

type provided by Nuovo before we embark on costly national programs that provide uncertain benefit.

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References

1. Nuovo J. Are oat products effective cholesterol agents: a critical review. *J Am Board Fam Pract* 1991; 4:229-36.
2. Diet and heart disease. Dallas: American Heart Association, 1965.
3. Sturdevant RA, Pearce ML, Dayton S. Increased prevalence of cholelithiasis in man ingesting a serum-cholesterol-lowering diet. *N Engl J Med* 1973; 288:24-7.
4. Gammal EB, Carroll KK, Plunkett ER. Effects of dietary fat on mammary carcinogenesis by 7, 12-dimethylbenz (alpha) anthracene in rats. *Cancer Res* 1967; 27:1737-42.
5. Carroll KK, Gammal EB, Plunkett ER. Dietary fat and mammary cancer. *Can Med Assoc J* 1968; 98:590-4.
6. Committee on Nutrition. Toward a prudent diet for children. *Pediatrics* 1983; 71:78-80.
7. Expert Panel. Report of the National Cholesterol Education Program; expert panel on detection, evaluation and treatment of high blood cholesterol in adults. *Arch Intern Med* 1988; 148:36-69.
8. Froom J, Froom P. Consequences of the national cholesterol education program. *J Fam Pract* 1990; 30:533-6.
9. Total serum cholesterol level of adults 20-74 years of age. United States, 1976-80. Hyattsville, MD: National Center for Health Statistics, 1986. DHHS publication no. (PHS) 86-1686. (Vital and health statistics, series 11, no. 23).
10. Laboratory Standardization Panel of the National Cholesterol Education Program. Current status of blood cholesterol measurement in clinical laboratories in the United States. *Clin Chem* 1988; 34:193-201.
11. Frick MH, Elo O, Haapa K, Heinonen OP, Heinsalmi P, Helo P, et al. Helsinki Heart Study: primary prevention trial with gemfibrozil in middle-aged men with dyslipidemia. Safety of treatment, changes in risk factors, and incidence of coronary heart disease. *N Engl J Med* 1987; 317: 1237-45.
12. Lipid Research Clinics Program: the lipid research clinics coronary primary prevention trial results 1. Reduction in the incidence of coronary heart disease. *JAMA* 1984; 251:351-64.
13. Anderson KM, Castelli WP, Levy D. Cholesterol and mortality: 30 years of follow-up from the Framingham Study. *JAMA* 1987; 257: 2176-80.
14. Benfante R, Reed D. Is elevated serum cholesterol a risk factor for coronary heart disease in the elderly? *JAMA* 1990; 263:393-6.
15. Mensink RP, Katan MB. Effect of diet enriched with monounsaturated or polyunsaturated fatty acids of low-density and high-density lipoprotein cholesterol in healthy women and men. *N Engl J Med* 1989; 321:436-41.
16. Kane JP, Malloy MJ, Ports TA, Phillips NR, Diehl JC, Havel RJ. Regression of coronary atherosclerosis during treatment of familial hypercholesterolemia with combined drug regimens. *JAMA* 1990; 264:3007-12.
17. Cashin-Hemphill L, Mack WJ, Pogoda JM, Sanmarco ME, Azen SP, Blankenhorn DH. Beneficial effects of colestipol-niacin on coronary atherosclerosis. *JAMA* 1990; 264:3013-7.
18. Willett W, Sacks FM. Chewing the fat: how much and what kind. *N Engl J Med* 1991; 324: 121-3.
19. Froom J. Glycemic control in elderly people with diabetes. *Clin Geriatr Med* 1990; 6:933-42.
20. Report of the U.S. Preventive Services Task Force. Guide to clinical preventive services. Baltimore: Williams & Wilkins, 1989.
21. Fiore MC, Novotny TE, Pierce JP, Hatziandreu EJ, Patel KM, Davis RM. Trends in cigarette smoking in the United States: the changing influences of gender and race. *JAMA* 1989; 261: 49-55.

Depression: Are We Too Busy To Listen?

If congestive heart failure symptoms and signs were as frequently and poorly recognized as depression, the multiple peer-review processes and reviewers would be in a dither. Depression is a very common problem¹; it ranks in the top 10 diagnoses in primary care,^{2,3} and the criteria needed to diagnose a mood disorder are well established.⁴ The central issue posed by the study of Coyne, et al.⁵ in this issue of the *Journal*, however, is that family physicians still have problems recognizing depression. What, then, needs to occur in the patient-physician encounter to allow good diagnostic sensitivity and specificity so an appropriate diagnosis can be made and an efficacious treatment can then be

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planned and provided? These questions are not necessarily moot, because depression can cause significant morbidity and death.^{6,7} The average family physician sees at least 6 suicidal patients each year, 1 in 100 threatens suicide, and 1 in 10 thinks about suicide.⁸ Moreover, most suicidal persons seek help from a nonpsychiatric physician,⁸ and as many as 10 percent of these patients (prior to a suicidal act) will see their physician less than 1 week before their death.⁸ These figures emphasize that a mood problem, if not recognized, can be lethal.¹

Using questionnaires and delegating others to gather data are common practices in many busy physician offices. Physician extenders are heavily utilized to save physician time and promote a cost-effective practice. Perhaps we should ask ourselves whether we can delegate others to gather the information needed to make a diagnosis of depression? Certainly, questionnaires are unable to respond to a patient's verbal or nonverbal cues. If one recalls that as much as 70 percent of meaningful communication is nonverbal, then many opportunities will be missed when using even the best questionnaires to gather essential criteria for diagnosing depression.

Do we as physicians have the education and experience necessary to gather critical data? If our medical school interviewing courses taught proper techniques and our residencies provided good behavioral science, knowledge, and experiences, what then are the barriers that prevent us from using our acquired skills in practice?

When interviewing depressed patients, physicians frequently must provide the structure and the time to help their patients communicate. The very nature of depression makes persons pessimistic about diagnosis and treatment, and they often are somewhat passive, uncomfortable, or reluctant to reveal depressive feelings or thoughts. Moreover, seriously depressed patients often do not come to the physician alone but are brought by concerned spouses or family members. A lack of initiative, energy, and motivation is often accompanied by intense feelings of helplessness and unworthiness. Frequently, the persons with the patient will speak to the physician as though the patient was not even present, or the patients are so incapacitated that they cannot communicate. Thus, when the wait-

ing room is full, we are suddenly asked to take more time, shift our interactive style, and make a deliberate effort to change how we approach depressed patients. It then becomes critical to look at motor movements, facial expressions, grooming, posture, and quality of speech, in addition to focusing on the words of the patients. The secret of getting the essential information to make the diagnosis is to focus not only on what is said by the patient, but how it is said, when it is said, and what is linked to the major nonverbal cues.⁹

Lacking spontaneity or being overly anxious when depressed can prevent patients from expressing thoughts clearly. If patients are slow to reply or if the replies are brief and repetitious, it will be hard for busy physicians to take the time to listen. Nevertheless, *time* for listening becomes critical if we are to allow depressed patients to relate their histories. Withdrawn persons may not be able to engage emotionally with their interviewing physician, and their replies are often in monotone and monosyllabic. Sharing silence is not a comfortable process and can be experienced as nonproductive by busy practitioners. On the other hand, insufficient listening can be misinterpreted by depressed patients as lack of interest or dissatisfaction and may cause patients to wonder whether they are worth the physician's time. In fact, this interaction with the physician may be the patient's last attempt to seek help before attempting suicide.

It is not uncommon to focus on physical symptoms during the interview because patients think the physician is more interested in these symptoms; hence, both are more comfortable discussing them. Weight loss, sleep, anorexia, nausea, headaches, bowel functioning, and so on, are perhaps a more comfortable way to start an interview, but it is important not to be sidetracked permanently by focusing only on the physical symptoms.

Evelyn Mayerson, in her book *Putting the Ill at Ease*,¹⁰ succinctly outlines and effectively reviews information gathering, information giving, facilitation, critical observation, communication, and its meaning to the physician. As W.B. Buckingham so aptly summarized in the book's foreword,¹¹ "The results achieved by a physician in terms of success in both diagnosis and treatment are directly dependent upon his [*sic*] ability to

communicate with his patients, perceive their problems, and deliver his message."^{ix} He goes on to point out that "scientific knowledge, personality of the practitioner, and communication" are all important, but that "the greatest of these is communication," which is essentially a "two-way street" between the patient and physician. As he notes,

Nonverbal communication often is more significant than its verbal counterpart. . . . Medical practice dictates that the physician "gets the message." The patient's difficulties in expressing his problems do not justify the physician's failure to perceive the problems. A diagnosis is impossible unless the patient's problem is communicated in some manner to the physician.^{p ix}

There are hereditary characteristics of depression,¹² as well as several biological markers,¹³ that can be used to identify depression, such as, dexamethasone suppression test abnormalities, platelet monoamine oxidase disturbance, cerebral fluid monoamine metabolite abnormalities, cholinergic rapid eye movement induction changes, circadian rhythm disturbances, thyroid dysfunction, and a host of receptor abnormalities. Nevertheless, most of us still identify depression in a patient by the clinical interview.

The difficulty of identifying depression is further compounded in medical or surgical patients, because depressive symptoms can be confused with medical or surgical problems. The challenge is then to determine whether the symptoms are due to the depression or to the illness. Cassem,¹⁴ in his excellent review, has noted that the depressive symptoms of the medical patient might be accompanied by feelings of worthlessness, self-reproach, excessive guilt, decreased ability to think, heightened ambivalence, impaired concentration, and recurrent thoughts of death or suicide. He emphasizes it still is difficult for physicians, and perhaps the lay public, to appreciate how devastating and painful it is for a person to be depressed in addition to having a medical problem. This burden is a terrible imposition on a patient whose depression should be recognized and treated. Such minimization of the effects of depression may be another barrier to physician recognition of depression.

As physicians, we still tend to look for a medical problem to explain the constellation of symptoms or signs, and frequently depression is considered only after many tests and by exclusion. Recognizing depression today remains a problem for many of us. It is best to remember that some clinical activities cannot be delegated to others and some questionnaires may not gather the necessary diagnostic information. We still need to take the time to use our professional and personal skills to listen carefully and to observe our patients so we can diagnose depression, treat it, and relieve our patients of this painful condition.

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References

1. Orleans CT, George LK, Houpt JL, Brodie HK. How primary care physicians treat psychiatric disorders: a national survey of family practitioners. *Am J Psychiatry* 1985; 142:52-7.
2. Nielsen AC III, Williams TA. Depression in ambulatory medical patients: prevalence by self-report questionnaire and recognition by nonpsychiatric physicians. *Arch Gen Psychiatry* 1980; 37: 999-1004.
3. Marsland DW, Wood M, Mayo F. Content of family practice. Part I. Rank order of diagnoses by frequency. *J Fam Pract* 1976; 3:37-47.
4. Steinhilber RM, Gulledge AD, Bope ET, Brock D. Reference guide: depressive disorders. 3rd ed. Lexington, KY: The American Board of Family Practice, 1989.
5. Coyne JC, Schwenk TL, Smolinski M. Recognizing depression: a comparison of family physician ratings, self report, and interview measures. *J Am Board Fam Pract* 1991; 4:207-15.
6. Snyder JA. The use of gatekeepers in crisis management. *Bull Suicidology* 1971; 8:39-44.
7. Rockwell DA, Pepitone-Rockwell F. Problems in family practice: the suicidal patient. *J Fam Pract* 1978; 7:1207-13.
8. Robins E, Murphy GE, Wilkinson RH Jr, Gassner S, Kayes J. Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides. *Am J Public Health* 1959; 49:888-99.
9. MacKinnon A, Michels R. The psychiatric interview in clinical practice. Philadelphia: W.B. Saunders, 1971:174-229.
10. Mayerson E. Putting the ill at ease. Philadelphia: Harper & Row, 1976.
11. Buckingham W. Foreword. In: Mayerson E. Putting the ill at ease. Philadelphia: Harper & Row, 1976:ix-xi.

12. Goldin LR, Gershon ES. The genetic epidemiology of major depressive illness. In: Frances AJ, Hales RE, editors. Review of psychiatry. Washington, DC: American Psychiatric Press Inc, 1988; 7: 149-68.
13. Ballenger JC. Biological aspects of depression: implications for clinical practice. In: Frances AJ, Hales

- RE, editors. Review of psychiatry. Washington, DC: American Psychiatric Press Inc, 1988; 7:169-87.
14. Cassem EH. Depression secondary to medical illness. In: Frances AJ, Hales RE, editors. Review of psychiatry. Washington, DC: American Psychiatric Press Inc, 1988; 7:256-73.

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