

papers on aspects of QOF in the June issue of *BJGP*. Their criticisms of QOF make sense from a deontological (duty based) ethical perspective. It is far from clear that medicine is a deontological enterprise any longer.

There is a strong utilitarian perspective on QOF that sees the greatest good of the greatest number of patients as being a worthwhile objective. If this good can be measured then so much the better. (The *felicitific calculus* is achieved.) Outcome measures would be ideal but intermediate process measures will do well enough. 'Scientific' measurements have apparently been made, and managers have 'accurate' spreadsheets and reports. Politicians can show that their targets have been met and that their 'investment' has 'performed' well. Individual GPs can play along with this game and reap the profits from it. So too can pharmaceutical companies, as under-treated illnesses and risk factors are systematically discovered and treated. It can all be justified as there is no shortage of under-treated disease and the rule of halves is so obviously a challenge that needs to be tackled.

General practice to this view is 'Applied Public Health', and the quirkiness of individual doctor-patient interactions is all very well, but ultimately stopping patients from smoking, and getting their cholesterol, blood pressure, and glucose levels normal is more important than the messy details of patient's lives. The patient becomes a means to a public-health goal, not an autonomous individual with their own specific goals. The doctor loses autonomy, and has to document deviance from guidance, rather than being trusted to do what is right in a given situation. Tallis describes this as 'sessional functionaries robotically following guidelines.'

This utilitarian imperative is in alignment with public health and political imperatives but is directly at odds with a model of medicine based on individual doctors and patients reaching shared understanding of life, events, times, and illness.<sup>2</sup> The ideals of patient-centred care, good consultation skills, respect for patient autonomy, the patient as an end in themselves, the doctor as a responsible agent, are all lost to this utilitarian mission. Much of the best general practice work of the last 30 years is

rendered impotent under the new contract.<sup>3,4</sup>

The new contract is a reflection of the democratic deficit and the loss of trust in British medicine. Instead of trusting professionals to do their jobs properly we have now lost toleration for error, and instead we are subjected to the external tyrannies of measurement and regulation.

Goodhart's Law is in full flow. In time the measures used for QOF will cease to measure anything. However, for now the utilitarians are in the ascendant, and as a GP I will use my QOF score to get through appraisals and revalidation, and to earn some money. It is quite clear that I will get next to no credit or recognition for doing real general practice well.

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The editorial by Mangin and Toop,<sup>1</sup> describes how the QOF has made British GPs into government data collectors and agents of pharmaceutical companies. QOF does not measure our clinical skills or kindness: there are no points for recognising rare diseases at an early stage or in giving sympathy. In medicine, despite all our cleverest scientific advances, all we can do is to influence the process, not the eventual outcome of life, which has an inevitable 100% mortality. A significant part of our role must be to help our patients live their lives to the full. Instead we have made many obsessed with numbers, which they have come to regard as the keys to happiness and eternal life, not realising that what we measure are merely fluctuating bio-statistics. To retain the enormous confidence invested in us by our patients, it is imperative that we keep our critical and clinical skills, honed by our professional training, and use them to the benefit of our patients to provide the best advice and

medical care we can in the interest of their individual wellbeing. This surely is the real value of general practice and the art of being a healer.

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## Confidentiality on ward rounds

I have a little anecdote relating to 'Confidentiality in the Waiting Room' by Scott, *et al.*<sup>1</sup> I myself call patients into my consulting room using first and last names. The person who responds is not always who I called, so I often ask them to confirm their address or DOB once they are in. While this is not very confidential, I am not aware of any specific complaints from the patients as yet, and I know of no better way to get them in at the right time, apart from 'Next please', and then having to ask them who they are.

However, I remember a ward round in a certain hospital once, where the usual entourage started the round at bed one: consultant, junior doctors (two), myself the student, ward sister and two nurses. The patients were all lying tidily in or on their beds in regimented readiness. One of the patients in the first bay was unable to walk, due to having a 'drip', and therefore having been tied down, but by the time we got to the fourth bed in the second bay, the 'entourage' had been augmented by the first six mobile patients. As we left the bay and moved towards the double doors that separated the men from the female end of the ward, all six dutifully returned to their own beds, and the two male nurses went to attend to the bedridden patient.

The same happened in the female ward, except that the only males present were the medical staff, of course.

I suppose it was not terribly good for confidentiality, but it did mean that the other patients on the ward knew exactly what was wrong with their neighbours, (due to various nationalities of the staff, the

explanation was available in at least two languages), and the mobile ones were able to correctly interpret untoward signs and help in the care of the less mobile.

I understand that neither staff nor patients were expected to speak outside of the hospital regarding the medical conditions of others, and perhaps therein lies the difference. We might not need confidentiality if we could trust everyone to mind their own business.

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## Depression as chronic disease

Whether they intend it or not, Walters and Tylee's<sup>1</sup> argument that depression needs a chronic disease model (CDM), conjures up a vision of another contractual recall of patients in order to go through an exercise in superficial questioning and box ticking.

What Chew Graham *et al.*<sup>2</sup> and others cited by the authors, studied is better thought of in the UK as a collaborative care model, in which intensive (5–10 sessions) personal care is offered over months (but not the years that the CDM implies). Such successful models typically offer choices to patients of drug and non-drug treatments, such as problem solving which are at odds with the simple biomedical conceptualisation of depression as a brain disorder, but harder to deliver with limited resources.

Walters and Tylee point out the failure of current methods of treatment for depression, yet imply that more or greater intensity of the same is required. Given the relatively poor response to antidepressants over placebo, it is difficult to see how more (medical management) could be better in the context of primary care defined depressive disorders.

Depression is not the same as diabetes or asthma, in terms of its daily impact and the personal and social implications of the

diagnosis. One of us has demonstrated the moral dilemma facing women in accepting help for depression, and in particular shown that in order to be acceptable, such interventions needed to be seen as short term and temporary.<sup>3</sup>

Patients with difficult lives meeting current conceptualisations of depression may well benefit from longitudinal care, but as Heath points out, human continuity easily becomes lost when medicine adopts disease based management.<sup>4</sup> Such a de-humanising approach is in direct opposition to the approach expressed in Chew Graham's study: to 're-humanise' people with depression.

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## Handshakes and dubious editing

You don't seem to have a 'quick response' section on your website, which is a bit of a shame as, although a rare contributor, I did feel the need of such a facility on reading the letter from Gary Parkes<sup>2</sup> and your subsequent Editorial comment. Don't you think there is a bit of a danger of taking yourselves FAR too seriously? In more blunt Yorkshire terms, you all seem to be in danger of disappearing up your own backsides.

I tolerate the *BJGP*, despite its overwhelming greyness, although I often wonder why. That letter from Dr Jenkins<sup>1</sup>

was an unusual shaft of light illuminating the gloom, and making more sense than the most of the rest of the Journal put together. The perception seemed valid to me, representing one of those rewarding aspects of general practice that still happen occasionally even after almost 30 years, and worthy of comment. Whimsical perhaps, but nevertheless appropriate for some light-hearted (but never-the-less valuable) research.

I think that both Dr Parkes' letter and your rather lily-livered response could be actually quite hurtful to Dr Jenkins, if he makes the mistake of taking either seriously. A bit more real general practice such as humanity and humour, and less of this 'informed consent' and 'ethics committee' nonsense would not go amiss. To use words like 'fraud', 'deceive', 'insulting' and 'arrogant' is way over the top. It does make me wonder how many handshakes Dr Parkes gets, or whether he is just content to go home each night with a general feeling of self-satisfied smugness for putting another colleague (or even patient) well and truly in their place ...

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The *BJGP*'s discussion forum is available for immediate comment on the *BJGP* or other relevant topics at [www.rcgp.org.uk/bjgp](http://www.rcgp.org.uk/bjgp)

## Correction

In the letter by Campbell M and Freeman JV. Survival statistics. *Br J Gen Pract* 2007; **57**: 410. The author JV Freeman was incorrectly named as John. The author's name is Jenny V Freeman. In the article Bartholomeeusen S, Vandenbroucke J, Truysers C, Buntinx F. Time trends in the incidence of peptic ulcers and oesophagitis between 1994 and 2003. *Br J Gen Pract* 2007; **57**: 497–499. The author C Truysers was incorrectly named as Carl. The author's name is Carla Truysers.

The corrected versions are available online at [www.rcgp.org.uk/bjgp/](http://www.rcgp.org.uk/bjgp/)