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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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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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

we come to our senses and see this for the lie that it is?

Let me take this opportunity to encourage you not to be afraid to inform a patient when appropriate, that you can acknowledge that they have difficulties in life but that it is not a mental illness.

Frederick II, King of Prussia is supposed to have shouted to his men as he led them into battle:

'What's wrong, you dogs! Do you want to live forever?'

I have little doubt that had he been a doctor he would not have over diagnosed mental illness.

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Depersonalisation in GPs

We thank the Editor and Dale and Old[1] for commissioning and writing an interesting commentary on our research on depersonalistion as a form of burnout in GPs.

Given that we received the biggest number of completed Maslach Inventories so far reported (564 GPs, with 42% depersonalised), we agree the findings merit serious attention. Their practical suggestions, such as making time for a weekly lunch between colleagues, in our experience, work well.

We, too, are interested in the finding that females suffered less depersonalisation and agree females may have much to contribute to considering responses. However, we are cautious about this finding since, as we stated, we did not have data on part-time working. We suspect that part-time working (much more common in females) may be protective against burnout.

We think it is very helpful that Dale and Old distinguish between depersonalisation as we used it (as defined by the Maslach Inventory) and the psychiatric state they describe. Although doctors may lose insight when depersonalised, our new finding was that they still maintain a professional face, so that patients answering questionnaires, did not perceive the depersonalised doctors as being different from other doctors.

We do not agree that a degree of depersonalisation (cynical feelings towards patients) is necessary. Maintaining a safe emotional distance is a skill GPs need to learn, but not at the cost of cynicism. As they write, our results show that most GPs achieve it.

Dale and Old undervalue doctors consulting GPs for stress. The two of us who are experienced GPs (PO and DPG) have both had the privilege of being consulted by several fellow doctors over many years. Doctors as patients do indeed have special difficulties, but with clear agreements, ground rules on privacy, adequate time, and personal care with continuity. We believe valuable support and treatment can be and often is provided for consultants and GPs within general practice. Indeed, this may be the optimal setting for care.

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Corrections

Table 1 headings were incorrectly published in an article from the June issue of the journal: Francis, *et al.* Antibiotics for acute cough: an international observational study of patient adherence in primary care. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X649124. The column headings from left to right should read: 'Network', 'Number of participants', 'Number prescribed antibiotics (for immediate use)', 'Initiated antibiotics (consumed at least 1 day)', 'Adhered to at least a 3-day course of antibiotics', 'Adhered to full prescribed antibiotic course', 'Consumed an antibiotic at any point during study follow period'. Data below these headings are in the correct order but do not match with the incorrect column headings. We apologise for these errors.

DOI: 10.3399/bjgp13X659609

An error was made in the Figure 2 legend of an article published in the September 2012 issue: Francis *et al.* Delayed antibiotic prescribing and associated antibiotic consumption in adults with acute cough. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X654614. The green section of the legend should have stated: 'Prescribed antibiotics for delayed use and no antibiotics consumed during the study period', and blue should be, 'Prescribed antibiotics for delayed use and consumed prescribed antibiotics during the study period'. We apologise for this error.

DOI: 10.3399/bjgp13X659618

Results were shown incorrectly in the abstract and Results section of the article by Mugunthan *et al.* Minimal interventions to decrease long-term use of benzodiazepines in primary care: a systematic review and meta-analysis. *Br J Gen Pract* 2011; 10.3399/bjgp11X593857. Findings in the abstract were (2.1, 95% confidence interval [CI] = 1.5 to 2.9, whereas these should have been: 2.04, 95% confidence interval [CI] = 1.5 to 2.8. And in the Results section it stated: 2.3 (95% CI = 1.3 to 4.2, P = 0.003), but should have read: 2.3 (95% CI = 1.3 to 4.2, P = 0.008). We apologise for these errors.

DOI: 10.3399/bjgp13X660715

Author affiliations were incorrectly shown in the December 2012 article: Middlemass *et al.* Integrating online communities and social networks with computerised treatment for insomnia: a qualitative study. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X659321. The affiliation for Jo Middlemass was listed as School of Sport, Exercise & Pre-Hospital Health Care, University of Lincoln, Lincoln, whereas it should have been Lincoln School of Health and Social Care, University of Lincoln, Lincoln; Kevin Morgan was listed at School of Sport, Exercise & Pre-Hospital Health Care, University of Lincoln, Lincoln but should have been School of Sport, Exercise and Health Sciences, Loughborough University, Loughborough; and A Niroshan Siriwardena was listed at School of Sport, Exercise & Pre-Hospital Health Care, University of Lincoln, Lincoln, but this should have been Lincoln School of Health and Social Care, University of Lincoln, Lincoln. We apologise for these errors.

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