

statements in your journal. I think there is a lack of editorial appreciation of the work that many GP commissioners are doing. We are not all entrepreneurial market-driven Tory radicals; in contrast, the ones I work with just want to make things better for patients and to limit the domination of hospital care. If we are to retain and even enhance the traditional GP role closer to that identified in Iona Heath's Harveian Oration,¹ we need to work hard at transferring resource from secondary care into primary care.

Carolyn Chew-Graham *et al* expressed concern that 'the continued downward pressure on referrals to specialist services may mean that access to best treatments will be limited for patients whose health needs are as significant and complex as those patients with diabetes'.²

Reports from the King's Fund back up the experience across the country, that many referrals from GPs to secondary care reflect an assumption that secondary care management of risk through investigation is preferable to taking the risk on ourselves and trying to prevent the transfer from illness to disease.^{3,4}

We are trying to make sure that patients with illnesses like psoriasis are able to be seen more quickly than they can at present, as many outpatient clinics are clogged up with people who didn't need to be there in the first place, are being seen for too long, and where their care is not being shared between the GP practice and specialists. We have successfully transferred many patients with type 2 diabetes from hospital to primary care, assisted by diabetes specialist nurses, with agreement from consultant diabetologists.

GPs have to accept patients back from hospital care; they are the doctors who can help patients make sense of either their symptoms, illness, or disease, with as little harmful intervention as possible, and can manage all of their problems, not just one. And hopefully with kindness.

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REFERENCES

1. Heath I. *Divided we fail: The Harveian Oration 2011*. London: Royal College of Physicians, 2011.
2. Cordingley L, Nelson PA, Griffiths CEM, Chew-Graham C. Beyond skin: the need for a new

approach to the management of psoriasis in primary care. *Br J Gen Pract* 2012; **62**(604): 568–569.

3. Foot C, Naylor C, Imison C. *The quality of GP diagnosis and referral*. London: The King's Fund, 2010.
4. Imison C, Naylor C. *Referral management — lessons for success*. London: The King's Fund, 2010.

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A rock and a hard place

I could not welcome the Schizophrenia Commission's report, published today, more.¹

I am a section 12 approved retired GP. I have decided that I no longer wish to assess patients as to whether they should be detained against their will. The majority of assessments I am asked to do are for 28 days of assessment. My experience is that due to bed cuts, a local bed is very often not available. The patient therefore starts his or her assessment far from home. There then seems to be a low threshold for transfer to a secure unit, then transfer to a more local bed follows.² As a result the patient, often suffering from schizophrenia, is looked after on a temporary basis by several psychiatric teams none of which seem to be making a full assessment. I will be asked to see someone towards the end of this 28-day period and no member of staff can tell me their 'story', stating as a reason that the patient has only recently arrived.

If a patient is not to be detained, reliance has to be placed on the crisis teams. Patients often do not engage with these community-based teams, complaining that they see a different member of the team on each visit and resent having to start their painful story from the beginning each time.² There seems to be a lack of engagement from the crisis team's side too, claiming as a reason that the patient doesn't really want to see them.

I have therefore been left choosing between a rock and a hard place.

Inpatient units are far from satisfactory, but it is important that they should be improved rather than cut, hopefully enabling them to offer the 'good care delivered by kindly, compassionate practitioners' referred to in the report, and to look after more disturbed patients rather than sending them to secure units. Secure beds could therefore be reduced

as the report suggests but the current general adult psychiatric bed shortages are part of the problem.

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REFERENCES

1. The Schizophrenia Commission. *The abandoned illness: a report from the Schizophrenia Commission*. London: Rethink Mental Illness, 2012.
2. Lodge G. How did we let it come to this? A plea for the principle of continuity of care. *Psychiatrist* 2012; **36**: 361–363.

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Are we medicalising normal experience?

Sometimes in clinical practice the most difficult thing is to do nothing. As a grizzled old professor of mine used to say, 'Less is more'.

There is a real danger that as gatekeepers to the 'sick role', we can be pressured into labelling people with diagnoses that are unnecessary and downright harmful. In my role as both a psychiatrist and a practising GP, I am increasingly seeing colleagues in both disciplines labelling normal life experiences as mental illness. They then appear to peddle the hope that a tablet (often an antidepressant) will sort out the patient's alcoholic husband and noisy neighbours.

Should we be reconceiving normal human experiences as being in need of medical intervention?

DSM-5 is due out next year. For those of you who are unaware, this is the American Psychiatric Association's standard reference work on mental disorders; the Diagnostic and Statistical Manual (DSM). There is a lot of money riding on it.

If it isn't in DSM then the insurance companies generally won't pay for treatment of it. We tend to follow the lead of the Americans and when the ICD-11 (International Classification of Diseases) is revamped in 2015 they will look to the DSM for ideas.

It is widely expected that the diagnostic net will be cast even wider, with bereavement for as little as 2 weeks being labelled as clinical depression. When will