepers to treatment. Again, this reinforced the power of treatment and resourcing in guiding practice.

The emphasis on problem-solving and symptom management apparent in GPs’ diagnostics was also seen in their approaches to labelling depression in consultations. GPs tended not to label someone as depressed initially, even if they had initiated treatment for mood. GPs descriptions of depression appeared to be reasonably patient-focused, balancing the need to speak plainly to avoid stigmatization. It seemed that GPs took a somewhat individual approach to this, informed by their perceptions of the patient in front of them.

### Strengths and weaknesses

This study is the first to examine real-world clinical practice about recognizing and diagnosing depression in the first

consultation in primary care. It draws on an important insight into the complexity of recognizing depression and the range of diagnosis approaches. The themes identified during our interviews affirm the complexity of consultations about depression in primary care. The findings highlight the significance of GPs for understanding and diagnosing depression and sensitive communication with patients regarding the topic.

Drawing on a modest sample of GPs, this study provides a useful starting point to examine the role of diagnosis in the first consultation with a depressed patient. It is, however, possible that the respondents surveyed are not representative of the broader GP population, given that they are part of an urban cohort, who were willing to participate in the survey. There may also be differences in what GPs report about their management, what happens in practice, and what patients experience. Other studies have identified such differences in the context of GPs accounts of their management and what happens in practice. It would be very interesting to understand the initial consultation from these perspectives and probe any differences.

### Comparison with existing literature

Others have suggested that primary care practitioners might prefer to focus on the impact of patients' symptoms than to use them for diagnostic purposes.<sup>[9-11]</sup> Our study appears to support this assertion, with a central theme being that it seems common to adopt a problem-solving approach or to observe symptoms over a period of time, rather than immediately engaging in diagnosis and formal treatment. One commentator suggests that a diagnosis should be of more benefit than harm to our patients and goes on to suggest that we consider removing some diagnoses from patients records just as we remove medications from patients current supply.<sup>[12]</sup> There is also a move internationally to use less pejorative terms such as "stuck" for common mental disorders such as depression and anxiety although we did not explore that issue in this study.<sup>[13,14]</sup>

Our findings indicated some support in practice for using screening tools to help assess the severity and enable access to additional services. While there are some legitimate criticisms of distress inventories, there is also evidence that they are helpful from the patients' perspective and can be used to build rapport,<sup>[8]</sup> and help doctors assess severity over time. Our study's gate-keeper role also deserves some attention—it seems that access to resources may sharpen clinic decision-making if used judiciously.

Our findings highlighted the variety of ways in which GPs communicated a patient's condition, both to the patient and in the patient record. GPs described waiting to document a diagnosis, which may help to explain the apparent discrepancies between the recognition and documentation of depression noted by other studies.<sup>[2]</sup>

### Implications for clinical practice and research

Distress is a universal experience that may attract a range of labels in clinical practice, including depression. It appears reasonable that primary care doctors are cautious about giving a diagnostic label to patients at the first appointment: they often see patients on the worst day of their lives and negotiate considerable clinical uncertainty.<sup>[4]</sup> Because of this, it may be a clinically sound approach to defer or avoid making a formal diagnosis.

There are dual expectations for doctors to maintain comprehensive clinical records and provide patients with an explanation of their condition in New Zealand, as elsewhere. If there is a significant discrepancy between what is being documented and discussed, it seems unlikely that the balance will have been appropriately struck. The tendency for GPs to soften their language when they have written a diagnosis of depression or major depressive disorder should be scrutinized in view of this: it may be that if a GP is not confident in talking to a patient about a depression diagnosis, it is prudent to document this uncertainty instead.

In some ways, the main goal of the first appointment is to keep the door open for the distressed patient to attend another—this will likely clarify diagnosis and, more importantly, help establish an enduring therapeutic relationship. It is patients who have little recent contact with their GPs who are the most difficult to diagnose with psychological problems,<sup>[1]</sup> while patients who require ongoing mental health support value continuity as part of their long-term management.<sup>[15]</sup>

On a wider plane is the issue of overdiagnosis and overtreatment. Moynihan and colleagues suggest a primary care-led, multidisciplinary, independent people-centered approach to defining disease.<sup>[12]</sup> In terms of mental health, diagnosis has been driven by psychiatrists with their Diagnostic and Statistical Manuals of the American Psychiatric Association. While this may work at the severe end of the spectrum, this is not the case for primary care where mild to moderate depression are most common and many of those with severe "low mood" at the first visit will improve over time. Moynihan *et al* 2019,<sup>[12]</sup> suggest investigating ways to make diagnoses more temporary where appropriate and less fixed in stone. They state that "the aim is to ensure diagnoses are in place only when there is a degree of certainty they will bring more benefit than harm."

The ongoing challenge is to understand how to achieve this best. That requires additional research into how the initial appointment proceeds in practice and what is important from the patient perspective. We suggest that longer interviews with more GPs about the nuances of diagnosis and labelling and how they deal with new patients versus those with recurrences.

### Conclusion

1. This is the first study to ask GPs what they do regarding diagnosis for a first consultation with a patient. Treatment

is possible without a diagnosis.

2. GPs are cautious with diagnostic labels in part due to constrained time and concern about the harms of labelling, e.g., life insurance premiums. They are more interested in patient functioning and problem solving with the patient.
3. GPs use diagnostic questionnaires more for billing purposes and getting access to services than for diagnostic purposes.

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**Ethics approval** was obtained from the University of Auckland Human Participants Ethics committee (UAHPEC) Ref # 021192 10<sup>th</sup> May 2018.

Alex Santos gave advice on how to outline the findings.

## Provenance

The original idea was from Bruce Arroll and the questionnaire was developed with Vicki Mount. The interviews were conducted by Lily Buttrick. The data analysis was done by Nada Khalil, Esther Walsh, Deanna Louis, Bruce Arroll, and Fiona Moir. Christopher Dowrick reviewed the findings and provided advice on the final paper. All authors contributed to the drafts and final draft of the paper.

### *What was known*

The first GP consultation presents a significant opportunity to assist a depressed patient. Reliably diagnosing depression is, however, fraught. In practice, there seem to be many ways of assessing patient distress.

### *What this adds*

GPs do not make use of a diagnostic and statistical manual of mental disorders (DSM) type of diagnoses for depression in contrast to psychiatrists. Indeed,

a formal depression diagnosis does not appear to be a priority for GPs initially, whereas impairment is. Screening/depression questionnaires are used commonly but often to gain access to talking therapies rather than for patient/severity assessment. Communicating a diagnosis to the patient and into the clinical notes was done with great care and caution. The caution was driven by a concern about stigma and the difficulty of making a diagnosis in brief consultation times. The priority seemed to be on starting treatment (not necessarily medication) without a formal diagnosis.

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## Conflicts of interest

There are no conflicts of interest.

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## Appendix 1

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### Appendix 1: Questionnaire

Management at first visit for depression: A survey of General Practitioners

Questionnaire for GPs

Name of GP–date of interview

Name of interviewer

1. How do you make a diagnosis of depression? (*unprompted*)
    - a. If the patient presents with physical symptoms
    - b. If a patient presents saying they are depressed or stressed or anxious, etc.
  2. Do you use any tools to make the diagnosis? (*unprompted*)
    - 2a. Do you use any of the following tools? (*prompted*)
      - PHQ-9
      - Kessler
  
      - DSM V
  
      - HADS
  
      - Any other tools?
    - 2b. Are these for diagnosis purposes alone or for getting resources such as CBT or counselling ?
    - 2c. Do you have access to a copy of the DSM IV or V: book or phone or other?
  3. Would you diagnose Major Depressive Disorder at the first visit?
    - 3a. What label/term do you use for this?Are you cautious about giving a label from the future life insurance point of view?
    - 3c. Do you code it on the computer? READ code (these are codes used in New Zealand for all health care diagnoses). (*either first presentation or recurrence*)
    - 3d. What do you say to the patient? Do you call it a mood disorder, low mood, distress etc.?
  4. Do you ever use time as a diagnostic test?

Dig a bit deeper here? e.g.:

    - If yes, how long would you wait before reviewing the patient?
    - if no, why not?
  - 4a. If it is a recurrence, what do you do in terms of diagnosis?
  - 4b. At the next visit are most patients improved? yes/no
    - If yes, then what do you think has improved things for them?
  - 4c. How do you monitor their progress, e.g., depression inventory or clinical impression or other?
5. What **treatment** would you offer for **Major Depressive Disorder** at the first visit?

(Both guiding people to a diagnosis



*(unprompted)*

Prompted

- 5a. Behavioral activation (get example)
  - 5b. Physical activity
  - 5c. Time off work
  - 5d. Problem solving
  - 5e. Medication
  - 5f. Sleep advice
  - 5g. Pleasurable activities
  - 5h. Other
  - 5i. If the patient is depressed, but you don't think meets the criteria for MDD
- 6a. How confident are you in using talking as a therapy for your patients very, somewhat, not much, not at all?  
-If partially or very confident is there are particular format you follow, e.g., active listening, CBT, ACT problem solving, other or do something eclectic?
- 6b. Do you think most GPs feel confident with doing talking therapy for depressed patients?
- 6c. Would you prescribe an antidepressant at the first visit? (always, most times, 50:50, less than half, rarely)
7. Do any of the following make you more likely to prescribe an antidepressant at the first visit? (*yes/no answers*)
- a) Previous history of depression
  - b) Last therapeutic response to antidepressants
  - c) Severity of symptoms (phrase this as "moderate or severe symptoms" so that we can get a yes/no response?)  
- If yes, what symptoms would these be and how severe and how would you determine those?
  - d) Patient preference or request for antidepressant
  - e) Long duration of lower levels of severity
  - f) Any other aspects
  - g) Ethnicity of the patient - if yes, then elaborate
8. What would you say to a patient presenting for the first time and asking for antidepressant medication in terms of how effective they are:  
Prompt: most people get a benefit, or some people get a benefit?
- a) If they had never used an antidepressant before? (*unprompted*)
  - b) If they had used an antidepressant previously?
9. Do you think GPs, in general, prescribe too quickly for depression from your observation  
If yes, why do you think they do that?
- 9d. If a patient is offered an antidepressant by you and they decline, what do you say to them?
10. Do you think Māori patients present differently with depression than non-Māori?
- 10b. Do you do anything differently with Māori patients, e.g., more/less likely to formally make a diagnosis and more or less likely to give an antidepressant or use talk therapy?