Letters

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Revalidation

Greenhalgh and Wong's editorial[1] on revalidation is timely and important. I have just completed a so-called 'Strengthened Medical Appraisal' or SMA, and found the experience not only infuriatingly clumsy in terms of its online functionality, but pathetically irrelevant to my own sense of what it is to be, I hope, an adequate GP. And, just as Greenhalgh and Wong foresee, the requirement for this annual exercise is very likely to dissuade me from continuing in practice part-time following my retirement in May.

At the heart of the appraisal process is the matching of 'supporting information' to 12 'attributes' clustered into four 'domains', the idea being that by filling in all the gaps over the 5-year revalidation cycle one thereby demonstrates oneself to be a fully-rounded and competent practitioner. Each year the 'personal development plan' is designed to fill in the missing gaps, while conscientious 'reflection' serves to consolidate the learning process. The problem, for me at least, is that this approach bears absolutely no relation to how I have spent my past quarter-century.

I believe myself to have internalised professional standards, imbued through training and subsequent experience, that I would find difficult to put into words (although I did try a few years ago[2]), but whose maintenance is a matter of personal pride. I expect to be judged by colleagues and patients, and like to think that I am aware of my shortcomings. As for my professional development, I have pursued various interests down the years, including a spell as a trainer, but rarely have I had a clear plan; chance and opportunity have played a greater part.

By all means let us build audit, significant event monitoring, and some form of feedback into our practice organisation; and let us admit that a regular objective test of our knowledge-base should be a requirement to continue in practice. But let's not allow ourselves to be cowed into the bureaucratic, prescriptive, painting-by-number exercise that is currently being foisted on us.

I cannot resist ending by pointing out that SMA is also the name of an infant formula. Coincidence or rich irony?

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DOI: 10.3399/bjgp11X572319

Trainees working in psychiatry

We welcome the attention to psychiatric training for future GPs, that seems important when there is still no requirement for trainees to undertake these placements.

However, we are concerned that the advice by Burkes *et al*[1] focuses too much on the minutiae and risks missing the real skills that they may need for a career in general practice. These include:

- To understand that the specific health needs of those with severe and enduring mental illness. This group has poor health outcomes exacerbated by lifestyle choices and the same medication that contributes to the improvement in their mental health.[2] There is a need to develop ways to tackle this major issue by working in partnership with secondary mental health care.
- To develop skills in assessing risk effectively in a short period of time, knowing when to continue to manage situations in a primary care setting, and when to involve mental health services.
- After a number of years of specialisation of mental health services, the awareness and understanding of the care pathways, and interlinking of different teams is vital knowledge.
- Mental health, perhaps uniquely among other medical specialties, offers trainees a chance to work in truly multidisciplinary services when medical knowledge is counterbalanced and enhanced by other professions and their expertise.

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DOI: 10.3399/bjgp11X572328

Questionnaire severity measures for depression

The paper by Leydon *et al* illustrates the continuing tension between two important elements of generalism: the biotechnical (use of the measures PHQ9 or HAD-D introduced as part of QOF) that the authors refer to as 'hard technology', and the biographical (a narrative-based approach to diagnosis, based on the patient's context) referred to as 'soft technology'.

Concern about the current extent of the contractual focus on QOF, and its potential to undermine the strength and complexity of the doctor–patient relationship, that supports quality at a deeper level, was one of the drivers behind the 'Essence of General Practice' project led by RCGP Scotland. This concern is confirmed by Leydon and colleagues in their paper when they suggest that, in some cases, the use of these tools causes dissonance within the consultation and may in some way 'trivialise' the consultation. However, the article also provides some reassurance that the evidence-based debate on the merits and problems associated with some

of the elements of QOF continues.

However, the central issue is this: in an evidence-based world, we should look for evidence of improvement of quality as a result of the introduction of a new instrument designed to measure performance. Is there evidence that the diagnosis and management of the complex set of conditions that are labelled as 'depression' has been improved by mandating the use of these tools in everyday general practice?

The authors end by quoting the excellent work done by Trish Greenhalgh where she suggests that we need to open up the 'black box' of clinical experience and judgement and how they interact with evidence. We concur with their suggestions that in the future, more piloting, more engagement with practitioners, and a more measured response to the difficulties caused by and pertaining to measurement would be helpful for patients and GPs alike.

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DOI: 10.3399/bjgp11X572337

Doctors and depression

Having read a number of articles over the last few issues about depression and its treatment and, speaking as a retired GP with lived experience of the 'condition'; 'symptom cluster'; 'diagnosis'; 'disease', I pose the simple question: why do doctors still struggle in relation to the brain? Professor Steven Pinker says that 'mind is one of the things the brain does' and my own experience suggests that is indeed the case and that 'mind is not all the brain does and the body's "minding" functions are not just vested in the brain, but throughout every cell, fibre, and synapse of our being"'.

It is obvious to me that the brain is a physical organ in a physical body and that its minding functions, along with those of the rest of the body, that are to what we ascribe the adjective 'mental'. Our 'mental' functions are delivered by the physical organs and systems that constitute a physical body, and are operating according to the same principles and laws that govern all such known physical processes in those aspects of this known universe that we know about.

There, I've said it. There is no evidence-based division between 'physical' and 'mental', brainmind and bodymind, mind and body. Descartian dualism is dead, but not buried; his spirit still stalks the halls of our schools, medical schools, policies, commissioning, procedures, and services.

Further, the schismatic thinking that results from 'either-or' and not 'both-and' thinking results in people using the terms 'mental health' and 'mental illness' synonymously and interchangeably, or implying that the former is the mere absence of the latter. It would be as logical to talk about peace being the same as war or as the mere absence of it (and vice versa).

Throughout my depression 'career' (pace Dr Joanna Moncrieff) I have benefitted from the wonderful care of a GP who has always treated me as a whole person. I am still on my journey, but I wouldn't be on it at all, were it not for that person and many others like him. So, if some GPs are not interested or competent in the management of, for example depression, then those who have 'got the plot' on the above need to start helping them to appreciate just how sexy, brilliant, wonderful, and awe-inspiring the brain is. The 'most complex mechanism in the known universe' as Einstein had it (and he should know). If people are not so inspired and their interest in the human condition, going north, terminates at the uvula, then we should be very worried that they are either worn-out or unfit to practise.

Ironically, it is the same organ that has evolved to 'game' — but perhaps I should simply stop there?

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DOI: 10.3399/bjgp11X572346

Novel treatments for type 2 diabetes

Jason Seewoodhary's article in the January Journal,[1] presents an optimistic view of the currently available alternatives to the standard treatments for type 2 diabetes.

However, he makes no mention of the cost of these newer agents, nor the fact