

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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## 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. Cartesian 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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## Novel treatments for type 2 diabetes

Jason Seewoodhary's article in the January Journal,<sup>1</sup> 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

that long-term studies of their effectiveness, not just in reducing HbA<sub>1c</sub> levels but in reducing morbidity and mortality, are lacking.

In view of the recent thiazolidinedione withdrawal, and that of troglitazone in the past, it is hard to develop enthusiasm for these newer agents, especially since, for many, their mode of action is to squeeze more insulin out of an already failing pancreas.

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## Oral and maxillofacial surgery

At present, I am working as a senior house officer in oral and maxillofacial surgery. Our department receives a lot of referrals for dental extractions for patients who are on bisphosphonate therapy.

Bisphosphonates inhibit osteoclast-mediated bone resorption and are used in the management of metastatic cancers and osteoporosis. They have been shown to reduce bone pain, skeletal events, and improve quality of life.<sup>1</sup>

However, the increased use of these medications has led to a correlated increase in bisphosphonate-related osteonecrosis of the jaws (BRONJ). This is a very painful condition resulting in bony exposures in the jaw that may be precipitated by any oral surgery such as extractions.

The incidence is said 0.8–12% of bisphosphonate patients who have had oral surgery. The risk increases with length of time patients are taking bisphosphonates

for and who are on IV bisphosphonates.

Due to the long half-life of these drugs, the risk of developing BRONJ is present many years after the patient has stopped taking these medications.<sup>2</sup>

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## How to protect general practice from child protection

Mike Fitzpatrick's views<sup>1</sup> are outdated. He begins his article by mentioning the tragic cases of Victoria Climbié and Peter Connelly (Baby P): in both cases the GPs were found to be negligent. He attempts to undermine the whole system of safeguarding. It is a cynical denial of what is a very real problem.

He is right to say that we should not be driven by media hysteria; that some cases will always be missed; and that attention is needed to contentious issues such as referral forms, case conferences in surgery hours, and impenetrable minutes. The Common Assessment Framework (CAF) referral form that he describes, for which, by the way, parental consent is usually required, is under Eileen Munro's beady eye<sup>2</sup> at the moment. The CAF process was intended to help early intervention and is

evidence based.<sup>3</sup>

He advocates that community paediatricians should mediate between GPs and the child protection system, but referrals are rarely straightforward. Safeguarding issues are uncovered in the process of investigating and treating other conditions, including adult ones, and the child is not complaining. Community paediatricians do not always have the same contact with children and their families or know them well.

I am most disturbed by Mike Fitzpatrick's explanation of the nature of general practice. He describes our job as simply attempting to diagnose and treat people when we see them episodically and infrequently. He says we should not 'adopt the role of social worker, psychologist, police, or priest'. But we are to get to know our patients, their families, and their circumstances. We are to understand and care for them as whole people, not just to diagnose and treat their episodic conditions. We are GPs; gatekeepers to all the specialist treatments the NHS has to offer; and called to know, love, and care for people in the context in which they find themselves, at every stage of their lives. When a case conference is needed it would be farcical without the GP present and playing a major part.

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