

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 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.*,² 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.³

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.⁴ 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 Parkes² 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 Jenkins¹

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

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, Truyers 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 Truyers was incorrectly named as Carl. The author's name is Carla Truyers.

The corrected versions are available online at www.rcgp.org.uk/bjgp/