

EDITORIAL

Records of psychiatric morbidity in general practice: the National Morbidity Surveys¹

Traditionally, epidemiologists have been concerned with counting the dead. Now, particularly when they are studying the natural history of psychiatric disorders, epidemiologists are putting more of their time and effort into the estimation of rates of incidence and prevalence of diseases and linking changes in these rates with environmental and genetic influences. What is the best way of obtaining the relevant epidemiological information? The best, but not necessarily the most convenient or cheapest, approach is to undertake a large-scale purpose-built sample survey, using fully trained personnel and adequately validated methods. What are the alternatives? Either one can make use of existing general-purpose surveys, such as the General Household Survey (see, for example, HMSO, 1973), or one can aim to obtain important information from routinely collected medical records. The latter can either be hospital-based or (in the UK, at least) based on the records of general practitioners.

The National Morbidity Surveys arose naturally from the setting-up of the National Health Service. Since then, most of the population of the UK has been registered with a general practitioner (GP), who represents a common channel through which individuals may obtain medical advice and care; his records offer a potentially unique opportunity to assess the rate of incidence and prevalence of psychiatric disorder in the community. This idealistic and optimistic view of the value of a GP's records was clearly expressed by J. A. Charles in the foreword to what was in effect the pilot study for the First National Morbidity Survey (Logan, 1953): 'Avoiding similitudes and comparisons one can say that medical record keeping, scrupulously careful, brief and purposeful, is necessary for the study of the measure and movement of disease, for providing information as to the success or failure of the methods of treatment, and for the acquisition of knowledge as to the broad economics of practice.' Charles also writes of the recording physician (Logan, 1953): 'His work as a recorder requires, within limits, the accuracy of the scientific observer; he relates the sequence of events as does the historian; like the man of affairs he can never escape the need of some form of accountancy'. It is the purpose of this brief review to assess, in the light of what is now known about psychiatric problems in the community, whether such optimism has been justified by the results of the first two National Morbidity Surveys (Logan & Cushion, 1958; Logan, 1960; GRO, 1962; HMSO, 1974, 1979), and to ask whether the data which they have provided have any real value to those wishing to study the epidemiology of psychiatric disorders.

Although she excludes the routine collection of medical records from her definition of 'surveys', and also avoids discussion of psychiatric disorders, Cartwright (1983) has recently provided a valuable critique of the scope and methods of conducting health surveys. In the chapter on general measures of health and sickness she provides a particularly useful assessment of the Survey of Sickness (Logan & Brooke, 1957). This survey was started during the second World War (1943) to assess how the stress caused by wartime conditions affected the health of the people in the UK. Despite a few methodological problems, the study was successful in illustrating how useful epidemiological information could be obtained from the large-scale surveys of this type. Nevertheless, the survey-method was abandoned in favour of using routine medical records as the major source of information on morbidity (Logan, 1953). This appears to have been due to the medical profession's misguided belief that doctors' routinely collected records are a better source of information on sickness than are the results of well-designed sample surveys.

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It has been known for several years that GPs in the UK come into contact with, and are responsible for treating, the majority of patients with psychiatric disorders (Shepherd *et al.* 1966). It is understandable, therefore, that GPs' records of psychiatric disorders should be thought of as a valuable source of information on psychiatric morbidity in the community. But how valuable are they? Should they be regarded as merely a summary of GPs' activities (which may, of course, be extremely valuable to those responsible for the training of GPs or to planners in the National Health Service), or are they indeed a reliable and valid data-base from which to construct measures of the nation's psychiatric morbidity? Clearly, they may be of great value to administrators, planners and teachers, but they have many drawbacks as a source of data for epidemiological studies. Estimates of the incidence and prevalence of psychological problems that are based *solely* on GPs' records can be very misleading, and should be interpreted with extreme caution.

The first major problem in the use of these records to estimate levels of morbidity in the community relates to the levels of case detection by GPs. It has been known for many years that many cases of psychiatric illness either do not come to the attention of GPs, or are missed by them (Logan & Brooke, 1957). GPs' records cannot by their nature be used on their own to provide an unbiased estimate of the prevalence of psychiatric problems in the population. One can train GPs to be better case detectors, or perhaps encourage more people with problems to seek medical help, but a GP's contact with a patient can never give a complete picture of that patient's mental state. When one begins to look at levels of case detection for individual diagnostic categories then the problems multiply. Given that a GP has an adequate and valid scheme for the classification of psychiatric problems and can reliably diagnose psychiatric disorders (see below), it should be clear that case detection rates will differ widely between different types of disorder. Patients suffering from manic depression or schizophrenia, for example, are much more likely to come to the attention of a clinician (whether a GP or a hospital-based psychiatrist) than those suffering from anxiety or tension-headache. Some categories of psychiatric patient are simply much more likely to seek or to need medical aid.

The second source of trouble, strongly related to the first, arises from the way in which GPs diagnose psychiatric disorders. This, too, is a problem that has been acknowledged for several years (see, for example, Watts, 1962). It is clear that GPs miss many cases of depression – the condition regarded by psychiatrists as being the most common disorder in general practice (Mayer-Gross, 1954; Clare, 1982) – and, instead, appear to give far too many people a diagnosis of anxiety (Watts, 1962; Clare, 1982). Rather surprisingly, the planners of the First National Morbidity Survey do not appear to have been unduly worried by the difficulties of validating a GPs' patterns of diagnosis (Logan & Cushion, 1958): 'Diagnosis is the identification of disease by means of the patient's symptoms and by clinical signs. A completely accurate identification is sometimes both unnecessary and unwise; unnecessary because the form of the treatment does not depend on it, and unwise because to establish an accurate diagnosis often means extensive examination and investigation'. Logan & Cushion go on to state that 'To lay down standard diagnostic criteria is impossible and, in any event, the improvement in the records would probably be slight, particularly in large-scale enquiries, such as the present Survey, where differences will tend to cancel each other out'. Is there any evidence that this statement is true? Unfortunately, those involved with the planning of the Second National Morbidity Survey appear to have ignored these problems, and to have concentrated more on the reliability of the records, rather than on their validity (HMSO, 1974, 1979).

According to the Birmingham Research Unit of the Royal College of General Practitioners, the National Morbidity Surveys serve 'as the essential baseline for epidemiological research and teaching in general practice' (RCGP, 1980). This may be true of many physical problems, but is hard to take seriously when considering psychiatric disorders. If, by 'essential baseline', they mean a valid measure of morbidity for each of the psychiatric disorders, then this baseline cannot be provided by records from general practice (at least when considered without information from other sources). To see why this is so, all one needs to do is to compare the First and Second National Morbidity Surveys. Consider, for example, the prevalence of 'depression'. Here there has been a dramatic increase in the reported prevalence of problems, but is this increase real? It is far more likely to be a change in the way in which GPs are 'detecting' depression. However, this cannot be

determined in the absence of any attempt in either of the surveys to validate GPs' methods of classification. If classifications are changing, what possible value can the results of the First National Morbidity Survey have for epidemiologists working in 1984? Very little. And in ten years' time the same conclusion will apply to the Second and Third National Morbidity Surveys.

If, however, the phrase 'essential baseline' implies a sensible estimate of a GP's workload, then the GPs' records are, of course, useful for teaching in general practice. A large-scale national survey, however, appears to be a rather costly way of obtaining these data. Practice Activity Analysis (RCGP, 1980) is a much more obvious route to this type of information. As the background information for special epidemiological studies (HMSO, 1979), in which the records are linked to retrospectively gathered information, the National Surveys are clearly of great value; but, again, in the absence of validation of the diagnostic criteria, it is difficult to see of what value they might be in, for example, the study of depression. Even though relatively complex statistical analyses yield interesting information on psychiatric disorders as seen by a GP (Dunn, 1983; Dunn & Skuse, 1981), it is still difficult to avoid coming to the conclusion that the psychiatric records are telling one more about the GPs than the patients themselves. Given that this is the case, it might be much more sensible to invest in custom-built surveys comparable with those of Shepherd *et al.* (1966) or of Goldberg and his colleagues (Marks *et al.* 1979; Goldberg & Huxley, 1980).

Whether or not the National Morbidity Surveys are to continue in their present form, much more serious work needs to be done on the apparent variation in morbidity between practices. My own contribution has highlighted some of the problems (Dunn, 1983). Data from the longitudinal file of the Second National Morbidity Survey, for example, indicate that there are huge differences in the rates of diagnosis of disorders such as affective psychosis. In one practice almost 10% of the registered patients were diagnosed as suffering from affective psychosis at least once during the six years of the survey, whereas in most practices there are no records of this diagnostic category. If these alarming differences in levels of insanity really exist, why is nothing apparently being done about them? Perhaps it is because everyone involved accepts that the data on this disorder are practically worthless. Yet these are still published in tables of official statistics as reliable and valid indicators of national levels of morbidity.

At present, the only national sample survey that provides information on health and sickness is the General Household Survey (see, for example, HMSO, 1973). As a general-purpose survey it is difficult to see how it could provide the detailed information required by psychiatric epidemiologists. A custom-built psychiatric survey would clearly be preferable. However, given certain improvements, the General Household Survey might be a more useful tool than the National Morbidity Surveys. The General Household Survey and the National Morbidity Surveys share many problems. Both, for example, suffer from the lack of time and funds for adequate analyses of the data once they have been collected. 'As it stands the balance seems quite ludicrous – so much time and money is spent on collection of data, so little time and thought on their analysis' (Cartwright, 1983). Like the National Morbidity Surveys, the General Household Survey suffers from the lack of validation. However, if more effort was spent on validating the responses to the questions in the General Household Survey, or, indeed, to those contained within a purpose-built health survey, they would have much greater potential as sources of 'true morbidity data' than routinely collected GPs' records.

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