those with more severe depression, due to the inaccuracy of practitioner clinical assessment of severity when compared to the HAD-D.[2] In the previous study more than 40% of antidepressants were offered to patients with sub-threshold scores compared to around 13% in this study. Measuring severity therefore does seem to improve the targeting of GP antidepressant treatment, which is the aim of the quality indicator.

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Competing interests

TK has received fees for speaking at educational events from Pfizer, Lilly, Wyeth and Lundbeck pharmaceuticals. He was a member of the expert advisory group on the mental health indicators for the 2005 Quality and Outcome Framework. He is Chief Investigator on a successful application for pharmaceutical company funding for a larger study of changes in the treatment of depression following the introduction of the severity indicators.

Privatising primary care

At last an article[1] in the *BJGP* reflecting the concerns of a large number of GPs. How can we stop the current politics? How can we move away from the needs for points towards the needs of patients? How can we spend more time in patient care and less in practice-based commissioning? Thanks again for publishing this leading article. Lets hope it is read by PCT chiefs, politicians and a pang of conscience is raised in the pro-marketeers.

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Should I go or should I stay?

Having been an NHS GP for 16 years, nowadays two things go through my mind every day I am in my practice:

- How to take the line of least resistance to get to the end of the day;
- How do I continue to engineer my career to reduce my frontline GP work (having already succeeded in reducing it to half time over the last few years, while being able to pay the mortgage).

It has been said that GPs become GPs rather than specialists because of their independence of spirit. This tendency has become an increasing problem as we move further and further towards being micromanaged to the point of absurdity. The control freakery, lurking in the background for some years, has reached new heights with the new contract.

The tipping point for me has been intrusive interference in that central facet of general practice, which is the consultation. This is largely due to the QOF requirements. Still, the pragmatic GP tries to make it work, trusting the no doubt wholly admirable intentions of those who come up with the formulae for 'good practise'. But making it work is often in the form of a 'work around' a system that is too complex and intrusive. Hands up those who have entered a systolic measured at 152 as 148 in the patient record, and then entered the code for the absurd 'Mental Health Review' while they are at it (it is unlikely anyone will actually check, isn't it?). Most of us just get on with it, because it pays the mortgage and we want to have a life rather than spend our lives at focus group meetings or conferences, or giving constant feedback to anybody who demands it.

Surely the time has come for us, the 'ordinary GPs' to demand a re-evaluation of the principles underlying the QOF, unless of course all the potential non-compliant doctors have already left the NHS? Is QOF likely to actually improve the quality of overall holistic care of patients, or just the quality of electronic coding to further its abilities as a management control tool, with annual incremental tightening of the screws?

Like most things in general practice one needs to try and get a feel for the potential benefits versus harms of the new contract. I don't see how the quality of the consultation is not being harmed by the present set up, but this is a lot more difficult to measure than checking for the right codes. In my view we need to find a way of trusting GPs with the freedom to do their job without constant interference, particularly if a robust system for individual revalidation is introduced. I won't mind if some computer nerd taps into my system as often as he wants and does all the interrogation he needs to do in order to test out the quality credentials of my work. Let these people do what they have to do, but please stop interfering with the area of my expertise.

I still have one foot in general practice, I am not sure that it will still be there in 10 years time. All I can say for now is thank goodness for the patients, and the observations and vitality of medical students and registrars who still have some room to think, and can see that there are always novel and alternative solutions to any problem. But I feel sorry for young GPs who will have no chance to work in an environment that allows for 'discovery', because everything is prescribed. For my generation of GPs I believe the zenith for general practice was reached when we were able to create novel solutions with fundholding and the out-of-hours revolution. It has now all gone sour.

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Euthanasia abroad

Rhona Knight[1] forms an interesting hypothesis in her letter and I think her opening point answers the question in her final paragraph. I would like to further the perspectives on this debate, the arguments about which do not seem to have progressed for decades. The point being that this country already condones assisted suicide. In that it allows patients

to be taken,[2] aided and abetted dare I say, to Switzerland where the distressed patient is helped to commit suicide. Now, whether you prefer to sit on the fence or shout from the other side, this activity continues and hardly provides a compassionate backdrop to the debate. Part of the call for a change in the law is to allow some of these people the satisfaction of dying in their own beds rather than in a shabby apartment abroad.[3]

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Living wills to provide a legal 'indication'

Diana Pasterfield[1] underlines that there is significant debate regarding euthanasia and living will in Europe. A recent questionnaire conducted in Wales indicates that a majority of GP responders did not favour a change in the law to involve them more in physician-assisted suicide and euthanasia.

Considering possible bias in the questionnaire, the authors included different respective views of many issues surrounding the nature and extent of potential procedures.

In Italy, a recent national survey managed by Adnkronos Health[2] indicates that GPs ask for legal initiatives in order to fix the terms and rules to help them decide if and when to act. This is also to stop 'hidden euthanasia' being carried out in many health facilities.

From this national survey on hospital doctors and GPs, 32% were in favour of euthanasia, 39% were in favour only when the situation is irreversible, but a majority were against an active role, with 39% in favour of living wills. So, we can see that the physicians are open to the problem, but with some apparent reservations, meaning that doctors are against an active role as doctors, but in favour when a clear and realistic wish is expressed in a will by a patient.

In this sense, the debate in Italy is now transferring to the real possibility for people to leave, when they are still fit and well, a living will registered by a lawyer, that considers very serious irreversible cerebral conditions, so that doctors could withdraw healing treatments when the clinical situation persists.

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NICE guidelines on antidepressants

In December 2004 NICE issued clinical guidelines regarding depression. These included restrictions on venlafaxine with baseline ECGs and prescribing by specialists only recommended. This was based on unpublished data regarding the cardiac effects of the drug and concerns of toxicity in overdose.

On 31 May 2006, MHRA released a statement following an appeal against the restrictions by the manufacturer, Wyeth. This conceded that baseline ECGs are unnecessary for most patients. Further, MHRA accepted data showing that venlafaxine is more likely than SSRIs to be prescribed to patients at risk of suicide. This leads to an increase in the 'fatal toxicity index' (deaths per million prescriptions) for the drug. The absolute risk of toxicity of venlafaxine is probably still higher than for SSRIs, though is far less than the risk from overdose with amitriptyline or dosulepin (dothiepin). MHRA concluded that venlafaxine was an appropriate second-line antidepressant (after an SSRI), and that it can be prescribed by non-specialists in doses less than 300 mg per day.

The original NICE recommendations have had a profound impact. We have examined antidepressant prescribing in three general practices in the North East of England (combined population: 23 217), both immediately before and 6 months after publication of the NICE guidelines. All patients newly prescribed an antidepressant in 3-month periods were identified (764 and 780) and their case notes screened to identify those with depression and/or anxiety. Prescribing of SSRIs significantly increased from 46.5% to 59.4% of patients ($P<0.001$). However, the proportion prescribed venlafaxine fell from 7.3% to 1.0% ($P<0.05$). This does not simply reflect practices who assiduously implement NICE guidance. Prescribing of dosulepin, which NICE also recommended for specialist use only, remained unchanged (3.7 versus 3.2%).

Our data raises concerns regarding the impact of NICE guidelines. Recommendations that are contentious and widely discussed, and followed up by industry as was the case with venlafaxine, lead to major changes in practice. However, recommendations that are not widely publicised, such as those regarding dosulepin, can easily get overlooked (especially when the name of the drug has changed). The major concern is that while the confusion over venlafaxine has been resolved, the most toxic of the commonly prescribed antidepressants, dosulepin, continues to be prescribed unchecked. There needs to be a concerted effort by all trust medicines management bodies towards reducing the small but significant numbers of patients prescribed dosulepin to prevent unnecessary deaths.

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