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**IN REPLY:** The model developed in the Wimmera hospital for clinical quality improvement has formed the basis for quality improvement systems in several regional and tertiary hospitals in Australia. The resources required to implement the model have been costed, and the Victorian Department of Human Services has allocated \$4.8 million to establish clinical risk management programs based on the Wimmera model in every Victorian public hospital in 2001–2002.<sup>1</sup>

Whichever programs are implemented, some adverse events will be missed. However, not all medical records need to be reviewed, nor all adverse events found. Regular identification of some events provides significant opportunities to improve care.

As clinician time is limited, some hospitals that have implemented the Wimmera model have paid clinicians with existing appointments for extra hours to participate in risk-management programs. Although feedback to general practitioners is logistically more difficult in a tertiary centre, it can still provide valuable information if limited to only a sample of inpatients. We agree that some departments in tertiary hospitals, because of their specialised nature, would need to develop additional screening criteria.

The actual cost of running a clinical risk-management program based on the Wimmera model depends on how many components of the model are implemented, but in our experience should not exceed 0.5% of a hospital's total budget. Cost-benefit analyses are difficult to undertake, as some adverse events arise through underuse of available evidence, and additional resources would be needed for full implementation of the evidence (eg, giving prophylactic antibiotics immediately before surgery to prevent postoperative infection,<sup>1</sup> or low molecular weight heparin postoperatively to prevent thromboembolism<sup>2</sup>).

We believe that in any institution, whatever its size, the initiation of effective programs for clinical quality improvement needs both enthusiastic

support from the highest level of management and champions at the “coalface” of patient care. If these two elements are present, adequate resources will often be found. However, providing resources without appropriate clinical and administrative support is unlikely to improve patient care.

1. Victorian Government Department of Human Services. Victoria — public hospitals policy and funding guidelines 2001/2002. Melbourne: Victorian Government Department of Human Services, 2001.
2. Therapeutic Guidelines Limited. Therapeutic guidelines: antibiotics. 10th ed. Melbourne: Therapeutic Guidelines Limited, 1998.
3. Therapeutic Guidelines Limited. Therapeutic guidelines: cardiovascular. 3rd ed. Melbourne: Therapeutic Guidelines Limited, 1999. □

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## SPHERE: A National Depression Project

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**TO THE EDITOR:** The recent supplement by Hickie et al looking at the mental health of Australians attending general practice<sup>1</sup> would have us believe that we are quite a mentally unwell nation indeed!

The authors propose a broad concept of “mental disorder” which they found in 49% of general practice attenders based on 12 questionnaire items (the SPHERE-12). These 12 items include six relating to psychiatric symptoms (PSYCH-6) and six relating to somatic symptoms (SOMA-6).<sup>2</sup> The SOMA-6 items are muscle pain after activity, needing to sleep longer, prolonged tiredness after activity, poor sleep, poor concentration, and tired muscles after activity. Patients with a total score of two or more in PSYCH-6 and/or three or more on SOMA-6 were classified as having a “mental disorder”.

Firstly, the SPHERE-12 is grossly oversensitive, as the six somatic items detect many medical conditions, glandular fever being just one example. Other validity issues include the two-week cut-off for symptoms (further adding to the overinclusiveness because of temporary distress and minor illnesses), and the lack of discussion regarding transcultural and inter-rater reliability, particularly with so many general practitioners involved.

Secondly, the authors' interchangeable use of neurasthenia and chronic

fatigue syndrome and somatisation needs discussion. Ten years ago, Hickie and several New South Wales physicians were dismissive of an article linking chronic fatigue syndrome and neurasthenia: "We have demonstrated immunological abnormalities in patients with chronic fatigue syndrome as compared with both normal controls and patients with major depression. Further, the demonstration of abnormal cytokine production in patients with chronic fatigue syndrome may underpin 'acquired neurasthenia'."<sup>3</sup> All the SOMA-6 items are key symptoms of chronic fatigue syndrome. With the overwhelming amount of biological data now available, purely psychological theories about chronic fatigue syndrome (as opposed to chronic fatigue) are totally untenable, as is the use of the term neurasthenia, introduced into medicine in 1869 and discarded by the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders*<sup>4</sup> as invalid.<sup>5</sup> A recent study from the Fatigue Clinic, King's College Hospital, UK,<sup>6</sup> found that an astonishing 68% of patients had been inappropriately misdiagnosed with a psychiatric illness. This is surely a warning for overzealous psychiatrists.

Thirdly, treatment implications are a concern. The authors comment that "only 27% of patients with *Level 1* disorders received pharmacological interventions" (*Level 1* implying positivity for PSYCH and SOMA items). They say that general practitioners mostly used "relatively ineffective non-pharmacological strategies", and that they had responded to missing all this "unmet need" by "criticising the oversensitivity of the screening instrument and inappropriateness of diagnostic systems used", implying an underprescribing of antidepressants. The recent National Survey of Mental Health and Well-being<sup>7</sup> showed that somewhere between two-thirds and a half of the 23% of the population diagnosed with psychiatric disorders did not visit their general practitioner. How does this fit in with the 49% found by Hickie et al?

In summary, the authors' broad and idiosyncratic conceptualisation of "mental disorder" and their use of a screening tool which labels many physically ill people with or without concurrent distress as cases of "mental disorder" implies that general practitioners need to prescribe more antidepressants — at what cost and for whose benefit?

For a longer version of this letter, contact the first author.

1. SPHERE: A National Depression Project. *Med J Aust* 2001; 175 (16 July Suppl): S1-S55.
2. Hickie I, Davenport T, Scott E, et al. Unmet need for recognition of common mental disorders in Australian

general practice. *Med J Aust* 2001; 175 (16 July Suppl): S18-S24.

3. Hickie I, Lloyd A, Wilson A, Wakefield D. Taking chronic fatigue syndrome seriously. *Am J Psychiatry* 1992; 149: 1755-1756.
4. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*, 4th ed (DSM-IV). Washington, DC: APA, 1994.
5. Phillips N. Response to prolonged fatigue, anxiety and depression: exploring relationships in a primary care sample [letter]. *Aust N Z J Psychiatry* 2000; 34: 692-694.
6. Deale A, Wessely S. Diagnosis of psychiatric disorder in clinical evaluation of chronic fatigue syndrome. *J Roy Soc Med* 2000; 93: 310-312.
7. Andrews G, Henderson S, Hall W. Prevalence, comorbidity, disability and service utilisation: an overview of the Australian National Mental Health Survey. *Br J Psychiatry* 2001; 178: 145-153. □

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**IN REPLY:** It is with great pleasure that we resume our ongoing correspondence with Phillips concerning the medical and psychological status of patients who present with non-specific somatic complaints such as chronic fatigue.<sup>1</sup> As we have reported previously,<sup>2</sup> we have been strong advocates of both the need to develop appropriate instruments for measuring neuropsychiatric states characterised by non-specific somatic symptoms and to promote effective medical and psychological management of patients with these disabling conditions.<sup>3</sup>

In their letter, Phillips and colleagues fail to grasp the essential issue. To describe a condition as a neuropsychiatric state (or mental disorder) does not necessarily lead to simplistic and entirely unhelpful assumptions about "medical" versus "psychological" causes or treatments. Phillips et al attempt to promote once again the notion of "biological" (ie, acceptable) versus "psychological" (ie, unacceptable) theories of the causation of chronic fatigue syndrome. Such an approach is not only intellectually sterile and inconsistent with the past decade of intensive research by a wide range of medical and psychological research teams,<sup>4</sup> but also profoundly unhelpful to people affected by these disabling disorders.<sup>5</sup>

In recent years, the very significant health burden of common mental disorders such as depression, anxiety, alcohol or other substance misuse, and neurasthenia (prolonged fatigue states lasting longer than three months) has been well documented in the Australian community<sup>5</sup> and in the primary care setting.<sup>6</sup> Phillips and colleagues appear to have no knowledge of the basic epidemiological fact that mental

disorders are two to three times more common in primary and other medical care settings than in community studies (hence the total rate of disorder in our study is about twice that detected in the Australian National Survey of Mental Health and Well-being). Contrary to their implications, the total rates reported in our general practice study are entirely consistent with the largest multinational study of primary care ever conducted.<sup>7</sup> That study indicated that a third of all primary care patients have mental disorders and another third have mental health difficulties (with or without concurrent medical disorders) requiring specific psychological assessment.

The significance of our study is that it has brought the extent of common mental health needs (including depression, anxiety, alcohol or other substance-misuse and somatoform disorders) to the attention of the Australian medical profession. What is now required is a concerted and integrated response — not a return to dualistic notions of illness that have for so long hampered the provision of effective pharmacological and non-pharmacological treatments to patients with mental disorders who present for medical care.

1. Phillips N. Response to "Prolonged fatigue, anxiety and depression: exploring relationships in a primary care sample" [letter]. *Aust N Z J Psychiatry* 2000; 34: 692-694.
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## EBM in action: Is laser treatment effective and safe for musculoskeletal pain?

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**TO THE EDITOR:** The EBM in Action article on laser treatment by Del Mar et al<sup>1</sup> raises my anxiety about the reliability of evidence-based medicine (EBM) in general and, at the very least, the authors' assessment of the question they set out to answer. One is seldom, if ever, in a position