Letters

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Multimorbidity and GP burnout

This important paper by Pederson and colleagues provides evidence of a relationship between GP burnout and patient multimorbidity in practices in Denmark.[1] This relationship was significant in unadjusted analysis, but disappeared when adjusted for patient age and sex, leading the authors to conclude that the burden of multimorbidity of older patients added to 'actual work pressure'. This conclusion, if correct, means that practices with older patients have greater work pressure, and GPs in such practices will be at greater risk of burnout.

Before such a conclusion can be reached, there are critical points to consider. It is established that multimorbidity is more common and occurs at an earlier age in deprived areas in high-income countries,[2,3] including Denmark.[4] A previous study by the same group showed higher burnout in GPs working in deprived areas.[5] These studies seem incompatible with the current findings.

The answer is likely to lie in how multimorbidity was defined and measured in this study. Multimorbidity was operationalised as two or more physical chronic conditions, as recorded in secondary care data. Such a definition will have two effects: to underestimate the true prevalence of multimorbidity in primary care and to exclude the contribution that mental health conditions make to multimorbidity (usually defined as two or more mental and/or physical conditions).

Our conjecture is that the management of mental–physical multimorbidity is more challenging than physical multimorbidity, especially if physical conditions are concordant. In our previous work, the common physical conditions in those with multimorbidity aged >75 years were all concordant: hypertension, coronary heart disease, chronic kidney disease, diabetes, and stroke.[6] In deprived areas, where patients are younger, the common physical morbidities are discordant (chronic pain, asthma, hypertension).[6] The combination of discordant physical conditions, a range of mental illnesses (for example, addiction, depression),[6] and the social problems that patients present in deprived areas[7] demands a holistic generalist response and has been shown to lead to increased GP stress.[7] It is essential that this is fully taken into account before reaching conclusions around the relationship of GP burnout to multimorbidity.

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Mental health in diabetes: can't afford to address the service gaps or can't afford not to?

I must admit that when the *BJGP* arrived, and I started this article,[1] I became cross and didn't finish it. The paper version was of course recycled. But, a couple of patients whose issues piqued my curiosity in the first place brought me back to it online. It still irked and then a throwaway comment in the final paragraph seemed to suggest, 'well all right then'.

I have no issues at all with the service described here but I think that final comment has things back to front. Yes, complex mental health issues in diabetes are an unmet need. Yes, this deserves to be funded properly. However, what is needed is not a diabetes-focused, or even long-term-condition-focused, mental health service. What is needed and has been for a very long time (I've been a doctor for 34 years, a GP for 27 of those, and I can't remember a time when mental health was adequately provided for) is a comprehensive, flexible mental health service.

If such were available, then I wouldn't have to fight for every single child or young person referral to be accepted and Adverse Childhood Episodes would be better managed. If such were available, then all of my patients with long-term conditions would get the support they need to optimise their management. For far too long the mind–body (false) dichotomy has failed to grasp the interdependence of physical and mental wellbeing. Funding is indeed needed in a sustainable fashion for mental health

services and not just for people with diabetes.

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The relevance of mobile applications helping in doctor–patient relationships

Smartphone applications are becoming a major part of 21st-century doctor–patient relationships.[1] Medical follow-ups that constantly monitor their health are extremely important for people with chronic conditions. These patients are more likely to develop additional symptoms, physical or mental, which will result in more visits to their GPs and unnecessary medical examinations. Or other patients with chronic illness might miss or neglect early symptoms of relapse as they rely too much on the routine of taking the same medications and going for only scheduled check-ups. For checking physiological data, 'logging applications' might prove useful because one's calorie intake, lifestyle, and activity can be monitored. However, these apps give relatively little and limited feedback to the users. Also, patients can only notify their physician in person if a problem occurs according to these applications.

To solve this problem, some new software is currently being tested and developed in Hungary that will help GPs and patients communicate more efficiently, and eventually it will be available for the whole population (NetDoktor, https://www.netdoktor.hu). The patients can call their doctor through the application, send their examination results right after receiving them, easily make an appointment, or pay medical bills. Moreover, the GP will see all the patient's prescriptions and the exact time the medicine was purchased, and can send reminders of an upcoming appointment. A fixed appointment will also appear on both parties' calendars. The patient's profile can be connected to an online database, where GPs can upload prescriptions using their digital signature. These are accessible to pharmacies, so patients can purchase their medicine easily. This process is meant to simplify health care by minimising face-to-face consultation between patients and GPs. The application is not only tested by healthcare professionals but by carefully chosen patients too, who are expected to give valuable feedback and ideas to improve this new system during the experimental period. To sum up, this innovation should be received positively as it's not only making health care more convenient and easier to use but will also improve compliance and adherence, and optimise persistence.

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Amending WONCA's P4 definition: the cure has been worse than the disease

We appreciate Martins *et al*'s effort to present an amendment to WONCA's P4 (quaternary prevention) definition. However, there are some problems with their approach. First, we found it problematic to state that *'demedicalisation is often not a science-based concept'*. Dating back to the 1960s and 1970s (for example, Ivan Illich's *Medical Nemesis* — 1974) there is an enormous amount of academic and scientific evidence on the political and social implication of medicalising human experience. Second, it is a mistake to assert that P4's new definition is *'more than demedicalisation'* since it diminishes the scope of P4 by getting rid of the scientific concept of medicalisation. Apart from individual clinical harms, there are social and cultural iatrogenies, which are characterised by humans' impoverishment in dealing with life's inherent crises. This generates excessive dependence on, and demands for, medical interventions for almost all human hindrances. Third, evidence-based medicine (EBM) is presented as the only valid paradigm. Unfortunately, EBM is not a neutral phenomenon, but a socially constructed approach to authority over medical knowledge.

There are vested interests in biomedical research, and its agenda is value laden. EBM deals, in general, with monodisease scenarios, excluding complex and multimorbid patients from clinical trials. In complex cases, the realm of P3 and P4 (as in medically unexplained symptoms), polypharmacy tends to be the norm. They need careful assessment by GPs. Fourth, the 'new definition' drops Jamoulle's insight on the origin of P4. P4 was born by highlighting a particular group of patients: those who feel unwell, but have no disease, which includes mental health problems. The latter needs a new understanding that surpasses the EBM paradigm, but includes the philosophical, sociological, and anthropological perspectives. Finally, GPs have to expand what counts as medical interventions. Thus, Martins *et al*'s proposal seems to portray that the 'cure has been worse than the disease'! Not all GPs' activities can be evaluated by 'EBM paradigm'; in fact, most of them cannot. Therefore, WONCA's P4 definition requires clinicians to reflect upon what sort of lens (the clinical gaze) they are using in order to constrain biomedical jurisdiction and to protect patients from being medicalised.

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