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CORRESPONDENCE

To the Editor:

Dowrick *et al*. found no relationship between the scores on the Depression Attitude Questionnaire and GPs' ability to identify depressed individuals in the surgery (Dowrick *et al*. **30**, 413–419). They concluded that the ability of GPs to identify depression was probably not an independent variable, but reflected other beliefs, attitudes and skills.

In a similar study in Hampshire, 60 practices were randomized to receive either a 4 h educational intervention on recognizing depression with expert follow-up or no intervention and 21409 consecutive patients were screened by researchers in the waiting room, of whom 4192 were classified as depressed by the HAD scale (Thompson *et al*. 2000). No differences were found in recognition rates between intervention and control groups.

Prior to the intervention, 147 GPs completed the DAQ. The DAQ scores were internally divided into tertiles (low, medium and high agreement with the statement). These were then related to sensitivity of recognition (percentage of GPs scoring mildly, moderately or severely depressed among subjects with HAD-D score $\geqslant 8$), and specificity of recognition (percentage of GPs scoring no depression or subclinical depression among subjects with HAD-D score $\leqslant 7$). For each of the 22 DAQ variables, the three tertiles were compared for both sensitivity and specificity, making 132 statistical comparisons in total, each of which was expressed as an odds ratio with associated 95% confidence interval. The confidence interval excluded 1·0 or had 1·0 on the boundary in only six cases (4·5%). This is less than would be anticipated by chance. Furthermore, for those comparisons that did achieve significance, a linear trend from low to high tertiles was not demonstrated.

Like Dowrick *et al*. we also conclude that DAQ measurement is not helpful in predicting doctors' ability to recognize depression.

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