

Primary Care Physicians' Attitude and Practice in Managing Geriatric Depression

Fatima Habib, MD, ABFM, MSc*

Objective: To evaluate the diagnosis and management of depression among elderly in primary care.

Setting: All the local health centers in Bahrain were included for the assessment of the physicians' practice.

Design: A cross-sectional study.

Method: A self-administered questionnaire was distributed to physicians in all health centers. It examined the current practice of physicians in detecting and managing elderly depression and the most important obstacles facing them. It also explored the needs for physicians to have training and clinical guidelines to manage elderly depression.

Result: This study included 132 physicians. Hundred and four (79%) physicians did not receive any formal training or course in geriatric psychiatry. Fourteen (10.6%) physicians were routinely screening patients for depression; hundred and one physicians (76.5%) were screening on occasional basis and 13 (9.8%) never had screened for depression. Thirty-nine (29.5%) physicians referred the cases immediately once they were identified. Ninety-six physicians (72.7%) felt competent but seventy-three physicians (55.3%) did not feel confident in treating late life depression. Seventy-six physicians (57.6%) had no time to discuss any psychological issues with the elderly. Hundred and fourteen physicians (86.4%) wished to have a specific guideline for the management of elderly depression and hundred and twelve (85%) felt the need to adopt a specific scale to screen for depression in primary care settings. Hundred and nine physicians (82.6%) thought that they need more training on the identification and management of old age depression.

Conclusion: Screening for depression among elderly patients in primary care is not sufficient leading to low detection rate of cases. Lack of training in geriatric psychiatry, short consultation time, and the absence of clear guideline were identified in this study as barriers to proper diagnosis.

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Projection of causes of global mortality and disease from 2002 to 2030 is showing that HIV/AIDS, unipolar depressive disorders, and ischemic heart disease will be the leading causes of disease in 2030^{1,2,3}.

*Consultant Family Physician
Ministry of Health
Kingdom of Bahrain
Email: zanrh64@yahoo.com

Depression among elderly people has usually profound effects; its prevalence is increasing and consequently its morbidity and mortality^{4,7}.

Depressed elderly usually have higher health care costs and this was shown to be true even after adjustment for chronic medical illness⁸. Depression was shown to be associated with decreased functional status and poor quality of life⁹⁻¹². Depression was also shown to be associated with hypertension and to be an independent risk factor for coronary heart disease^{13,14}.

A meta-analysis of community-based study reported the average prevalence to be 13.5%¹⁵. Other reported the prevalence of depression among elderly people to vary with the setting in which the prevalence was measured: from 15% in the general population, 25% in the primary care setting, to more than 30% in those elderly in residential homes¹⁶.

A study performed in Bahrain in one health center in 1996, showed that the prevalence of depression was 23.1%¹⁷.

Despite the high prevalence of this condition, many studies had shown that the detection rate among primary care patients is low and the case management is suboptimal^{18,19}.

Researchers found that in many countries almost 50% of depression cases are missed in the primary care settings²⁰. A study had pointed out that family physicians detected only 34.9% of severe depression and 27.9% of the other milder forms²¹.

Twenty-two out of 27 per thousand who had depression yearly consulted their family physician and in turn, he/she diagnosed depression in 5 of them and only 10% of them were referred to a psychiatrist²².

The aim of this study is to evaluate the current practice of primary care physician in the detection and management of depression among elderly.

METHOD

A structured self-administered questionnaire was distributed to all the physicians working in the health centers (200 family physicians working in 21 health centers).

The questionnaire was designed to gather the following information: physicians' personal characteristics, working experience, specialty and training in geriatric psychiatry.

Common risk factors of elderly depression and the scales used to diagnose it were included in the questionnaire; as well, it included the method of screening and managing elderly depression:

- The frequency of screening for depression among the elderly patients
- The number of cases identified over one year and the method of identification
- The physician specific management of the identified cases

The last part of the questionnaire was to explore the obstacles hindering the physician from detecting depression.

Analysis

Data were analyzed using SPSS software, version 15. Chi-square test was used to determine the significant difference in the management of depression among physicians according to their specialty, years of experience, and study background. *P-value* less than 0.05 was considered statistically significant.

RESULT

One hundred and thirty-two out of two hundred physicians returned the questionnaire with a response rate of 66%. Eighty-five physicians (64.4%) were females and 45 (34.1%) were males. Fifty-two physicians (39.4%) were in the age group 30-39 years. The mean age for males was 46.86 ± 8 and the mean age for females was 38 ± 6 years.

One hundred and two (77.3%) were family physicians. General practitioners with no specialization in family medicine were 24 (18.2%). Only 4 physicians (3%) were having other specialties.

Fifty-one (38.6%) physicians have been working for less than five years, eighteen physicians (13.6%) have been working between 5-10 years, and forty-eight physicians (36.4%) have been working for more than 10 years.

The mean duration of work for family physicians was 7.3 ± 7 years. The mean duration of work for general practitioner was longer 10.4 ± 6.5 years. For doctors with other specialties, the mean duration of work was shorter 2.8 ± 1.6 years.

Hundred and four (78.8%) physicians stated that they did not receive any formal training or course in geriatric psychiatry, see Table 1.

Table 1: Training Background According to Specialty

Specialty	Training Received		Total (%)
	Yes	No	
Family physicians	20 (20%)	80 (80%)	100 (75.8%)
GP	3 (13%)	20 (87%)	23 (17.4%)
Others	0 (0%)	4 (100%)	4 (3%)
Did not respond to the question			5 (3.8%)
Total	23 (17.4%)	104 (78.8%)	132 (100%)

One hundred and three (78%) had fair knowledge of the risk factors of elderly depression, only twelve (9%) were aware of some of the scales used to diagnose it.

Fourteen physicians (10.6%) were always screening for depression, while 101 (76.5%) were screening occasionally and thirteen physicians (9.8%) never had screened for depression, four physicians (3%) did not respond to the question, see Table 2.

Table 2: Screening for Depression According to Specialty

Depression screening	Family Physicians	GP	Other	Total
Always	10 (9.8%)	3 (13.6%)	1 (25%)	14 (10.6%)
Usually	30 (29.4%)	2 (9.1%)	1 (25%)	33 (25%)
Often	26 (25.5%)	8 (36.4%)	0 (0%)	34 (25.8%)
Occasionally	26 (25.5%)	6 (27.3%)	2 (50%)	34 (25.8%)
Never	10 (9.8%)	3 (13.6%)	0 (0%)	13 (9.8%)
Did not respond to the question				4 (3%)
Total	102 (100%)	22 (100%)	4 (100%)	132 (100%)

Eighty-five (64.4%) physicians identified 1- 4 cases per year; thirty-four (25.7%) physicians identified five and more cases; eleven physicians (8.3%) identified no cases at all during the year, two physicians (1.5%) did not respond to the question, see Table 3.

Table 3: Number of Cases of Depression Identified per Year

No. of cases	Number of Physicians	Percentage
0	11	8.3
1 - 2	50	37.9
3 - 4	35	26.5
5 - 6	16	12.1
6 +	18	13.6
0	2 (No response)	1.5
Total	132	100

Thirty-nine (29.5%) physicians referred the cases immediately once they were identified. Thirty-three (25%) physicians treated and followed up the identified cases while forty-eight physicians (36.4%) initially started treatment then referred the patient if needed.

Ninety-six (72.7%) felt competent in diagnosing late life depression while 33 (25%) did not.

Seventy-three (55.3%) physicians did not feel confident in treating late life depression. Seventy-six (57.6%) physicians have not enough time during consultation to discuss any psychological issues with the elderly.

One hundred and fourteen physicians (86.4%) wished to have a specific guideline for the management of elderly depression. One hundred and twelve (84.8%) felt the need to adopt a specific screening scale. One hundred and nine (82.6%) thought that they need more training on the identification and management of old age depression.

Eighty-five (64.4%) physicians disagreed that elderly patients usually do not accept questions about their psychological problems, see Table 4.

Table 4: Barriers to Diagnosis

Item	Strongly Disagree	Disagree	Agree	Strongly Agree	No response	Total
Elderly patients don't accept questions	34 (25.8%)	51 (38.6%)	32 (24.2%)	13 (9.8%)	2 (1.5%)	132 (100%)
Short consultation time	13 (9.8%)	42 (31.8%)	49 (37.1%)	27 (20.5%)	1 (0.8%)	132 (100%)
Need for specific scale	11 (8.3%)	8 (6.1%)	31 (23.5%)	81 (61.4%)	1 (0.8%)	132 (100%)
Need for more training	10 (7.6%)	11 (8.3%)	50 (37.9%)	59 (44.7%)	2 (1.5%)	132 (100%)
Need for specific guideline	12 (9.1%)	4 (3%)	31 (23.5%)	83 (62.9%)	2 (1.5%)	132 (100%)

There was no significant difference in the practice to screen for depression among different specialties ($P=0.5$). Moreover, there was no significant difference in the number of cases of depression identified by each specialty ($P=0.29$).

Specialty also did not affect the way in which the case of depression was managed once it was identified ($P=0.5$).

The duration of work did not influence the practice to screen for depression ($P=0.06$). In addition, it did not influence the number of cases of depression identified by the physicians ($P=0.6$) or the way in which the depressed elderly was identified or managed ($P=0.69$ and 0.98 respectively).

Receiving a formal course in geriatric psychiatry did not significantly influence the attitude to screen for depression; there was no difference in screening between those who received and those who did not receive such a course ($P=0.35$). Furthermore, there was no significant difference in case management between those who received a training course or those who did not ($P=0.28$).

DISCUSSION

Primary care physicians are usually the first to encounter elderly patients with depressive symptoms. Elderly depression is prevalent and can lead to serious consequences to elderly health and quality of life⁹. Diagnosis and management among elderly patients poses a challenge to the treating physician. A qualitative study explored the challenges facing primary care physicians dealing with elderly patients. It identified difficulties pertinent to the elderly himself which are mainly the multiple diseases the elderly usually suffer from and the chronic nature of such diseases. The other important obstacles are those related to the medical education of the physician and to the structure of the health care system in general. The researchers suggested a change in the health care system and in physician education in order to overcome these obstacles²³.

This study showed that screening for depression among elderly attending the primary health services is not adequate. Although the majority of the physicians (72%) thought that depression is common among the elderly people, only (10.6%) of the physicians were always

screening for it. These results are consistent with the results of other studies which showed the low detection rate of this condition¹⁸⁻²⁰.

The experience and the duration of work did not influence the practice to screen and to manage depression. This was in contrast to other studies which found that recognition of depression was better if the doctor had experience in work more than 5 years²⁴.

The majority of physicians regardless of their specialty admitted the need for a suitable scale, a specific guideline and more training in the field of old age depression. This was similar to the result from other countries, which found that general practitioners had no difficulty in diagnosing depression in elderly people but rather they do not treat these elderly with antidepressants and do not refer them to a specialist^{25,26}.

Short consultation time and non-friendly environment for the elderly patient interfere with timely detection and proper management. A large number of the physicians (57.6%) do not have enough time during consultation to discuss any psychological issues with the elderly patient. Physicians in a similar study reported that the single item which would be most helpful for improving care for geriatric depressed patients is to have more time spent with these patients²⁶.

Under-diagnosis is aggravated by the fact that late life depression presents usually with atypical symptoms such as weight loss, constipation or mental slowing. The presenting symptoms of depression may mimic the symptoms of other medical conditions that the elderly usually suffer from^{16,27,28}. The other barrier to diagnosis is that elderly patients usually do not condone questions about their psychological problems, 34% of physicians concurred to that.

The cooperation between primary and secondary services should be addressed in any recommended protocol as this was shown to improve the management. A group of researchers assessed the introduction of a special care program involving a psychiatrist cooperating with the primary care physicians in the care of depressed elderly. They showed that depressed elderly benefiting from this program had better social activities and fewer disabilities than those receiving the usual treatment program²⁹.

CONCLUSION

This study shows that screening for depression among elderly patients in primary care is not sufficient leading to low detection rate. Among the reported barriers interfering with the detection and treatment of this condition by family physicians are the followings: lack of training in geriatric psychiatry, short consultation time, the absence of a clear guide-line and the need for a practical and simple screening test.

Therefore, it is advisable to include modern training in medical schools and in the family physician residency program. In addition, it is necessary to adopt a practical screening tool and to develop evidence-based guideline to manage old age depression in primary care setting.

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