



The Management of Depressed Patients by the Tunisian General Practitioners: A Critical Trans-sectional Study

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Abstract

Under-diagnosed and under-treated, depression has a pejorative prognosis. The general practitioners (GP) represent the most often consulted healthcare professionals by depressed patients. The aim was to describe how the Tunisian GPs manage the depressed patients and to note the difficulties they encounter in order to suggest corrective measures. A survey was conducted among 140 GPs in Sfax Governorate. The percentage of the GPs whose responses conformed to the scientific data in at least 67% of the items was 31.4%. Four factors were correlated to a good management of depression: age ($p=0.028$), masculine gender ($p=0.016$), long career ($p=0.034$) and participation to continuous medical education sessions on depression ($p=0.01$). Our study revealed inadequacies in the management of depression by the GPs. GPs were invited to sensitizing meetings. A training on depression was assured for the future internship supervisors by the commission of medicine of family in the Faculty of Medicine of Sfax.

Keywords Critical study · Depression · General practitioners · Management

Introduction

Depression is among mental disorders which have the greatest social, economic as well as personal impacts (Mathers and Loncar 2006). According to the World Health Organization (WHO), depression would become in 2020 the second cause of disability in the world, after cardiovascular disorders (Murray and Lopez 1997). In the developed countries, Boyer et al. (1999) estimated that only 35% of the patients suffering from depression were properly treated. Under-diagnosed and under-treated, this disorder has a pejorative prognosis and is now considered as much disabling as diabetes, asthma or hypertension (Magalon-Bingenheimer et al. 2012). Tunisia is not an exception to this general trend, with a prevalence of depression estimated at 8.6% (Douki et al.

2005). Thus, there is a need for care concerning depression, especially with regards to insufficient psychiatry-specialized care staff. The general practitioners (GP), whose number is more important and who are better distributed than the specialized physicians, represent the most often consulted healthcare professionals by depressed patients. In addition, patients prefer to consult a general practitioner. Psychiatry is still stigmatized in Tunisia, and there is no psychological support network. For this, the GP role in the management of depression is considered crucial. Indeed, according to the French National Agency of Accreditation and Assessment in Healthcare (ANAES: Agence Nationale d'Accréditation et d'Évaluation en Santé [ANAES], 2002), a psychiatric advice is only recommended in certain specific situations such as comorbidity, inadequate response to the treatment within 8–10 weeks, « or at any moment of the follow up if the patient wishes to ». Apart from such situations, the GP should be able to treat a major depression.

The purpose of this study was to describe how the Tunisian GPs manage the depressed patients and to note the difficulties they encounter in order to suggest corrective measures.

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Subjects and Methods

Study Design

A trans-sectional survey was designed to explore the knowledge, the attitudes and the practices of GPs concerning depression.

Study Population

The survey was conducted with a representative sample of the target population, selected from the list of the registered GPs in the Council of the College of Physicians, working in Sfax Governorate, in both public and liberal sectors. To calculate the sample minimum size, we referred to the literature data according to which about 35% of the GPs would know the guidelines of clinical practice of depression (Mercieret al. 2009). For a precision of 5% and a confidence interval of 95%, the minimum size of the sample was estimated at 136 doctors. Thus, we solicited 140 GPs. They were contacted directly by the same person who explained to them the scientific purpose of the study and guaranteed anonymity.

We solicited as many doctors working in urban areas ($N = 70$) as in rural ones. We also contacted as many GPs from the public sector ($N = 70$) as from the private one.

Half of the solicited doctors ($N = 70$) had less than 10 years of seniority whereas the other half had more than 10 years of seniority.

Among the 140 solicited doctors, 70 refused to participate to the survey. Thus, the participation rate was 50%.

Data Collection

The GPs who accepted to participate to the survey were supposed to answer an anonymous self-assessment questionnaire given in French. The questionnaire consisted of four pages. Filling it out took on average 15–20 min. It contained items concerning the general profile of participants, their self-assessment of their management of depressed patients and their knowledge about major depressive episode (MDE). The last 27 items consisted in scientifically valid data, according to the recommendations of the French Health Products Safety Agency (AFSSAPS: Agence Française de Sécurité Sanitaire des Produits de Santé 2006). These items covered the following domains: antidepressant choice and dose, antidepressant and benzodiazepine association, the average time to reassess the patient's state, the continuation-phase treatment and the total duration of the treatment of the first MDE.

We resorted to the French recommendations as main references because Tunisia is a francophone country; where there is no national recommendation concerning the management of depressed patients.

We considered that a GP should be able to respond, in a consistent manner to the scientifically valid data, to a minimum of 67% of the 27 items related to knowledge about the MDE, which means at least 18 items.

Data Analysis

The data were collected and analysed with the SPSS computer software in its 18th version. The qualitative variables were expressed in percentage while the quantitative ones were expressed in average with their standard deviation. The comparisons between the doctors who responded in a consistent manner to scientific data and those who did in the wrong way, were made by the Chi square test (χ^2) or the Fisher exact test, and by Student *t* test. The significance threshold was fixed at 5%.

Results

Descriptive Study

Population

The average age of the doctors who participated to the study was about 47.5 with extremes of 30 and 64 years [standard deviation (SD) = 8.72]. The sex-ratio (M/W) was of 1.9. Among the investigated GPs, 74.2% had more than 11 years of experience. The exercise area was urban for 58 GPs (83%). Forty-three GPs (61%) practiced in the private sector. Twenty-eight GPs (47.4%) declared that their activity level was between 2 and 15 patients daily. Half of the investigated doctors ($N = 35$) had participated to continuous personal development about depression, during the last 3 years. Concerning hospital experience, nine doctors (12.8%) had an internship in a psychiatric department.

Diagnosis and Management of Depression

Diagnosis

Most of the GPs (95.7%; $N = 67$) reported that they made the diagnosis subjectively: when they find a few warning signs of depression and they have the impression that their patient is depressed, they start the management. As for the other GPs (4.3%), they used diagnostic criteria of nosographic classifications (DSM or ICD).

Sixty-eight GPs (97.1%) declared that they do not use any of the psychometric tools available for depression (such

as Beck Depression Inventory, Hamilton Depression Scale, Montgomery Asberg Depression Rating Scale...).

Management of Depression

Thirty-six GPs (51.4%) declared to know the international recommendations on the management of depression.

The Antidepressant Choice

Among the investigated doctors, 46 (65.7%) chose the antidepressant according to the product efficiency and seven (10%) according to its tolerance. Thirteen participants (18.6%) treated the MDE on the basis of the previous episodes and three GPs (4.3%) did in line with the patient's preference. One GP put two criteria for the antidepressant choice.

The most prescribed antidepressants' class was the selective serotonin reuptake inhibitors (SSRI) (77.1%). The most prescribed antidepressant was paroxetine (38.6%).

The Antidepressant Dose

For the tricyclic antidepressants and the venlafaxine, 19 participants (27.1%) estimated that the minimal daily dose for the antidepressant effect was around 75 mg. The daily antidepressive dose was around 20 mg for fluoxetine and paroxetine, according to 35 GPs (50%) and 42 GPs (60%) respectively. It was around 50 mg for the sertraline, according to 40 GPs (57.1%). As for the escitalopram, 27 GPs (38.7%) estimated that the antidepressive dose was around 10 mg.

The Acute-Phase Treatment

Among the GPs, 52 (74.3%) declared to prescribe straightaway the antidepressant dose. According to 38 participants (54.3%), the association antidepressant–benzodiazepine should be systematic in case of a first MDE. The average time at the end of which the GPs re-examined their patient was 26 days with extremes ranging from 7 to 90 days. Twenty-six doctors (40.6%) re-examined their patients within a period ranging from 22 to 30 days. Sixty GPs (85.7%) thought that the psychological support occupies a prominent place in the management of a MDE regardless of its severity.

Continuation-Phase Treatment

Thirty-one GPs (44.3%) declared that they prescribed half of the acute-phase treatment dose during the continuation phase. As for the duration of this phase, 40 participants (57.2%) estimated it at around 6 months.

Total Duration of the Treatment of the First MDE

According to 44.3% of the participants, the whole treatment duration of a first MDE (acute and continuation phases) was inferior to 8 months. While 12.9% did not answer that question, 37.1% estimated it at between 8 and 12 months and 5.7% at over 12 months. Fifty-two doctors (74.3%) saw their patient at least four times throughout the MDE management and 52 (74.3%) considered that the antidepressant treatment discontinuation should not be brutal.

Overall Assessment of Management

The answers of 31.4% of our GPs were consistent with the recommendations of the French AFSSAPS on the management of depression, in at least 67% of the items.

Among the GPs of our study, 44.3% considered their management of depression unsatisfactory. Almost 25% (24.3%) recognized that their utilisation of psychotropic drugs was not good enough.

Analytical Study

Socio-demographic Factors

There were correlations between the score of correct answers and socio-demographic factors: age ($p=0.028$), male sex ($p=0.016$), and number of years of practice ($p=0.034$).

Continuous Medical Education and Psychiatry Internship

The continuous medical education was correlated with a high score of correct answers ($\geq 67\%$), $p=0.01$.

Discussion

Response Rate

The holdings percentage in our study was around 50%. This percentage is greater than those reported in other studies: 44% in a study carried out in Belgium (Hadoun et al. 2007) and 25% in a French study (Mercier et al. 2009). Such a discrepancy could be explained, at least in part, by the difference between the sizes of samples. The number of GPs who participated to these two studies, respectively 798 GPs and 8709 GPs, was greater than that of ours. In other studies, carried out in almost the same socio-cultural context as ours, namely in Morocco (Berhili 2010) and in Abu Dhabi (Saeed and McCall 2006), the holdings percentages were superior to ours, respectively 68% and 81.8%.

Most of the GPs who refused to participate in the study worked in rural areas. They probably were “not concerned with the subject in their everyday work” as was the case for 42.3% of the German physicians surveyed by Kühne et al. (2011) on end-of-life care for the elderly. Indeed, in Tunisian rural areas, people do not pay enough attention to mental health. Depression may be regarded as a weakness and a lack of will rather than as an illness requiring a medical consultation.

As for the GPs working at the Tunisian public sector, they usually have a greater number of consultants than their colleagues from the private sector. Therefore, most of them did not fill in the questionnaire due to “lack of time”. Such a response was the second most frequent reason for non-participation in the study of Kühne et al. (2011) and the most frequently stated in that of Seale (2009) on the subject of euthanasia and physician-assisted suicide.

In another study on almost the same subject (i.e. medical end-of-life decisions), carried out by Fischer et al. (2006), non-respondents were found to have significantly fewer patients in the terminal stage than respondents. In ours, most of the participants had more than 11 years of seniority. Hence, most of the GPs who refused to take part in the study had a lower seniority than the participants. They probably had not met as many depressed patients as their older colleagues during their shorter career.

Our response rate could also have been influenced by the length of the questionnaire. Even though we tried to respect the recommendations according to which the questionnaire should be short, not more than 16 pages (Ransdell 1996; Porst 2001), the use of a shorter questionnaire could have increased the response rate in our study, as noted by Kellerman and Herold (2001).

Percentage of the GPs Whose Responses Conformed to the Scientific Data in At Least 2/3 of the Items

This percentage was 31.4%. It is greater than that reported in the study of Berhili (2010) (23.3%), and less than that found by Saeed and McCall (2006) (50%). Heterogeneity in the methodologies and the range of questions employed in the assessment of GPs’ knowledge could explain partially these differences. The result of our study is worrisome as an uncomplicated depression is supposed to be managed by a GP (ANAES 2002). The study of Amara et al. (2010), carried out in 2005, found that the number of Tunisian psychiatrists for 100,000 inhabitants was 1.9. This number is less than the minimum of 2.5 for 100,000 inhabitants required by the WHO (2001) which considers that the management of mental disorders at the level of primary care is a key measure as it enables the greatest number of patients to have access more rapidly to services.

Nevertheless, our results should be considered with reserve. Indeed, our study consisted in a survey of what physicians said rather than an observation of what they did. As such, the data it provided us with were probably some combination between what the GPs thought was best practice and what they were actually doing. Our results would have been more authentic if we had surveyed doctors and patients at the same time, like did Johnston et al. (2007). However, even these authors could not match surveyed GPs, whose number was less than half of ours, with their own patients.

Factors Correlated with an Appropriate Management of Depression

We found a significant correlation between a percentage of correct answers of at least 67% and four factors: advanced age ($p=0.05$), male gender ($p=0.016$), high number of activity years ($p=0.034$) and participation to continuous personal development sessions ($p=0.01$). Unlike the results of Berhili (2010) showing an association between an internship in psychiatric departments and a higher level of knowledge related to depression, these two variables were not correlated in our study. The absence of impact of psychiatric internships prompts us to wonder about the reasons of their inefficiency: lack of GPs’ motivation during these sessions? Lack of clinical supervision? Or objectives not answering the needs of a GP? Especially that the internship is usually made in closed departments where most patients have psychotic features.

In our study, the older the GP was, the better was his management of the depressed patients (50.9 vs. 46; $p=0.028$). Further experience is very likely underlying this result. However, this result is not found in all the surveys. Berhili (2010) found that an age less than 35 was associated with a better knowledge. For Sagduyu et al. (2008), what is influenced by an early age is rather the distance of the doctors towards depressed patients. The youngest GPs have therefore a tendency to set a considerable distance between them and the depressed patients.

Our results showed that men had more answers exceeding the required threshold (67%) than women (41.3% vs. 12.5%). This difference would be due to the uneven distribution between two sexes (66% vs. 34%). Saeed and McCall (2006), found a difference between men and women for the questions assessing attitudes, but no difference in knowledge about depression.

The GPs whose percentage of knowledge reached the required level had more seniority than the others (20.7 vs. 15.6; $p=0.034$). A similar result was reported by Hadoun et al. (2007), who noted differences between GPs generations concerning theoretical knowledge on depression and

especially the therapeutic aspects. These considerations emphasize the importance of the professional experience.

We noticed that the GPs who benefitted from continuous medical education sessions on depression during the last 3 years were more able to take good care of the depressed patients ($p=0.01$). This result was predictable and confirms once again the importance of such sessions for the quality improvement of mental health care provided by the GPs. This finding is consistent with those of other studies showing that higher training levels related to depression are associated with more favorable attitudes (Liu et al. 2008; Saeed and McCall 2006). The development of interactive medical education sessions in small groups, ideally completed by recalls at the time when decisions are taken, could improve these practices (Mercier et al. 2009).

Depression Diagnosis

Most of our participants reported that they made the diagnosis subjectively. Such an observation raises the issue of difficulty for the GPs to carry out the diagnosis of depression in current practice. Berhili (2010) points out that although 84.7% of the GPs of his survey state having already diagnosed depression during their exercise period, only 5.7% among them knew the set of three major clinical symptoms of depression (mood sadness, psychomotor slowing down and somatic symptoms). The lack of knowledge of reference tables should not, however, be too quickly interpreted as a lack of professionalism (Mercier et al. 2009). Indeed, according to the French Society of General Medicine (Martinez 2002), the knowledge of these guide books could help the practitioner at most for half of his depressive patients. Beyond the knowledge of these guides, GPs' conviction of the relevance of such diagnostic tools is important.

Therapeutic Management

Only 31.4% of our participants gave responses that conformed to recommendations of good practice according to the French AFSSAPS (2006). This percentage is much less than that of Amourda (2012) who found, in a survey carried out in 2011 with 148 GPs from Île-de-France, that 86.4% among them knew the recommendations of good practice. Even though the GPs know these recommendations, they do not necessarily respect them. According to Lamboy (2006), despite establishing recommendations of good clinical practice particularly consensual at both the national and international levels, the health behavior and the care practices were rarely consistent with these recommendations.

Choice of the Antidepressant

Our study revealed that most of the investigated GPs considered the efficiency as the most important criterion for the choice of the adequate antidepressant. Whereas several published articles (AFSSAPS 2006; ANAES 2002; Anderson 2000) showed that there was no difference in effectiveness between antidepressant classes.

For the antidepressant choice, we put a closed response format out of respect for the recommendations concerning the increase of the response rate (Ransdell 1996; Porst 2001). However, we need to recognize that by doing so, we probably applied a forced categorical choice to what might be a more complicated decision processes. Indeed, clinicians may balance efficacy with patient preference, for instance, especially that previous studies emphasized on taking the patient's perspective into account (Johnston et al. 2007).

Antidepressants Dose

Compared with literature data (Hérique and Kahn 2007), the proportion of the GPs who knew the correct doses of antidepressants, in our study, seems low. Nevertheless, other studies have already made the same statement. In Australia, McManus et al. (2003) found that among the patients suffering from a MDE, treated by a GP, only a quarter received an antidepressant, with an often low dose and for a very short duration. Taleb et al. (2006) noted that even if the correct diagnosis of MDE was made by the GP, this would not automatically lead to an adequate treatment. Substances without antidepressant effect are prescribed and when an antidepressant is chosen it is often for a too short duration or at a too low dose.

Continuation-Phase Treatment

Thirty-one GPs (44.3%) asserted that they prescribed half of the acute-phase dose during the continuation-phase. Although widespread, such an attitude goes against the therapeutic strategies recommended for depression. The AFSSAPS (2006) recommends similar doses during the acute-phase, the continuation-phase and, if necessary, to prevent recurrences.

Association Antidepressant–Benzodiazepine

Unlike what is recommended by the French AFSSAPS, 54.3% of our GPs considered this association as systematic. Actually, such an association should not be systematic because of the side effects of benzodiazepines. It can

be justified at the beginning of treatment in case of disabling insomnia and/or anxiety or a suicide risk (AFSSAPS 2006).

Deadline to Re-examine the Patient

The average time to reassess patient's state was longer than recommended (AFSSAPS 2006). The aim of close consultations is to evaluate regularly the drugs' safety, particularly at the beginning of treatment. Moreover, the occurrence or the persistence of suicidal thoughts justifies an increased surveillance.

Treatment Duration

Among our GPs, 42.8% did not follow their depressed patients long enough after a complete remission. Yet, most of the consensuses are unanimous on the issue. The ANAES (2002) recommends, in case of a single MDE, that the antidepressant treatment discontinuation should only be discussed 6 months to 1 year after the clinical remission in order to reduce the risk of relapse or recurrence.

According to the AFSSAPS (2006), at the end of a well-managed treatment, it is recommended to reduce the dose progressively, as mentioned by three quarters of our GPs, so as to prevent the occurrence of a withdrawal syndrome.

Place of Psychological Support

Although most of our participants considered psychological support as crucial for the management of a MDE, recognizing its importance does not necessarily implicate its utilization. Indeed, several studies showed that pharmacotherapy continues to be the main approach chosen by the GPs in order to treat depression (Berhili 2010; Briffault et al. 2008; Lamboy 2006; Mercier et al. 2009), and this in spite of patients' expressed needs for listening (Johnston et al. 2007).

Overall Appreciation of Management

Among our GPs, 44.3% were dissatisfied with their management of depression. This result is in accordance with those of other studies. Mercier et al. (2009) found that the GPs were aware of their lack of competence and were willing to get a specific training, especially in the field of relationship aid. Frémont et al. (2008) found that 40% of the GPs interested in depression considered that they were misinformed about the issue.

Corrective Measures

Our study revealed inadequacies in the management of depression by the GPs. To palliate these errors, the GPs who participated to the study were invited to sensitizing meetings to tell them the results of our study and make a "positive" confrontation with the error. For the long term, and within the framework of the commission of medicine of family in the Faculty of Medicine of Sfax, a training on depression was assured for the future internship supervisors. These are GPs who have a competence in family medicine and will be responsible for guiding the other GPs during their internships, especially that, currently, the latter do not bring the expected profit. Training on cross-curricular skills such as communication has been included in the curriculum of GPs. An assessment of the knowledge and the practices of the GPs who will benefit from this follow-up is envisaged to judge the efficiency of such measures.

Limitations of this Study

Our study was carried out with a representative sample of the target population. However, our non-response rate was high (50%). This rate may disturb estimates and may reduce the accuracy of the results.

Besides, the dichotomous and closed nature of our questions could have had negative effects, by limiting the respondent's opportunities of self-expression.

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Compliance with Ethical Standards

Conflict of interest The authors declare they have no conflicts of interest concerning this article.

Ethical Approval This manuscript complies to the Ethical Rules applicable for Community Mental Health Journal.

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