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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Confidentiality in the waiting room: an observational

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., 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.2

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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management model for depression in primary care. Br J
randomised controlled trial to test the feasibility of a
collaborative care model for the management of
depression in older people. Br J Gen Pract 2007; 57:
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3. Maxwell M. Women’s and doctors’ accounts of their
experiences of depression in primary care: the influence
of social and moral reasoning on patients’ and doctors’
4. Heath I, Nessa J. Objectification of physicians and loss of

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 Parkes1 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’
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-ivered 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’, ‘deceit’,
‘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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2. Parkes G. Handshakes and spoof publications. Br J Gen

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.
The author JV Freeman was incorrectly named as
John. The author’s name is Jenny V Freeman.
In the article Bartholomeeusen S, Vandebrouke
J, Truyers C, Buntinx F. Time trends in the
incidence of peptic ulcers and oesophagitis
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/