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Negotiating ‘depression’ in primary care: A qualitative study[☆]

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ABSTRACT

Psychiatry has provided primary care physicians with tools for recognising and labelling mild, moderate or severe ‘depression’. General practitioners (GPs) in the UK have been guided to manage depression within primary care and to prescribe anti-depressants as a first-line treatment. The present study aimed to examine how GPs would construct ‘depression’ when asked to talk about those anomalous patients for whom the medical frontline treatment did not appear to be effective. Twenty purposively selected GPs were asked in an interview to talk about their experience and management of patients with depression who did not respond to anti-depressants. GPs initially struggled to identify a group, but then began to construct a category of person with a pre-medicalised status characterised by various deviant features such as unpleasant characters and personalities, manipulative tendencies, people with entrenched social problems unable to fit in with other people and relate to people normally. GPs also responded in non-medical ways including feeling unsympathetic, breaking confidentiality and prescribing social interventions. In effect, in the absence of an effective medical treatment, depression appeared to become demedicalised. The implications of this process are discussed in relation to patients’ subsequent access or lack of access to services and the way in which these findings highlight the processes by which medicine frames disease.

Introduction

In the middle of the mid 20th century the close relationship between a diagnostic label and a disease, between the word and the thing, began to dissolve. The essentialist belief that diseases simply lay around in nature waiting to be discovered (and given a label) gave way to a nominalist view in which the relationship between diseases and their labels was more problematic: far from diseases ‘existing’ independently, they were, in a sense, constructed from their label. Disease labels therefore rarely emerged fully formed but evolved gradually through a complex social, cultural and political process in which clusters of symptoms and signs and a unifying descriptor interacted over time (Rosenberg & Golden, 1992). The process of negotiating a label for a disease has thus been understood by sociology as a social one and in many ways the status of medicine has been seen to derive its legitimacy from assigning a diagnostic label to patients’ misfortunes (Parsons, 1951).

The increasing disassociation of the label from the disease or ‘pathology’ has given impetus to wider conceptual shifts in medical sociology such as medicalisation (Conrad, 2005; Conrad & Schneider, 1992). Debates in sociology have considered whether medicalisation is preventable or inevitable, desirable or undesirable (e.g. Parsons, Friedson and Armstrong’s contrasting positions are summarised by Gerhardt, 1989). More recently, it has been recognised that the range of conditions considered to be medicalised have not remained constant (see Smith, 2002) suggesting that those conditions or states described as ‘medicalised’ at a particular point in time represent the contemporary boundaries of medicine and themselves tell us about the historicity of shifting management of deviance.

Wilson contended that mental illness had been medicalised in the 19th century by the dominance of Kraepelinian descriptive psychiatry (Wilson, 1993). Wilson also described the dominance of the psychosocial model in the ideas of Meyer, Menninger and Freud in post World War II USA representing a demedicalisation of mental illness, followed by a period of re-medicalisation in the 1970s coupled with the increasing numbers and uses of psychotropic drugs. It has been argued that the pharmaceutical industry contributed to the medicalisation of misery or unhappiness through marketing practices which required drug branding and linking to medical diseases and thus while evidence suggests that ‘anti-depressants’ have non-specific effects on psychological states

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including anxiolytic effects (Goldberg & Huxley, 1992), the pharmaceutical industry has branded 'depression' with a medical label to enhance sales (e.g. see Healy, 1999). The idea that the pharmaceutical industry has an ongoing pernicious role in health care through the 'corporate construction of disease' has been extended more recently for example by Moynihan, Heath, and Henry (2002) who argued that some forms of medicalisation may in fact be described as 'disease mongering'. Examining the medicalisation of 'misery', Pilgrim and Bentall (1999) set out the way in which medicalisation joined the label 'depression' to operational definitions such as the DSM classification which has led to a narrowing of focus and obscuration of any social conditions that may give rise to unhappiness. Chodoff (2002) has also criticised the role of the DSM system in the medicalisation of misery and suggested that psychiatrists may sometimes be motivated to apply the diagnosis of depression in order to justify the prescription of an antidepressant rather than engage in psychotherapy.

Within this broad context, the present study is concerned with the ways in which 'medicalisation' and 'demedicalisation' may be achieved in vivo through the discourse of individuals working in a clinical context. At the time interviews for this study were carried out, UK national guidelines for the management of depression in primary care indicated anti-depressants as the first-line treatment (Littlejohns, Cluzeau, & Bale, 1999). It was therefore expected that primary care physicians would be able to diagnose and treat clinical 'depression' in everyday practice. In the current study, general practitioners (GPs) were specifically asked to consider patients whom they considered to have 'depression' but for whom the medical paradigm specified treatment (anti-depressants) did not work. The aim was to explore the implications for labels and disease construction in a context in which a medical label (depression) and a corresponding medical treatment (anti-depressants) became decoupled. This was considered an interesting context to examine professional discourse since a potential threat to the medical paradigm would be present in the juxtaposition of a diagnostic label with an implicit challenge and the medical professionals in the study would find themselves constructing explanations for this discrepancy.

Methods

Ethical approval for the study was granted by Camden and Islington Local Research Committee (London) in May 2004 and site specific approval for additional London areas was obtained subsequently. Interviews were carried out between April and September 2005.

Twenty GPs were interviewed. The sampling method was purposive, in that participants were selected according to certain criteria based on a consideration of which criteria might contribute to the participants having varied experiences of mental illness which, in their turn, would lead to a range of different views. Sampling criteria were generated by a focus group including primary care and mental health researchers and clinicians. Those sampling criteria were ethnicity (White British or Other), mental health needs of area defined by Mental Health Needs Index ward scores (McCrone & Jacobson, 2004), mental health links at the practice (none, in-house counsellor or linked workers such as Community Psychiatric Nurses); practice size (single or group practice) and length of time in practice (<18 years or >18 years). These criteria were considered to be most likely to have an impact on the range of experiences and views the GPs might have about patients with depression.

GP participants were visited at their practice or home according to their preference. Every participant was paid £60 for their time except the first three 'pilot' interviews, who participated for no payment. The interview was intended to enable participants to construct a category of patient in the interview based on an initial prompt ("I'm interested in patients who have had depression for a long time and haven't responded to anti-depressants or didn't find them helpful"). The intention with this opening question was not to provide any diagnostic rubric for 'depression' which might direct participants towards any particular conceptual framework before choosing which patients to have in mind during the interview. The patients that the participants would bring to mind would therefore be those that they themselves considered to have 'depression'. There would be no necessary shared understanding or joint definition of 'depression' between interviewer and participant but this was not the purpose of the study; rather the intention was to access participants' rationalisations and explanations of the problem of the decoupled medical label and medical treatment, irrespective of what their specific construction of the depression label might be.

The ensuing semi-structured interviews went on to cover areas relating to what these particular patients were like, why and how the participant tended to manage them and what they thought about them. Interviews lasted roughly 1 h. Interviews were audio-recorded and later transcribed verbatim. Transcriptions were loaded into the software package MaxQDA. The analysis followed a process of thematic analysis (see Braun & Clarke, 2006) driven by a social constructionist framework.

Results

Following purposive sampling described above, the final sample consisted of ten White British (WB) GPs and ten non-White British (NW), all within Greater London. Ten were in areas of higher mental health needs category (High MHN) and ten in areas of lower mental health needs (Low MHN). Ten GPs had an in-house counsellor or psychologist in their practice (In-house) and ten did not. Seven were single-handed GPs (SH) and thirteen were in group practices (Group), although of these, four were two-partner practices (2PP) which arguably operate more similarly to the single handed practices than the large group practices. Seven GPs had been practicing for less than 18 years (<18Y) and thirteen had been practicing for over 18 years (18Y+). The sample was therefore relatively varied yet also reasonably representative of inner-city GPs in the UK.

Nine major themes were identified from the first stage of the analysis each with a number of sub-themes. These are listed in the Appendix. Each theme will not be described in detail here as they provide primarily a descriptive account of the content of participants' discourse. The subsequent analysis reported here was intended go beyond a description of the thematic content and to provide an analytic interpretation employing a broadly social constructionist epistemology based on a close examination and interpretation of connections between themes.

Explanatory frameworks

In common with other recent studies of GP views on depression (e.g. Andersson, Troein, & Lindberg, 2001; Chew-Graham, May, Cole, & Hedley, 2000; Murray et al., 2006), the present study found that GPs tended to prefer sociological or psychological causal accounts of depression. Even those domains of explanation which appeared more biological in origin such as genetic or alcohol models were elaborated on by drawing on psychosocial pathways.

> *Often it is the circumstance they have brought on, they've been alcoholic all their lives, they have now packed up drinking, but of course they are homeless and all their friends are alcoholics, […] "I am fed up with that, and I haven't got a home, and I had a wife but*

> *she divorced me because of the drink, and my kids won't see me because of the drink". (GP12, Low MHN, WB, Group, In-house, 18Y+)*

However, in the present study, GPs were asked why they thought some people did not respond to anti-depression medication (other studies noted above asked GPs what causes depression, not why there was a non-response to treatment). A notable difference in the present study findings compared to previous studies was the extent to which GPs presented 'personality' as an explanatory framework. When probed on the meaning of personality, participants tended to draw on a range of terminology from formal psychiatric diagnoses such as personality disorder to lay terminology such as 'horrible':

> *Maybe he needed somebody who said to him stop being horrible. But I mean that I look back and I think this man had a personality disorder and there were signs of it there were all sorts of signs of it. (GP1, Low MHN, WB, Group, In-house, <18Y)*

A further aspect of respondents' accounts of non-response treatment was in relation to the efficacy of the medication. In spite of a general consensus that anti-depressant medication should be prescribed for depression and should work if adhered to, non-response was commonly described as inevitable if patients had particular life problems or a particular attitude or personality which defied the medical logic of psychotropic drugs.

> *It depends on other factors. Maybe they have got a bit of a personality disorder, or a bit of a depressive personality, which won't necessarily respond to antidepressants, or they've got other life stresses which unless they are addressed their sort of outlook on life is not going to improve significantly. [GP 17, Low MHN, WB, 2PP, <18Y)]*

While some GPs explicitly referred to the term 'placebo' as part of their explanatory framework, there were numerous remarks similar to that above which implied rather than stated a placebo effect. Hence respondents appeared not to draw on any pharmacological explanatory frameworks to account for non-response to anti-depressants and instead constructed the mechanism of anti-depressants within a psychosocial paradigm implying a treatment worked only when the psychosocial conditions were right.

Loss of empathy

Connected to the notion of 'personality' the concept of manipulation emerged fairly frequently and appeared within the theme 'burden'. While a previous study of GP views of depression referred to the notion of manipulation (Chew-Graham et al., 2000), this was only discussed in negation suggesting that GPs tended to view patients' secondary gain from depression as contextual rather than specifically manipulative. Data in the present study which examined GP's views of depressed patients who did not respond to treatment suggests a different response of this group of patients:

> *Sometimes they're trying to manipulate me because they can't manipulate the person who is victimising them so it is, it is their way of getting even or however one wants to say that but sometimes of course if they are manipulating the system to gain benefit it upsets me. (GP11, High MHN, NW, 2PP, 18Y+)*

Comments made by participants about manipulative patients could be considered unexpected from a 'caring' professional where there is an expectation of sympathetic responses towards patients' problems. Such comments were not extreme or rare in the sample and when taken alongside comments indicating loss of empathy, 'heart sink' and sense of being burdened both mentally and practically by these patients there was an overall sense that the patients that were brought to mind during this interview were constructed as having generally unpleasant characteristics and who do not generate caring or helping responses.

In addition to such negative descriptors of patients' characters, there were indications that empathy could be lost as a result of GPs feeling frustrated by not being able to close consultations, but also that loss of empathy represented a fundamental problem in GPs' interactions and conceptualisations of non-responsive patients.

> *They think it is your job to make me better. "You have given me tablets and this and that, but I'm not feeling better". If you ask them what are you doing to make yourself better, "Oh I am ill, you are the one who is supposed to get me better". (GP16, Low MH, NW, 2PP, 18Y+)*

The construction of non-responsive patients in this study could be characterised by the idea of patients with lives replete with failed relationships, frequent arguments, broken families, inability to get on with colleagues and hold down a job and who were experienced by GPs as difficult or manipulative. As in the quote above, these characteristics were often associated with discourses of personal responsibility. GPs subsequently appeared to convey the notion that there is a 'need to be tough' with patients rather than showing unconditional sympathy and yet few GPs reported feeling able to 'be tough'. One GP did feel able to 'be tough' but connected this to his own cultural difference coming from "a culture where shouting is a norm, you're allowed to express your emotion" and that he would indeed shout at his patients. However, he then went on to say that it was possible to get away with a lot of 'unacceptable behaviour' with patients who are depressed. This comment provides evidence that responses such as losing empathy and confronting patients are not responses associated with medical behaviour and hence the majority of GPs interviewed appeared to be responding non-medically to the group of patients they were prompted to recall.

Unhelp-able patients

GPs tended to report that they would be less likely to help patients perceived as un-helpable or unwilling to help themselves. Any catalysts for new management strategies were patient driven in terms of the patient asking for a treatment or demonstrating some new sense of insight into their problems. GPs therefore presented a mostly reactive style of management in which they as professionals appeared to have no role in the change occurring in patients other than as gatekeeper to further services. GPs also reported using strategies to reduce contact with those patients seen as most difficult or tiresome both during consultations as well as more broadly by avoiding consultations altogether.

> *Some of them, we have to get rid of and they have a system of allocation… they will stay no more than three months with the doctor, which is bad for them but they are so difficult that you don't have time or energy to look after this heavy demand. […] Eventually some of them have to be admitted really because they are so sick, or so demanding, or so difficult, that it is impossible. At least they give a break to everybody by being in hospital for a few weeks… (GP14, Low MHN, NW, 2PP, 18Y+)*

On the whole, GPs conveyed the impression that there were no interventions that could be made for non-responsive patients as cognitive behaviour therapy and counselling were considered too brief for the complexity of the problem and psychiatry was not considered appropriate unless the patient was actively suicidal. There was a strong sense of hopelessness conveyed by GPs about the potential for helping this group of patients owing to the patients' intrinsic unhelpability and the perceived unavailability of any treatments.

> *Some have been that way since they were 17 year old kids, and stay that way. There are some who seem to revel in it, but I'm not overly convinced there is an actual disease or a state of mind.(GP7, High MHN, NW, SH, 18Y+)*

The one positive role that GPs appeared to consider as a tool for managing depression was providing a 'sounding board' for patients.

> *They don't have anywhere to go, nobody to communicate, who better that their GP so, they tend to come, use the GP to communicate as a sounding board (GP11, High MHN, NW, 2PP, 18Y+)*

GPs tended to feel that allowing patients to sound-off about their problems with neighbours, families and partners was intrinsically therapeutic for patients. This kind of role is not a particularly medical activity, not even in the sense of psychological treatments since even talking treatments aim to have some structure and theory-driven approach to listening.

Social prescribing

Those participants who mentioned guidelines were uniformly unimpressed by them and considered them to be of little help or relevance for this sort of patient, either because they were unaware of any guidelines that covered this particular non-response problem or because they did not believe that guidelines recommended psychological interventions for this type of patient.

> *So I dunno I mean there's no sort of, there's no flow chart algorithm to come to a decision that I know of (laughter). I mean do you, do you know of any umm since you mentioned it, do you know of any guidelines which have been helpful or are helpful in this area? (GP6, High MHN,WB, Group, In-house, <18Y)*
> *We've been told that for CBT, ideally it's only really for those with a history of six months or less so perhaps it is not so applicable for chronic depression. So, I suppose… I don't think these patients would be suitable for that at all. (GP5, Low MHN, NW, Group, In-house, 18Y+)*

There was a sense that these patients would not benefit from referral for specialist treatment. Meanwhile participants described a range of social interventions including intervening in family disputes, prescribing English lessons, walking or social clubs, volunteering, sewing or visiting patients at home to comfort them. While such social prescribing may or may not be beneficial, UK guidelines for depression do not provide medical sanctioning for such social or community based interventions nor do they consider the potential benefits or harms that may arise from GPs acting for example as a 'sounding board' as discussed above or about the potential benefit or harm of breaching what are considered to be sacrosanct boundaries of doctor-patient confidentiality.

In the present study, alongside social prescriptions, participants described ways in which they intervened directly in the social or community sphere by helping with benefits applications, supporting housing applications, advocating for the patient, helping when the patient had been arrested, making home visits when the patient was probably not ill but was having a crisis and taking up issues with local religious leaders. The latter might in a strictly medical paradigm be seen as controversial in breaking confidentiality of the patient. While such interventions were mostly conveyed in a positive sense, one participant described these kinds of activities as 'wiping [patient's] bottoms' which has some negative connotations and confers a non-medical potentially denigrated role. Several GPs suggested that there was a confidentiality issue to be aware of when treating members of the same family or getting involved in patients' family problems; however, one GP spoke freely about taking up patients' problems directly with family members and suggested that the patients found this helpful and reassuring to have someone on their side:

> *They get reassured that I will take a step to prevent all this triggering factors and put peace everywhere and solve the family situation one way or another (GP14, Low MHN, NW, 2PP, 18Y+)*

One GP compared their role to that of the 'priest role' in earlier centuries. Indeed many of the functions performed by GPs with depressed patients as reported in this study lie outside of a conventional medical discourse that upholds evidence-based practice and confidentiality as positive medical values. The 'priest role' is very different to this and implies a role of social involvement that breaks confidentiality for the greater good of the individual, family or community. Because this role is in conflict with medical discourse, it was revealed by some participants almost as a secret or denied by others in a relatively defensive way.

The conflict between the 'priest role' and medicine was also highlighted by the difficulty experienced by GPs' in their involvement in applications for welfare benefits. This required GPs to take on an official or authoritative role in a fundamental social aspect of patients' lives but provided no medical discourse or authority to regulate this outside of the limited language of 'depression'. GPs who may feel they were being manipulated did not have a medical framework to take account of this and to apply it to the 'medical' information provided on benefits forms.

Labelling

'Not Depression' was an important theme which appears as a sub-theme of 'explanatory and contributory models'. This theme captured comments made by participants which suggested that they did not really conceive of this group of patients as being depressed at all and that this may be the wrong framework in which to locate them. For example:

> *Sometimes they are not really depressed they are just they call them heart sink patients because they are always complaining of something, and never getting any better and never you know improving and never happy of anything you do for them. So but heart sink patient usually is somebody you refer to patients which are not typically depressed but just a nuisance. (GP14, Low MHN, NW, 2PP, 18Y+)*

It should be noted that while this type of comment was not uncommon, participants had been asked to talk about patients with 'depression' as described in the Methods section and indeed did also talk frequently about the patients' depression without any apparent dissonance. Hence, while participants had themselves constructed a group of patients initially thought of as having 'depression' for the purposes of the interviewers' questions, clearly during the interview there were times when participants experienced a dissonance between the patients they were talking about and the label 'depression'.

Discussion

Depression has been widely described as a medicalised condition in that an everyday emotion, albeit often severe, is given a disease label. In this study, physicians who operated most of the time with this medicalised label were presented with an opportunity to discuss anomalous patients who had 'depression' (as defined by participants) yet did not respond as expected to medical treatment. In various ways, demedicalisation of patients, of medicine and of GPs' own roles appeared to occur through the discourse of GPs in this study.

Demedicalisation of the patient

GPs in this study appeared to begin to construct a category of person with a pre-medicalised status characterised by various deviant features such as unpleasant characters and personalities, manipulative tendencies, people with entrenched social problems unable to fit in with other people and relate to people normally. Respondents also appeared at various points in the interview to attach and later detach the label 'depression' from these patients as suggested in the last part of the analysis.

Medicalisation has previously been conceptualised as drawing certain kinds of problems into the medical domain through the provision of a label and a treatment from within the medical paradigm. In this case study of depression, non-response to the paradigm-prescribed treatment appears to have led to the patients' problems being reconstructed as non-medical social deviance. In other words, in the absence of an effective medical treatment, the label of depression appeared to become less securely attached to such persons and a host of socially deviant constructions put in its place. There was however evidence that some GPs attempted to apply an alternative medical construction of Personality Disorder (PD) to label this social deviance.

In its current sense, 'personality' refers to 'a personal quality or characteristic; an individual trait', a meaning stemming back to 1710 (OED, 2007). It was not until the twentieth century that the term was taken up as an object of psychological research (OED, 2007). Alongside psychological research on types of personality (such as the work of Eysenck on introvert and extrovert types), which influenced lay and scientific concepts of personality, Psychiatry was also developing the notion of 'personality disorder' to imply "a deeply ingrained and maladaptive pattern of behaviour of a specified kind that causes difficulties in forming relationships or in functioning within society" (OED, 2007). The diagnosis of 'personality disorder' has often been described as controversial or 'contested' and Pilgrim (2001), for example, set out a thorough case demonstrating the ways in which the diagnosis did not hold up as a medical category and argued that the label represented a form of medicalisation of social deviance. MIND (a mental health advocacy group) patient information (MIND, 1997) suggested that a diagnosis can be controversial because medical professionals may use the label to explain why a patient is simply 'difficult'.

GPs in this study appeared to have access to a range of lay and professional terminology in the personality domain and seemed to want to find an alternative concept to apply to their feelings towards the patients such as being manipulated or losing empathy. Many features of PD overlap with some of the features of patients as depicted by GPs in this study (for example, see MIND, 2001 on Borderline Personality Disorder). Some superficial knowledge of the PD diagnosis may account for the way in which some GPs used medical labels of PD in their discourse. Yet others used lay terminology and generally all participants seemed to lack access to a full formal clinical discourse to draw upon, presumably because this discourse and associated training is generally reserved for mental health professionals.

Research on the use of lay and scientific language by GPs has suggested that GPs may access lay discourse alongside medical discourse to tap into folk knowledge systems as a means of constructing explanations that patients can understand (e.g. Helman, 1978). However, in the present study the GPs were not constructing an explanation for the benefit a patient or lay person and therefore arguably switched to lay terminology owing to their own lack of access to a formal psychiatric discourse of PD. A further understanding of the switching between lay and professional discourse is offered by Thomas-Maclean and Stoppard (2004) who conducted a discourse analysis of a set of interviews with GPs about their experiences of patients with depression. These authors found that that there was tension evident in GPs' discourse between the idea of depression as a 'normal response' to social difficulties and the medicalisation of depression in their talk about depression as something 'wrong' such as a biochemical imbalance and their descriptions of a mechanistic approach to treatment. The authors accounted for the dissonance in proposing that the conceptualisation of depression as a 'normal response' causes a problem for the Western notion of treatability in medicine. Furthermore, if depression is not treatable because its causes are outside the medical domain, the GP, who normally has a powerful position in the consultation as a medical expert drawing on medical discourse, is rendered powerless in consultations for depression as the medical discourse fails to provide effective explanatory accounts or treatment cures. In the present study, GPs arguably attempted to draw on an alternative medical discourse to resolve this loss of power, but did not have full access to this. This illustrates the way in which the medicalisation of problems may be dynamic and changeable across the domains and specialities of the Medical profession depending on what medical discourses and clinical frameworks are available within different speciality trainings.

Demedicalisation of the pill

Participants in the present study also constructed the antidepressant medication (ADM) itself as non-medical and drew on the placebo effect as an explanatory framework in that the treatment worked but not by virtue of any pharmacological properties and its efficacy could be reduced by the presence of certain psychosocial factors.

Amongst others, Shapiro (1959) has argued that the history of medical treatment prior to psychotropic drugs and randomised controlled trials is a history of the placebo effect implying that only modern drugs have a genuine biochemical pathway leading to their positive effects in psychiatric disorders. However, critics of modern Psychiatry's reliance on psychotropic drugs have argued that ADMs may indeed be placebos in that reviews of ADM trials fail to show positive effects and that where there are positive effects, these are often associated with the drug's side effects which are likely to enhance the suggestive power of the pill (Moncrieff, 1997).

In the present study, this debate about ADMs is not present explicitly in participants' discourse and the observation that a placebo effect may be necessary for ADMs to work is implied rather than explicitly stated. In common with other studies of GPs' experiences of depression (e.g. Andersson, Troein, & Lindberg, 2001; Chew-Graham et al., 2000), GPs in the present study remained in favour of prescribing ADMs for depression. However, this clearly gave rise to dissonance given that participants had been asked to account for the patients' non-responsiveness to the treatment. It appears as though demedicalising of the patients' problems and the detaching of the depression label also began to lead to participants' inadvertently demedicalising the treatment itself.

Demedicalisation of the physician

GPs in the present study often responded in non-medical ways including feeling unsympathetic, breaking confidentiality and prescribing social interventions. Medical interventions sanctioned by guidelines (including cognitive behaviour therapy (CBT) and counselling) were considered to be of little value and hence referrals for such treatments were rarely made.

The loss of empathy represented a fundamental problem in GPs' interactions and conceptualisations of patients. In addition to the loss of power discussed above owing to the lack of a medical discourse to frame the patients' problems, it could be argued that GPs come up against a further tension when trying to align their experiences of patients with another potentially powerful discourse of 'the caring professional'. The term 'caring professional' clearly applies to all health care professions and the word 'care' itself is often used synonymously with 'service' as in 'Primary Care'. However, it has been argued that the notion of 'caring' is something nowadays attributed only to the nursing profession and specifically not associated with other health care professionals including doctors. Paley (2002) for example drew on Nietzsche in order to argue that 'caring' and 'compassion' have been constructed as part of the Western ethical consciousness to represent a positive moral value whereas in fact it could be seen in an alternative way as a subversion of the values of the medical model which values objectivity and emotional distance from patients.

Similarly, a number of authors have drawn attention to the loss of empathy in modern Medicine. Scherer (1996) noted the modern process of secularisation of Medicine in contrast to its origins in the Middle Ages in which the clergy acted as priests and physicians. Marcum (2008) argued that the secularisation of Western Medicine led to patients becoming seen as objects and physicians losing empathy or 'pathos'. These discussions of the secularisation of Medicine tend to suggest that the loss of a ministerial empathic type of concern for patients came about in conjunction with advances in science and technical competency within Medicine. An interesting contradiction in the present study is the finding that GPs often reported losing empathy for the patients they were describing and yet also reporting that their ways of managing these patients tended to involve the types of roles more commonly associated with these historical ministerial roles of clergy-physicians. This contradiction may be explained by the fact that in the past the more community oriented empathic priest roles may have been institutionally sanctioned whereas in Modern medicine they are not. Therefore, when GPs find that the modern sanctioned remedy is ineffective, they may consider intuitively that various social prescriptions or interventions may be helpful and yet the powerful sanctions of modern Medicine such as modern ethics, confidentiality and evidence-based guidelines prevent the GP performing these roles 'above board'. Given that neither the medical structure of the primary care encounter, nor the language or tools available to GPs seem to be adequate for the patients concerned and given that any alternative tools potentially contravene guidelines or medical ethics, GPs may lose empathy with patients owing to the sense of frustration that would come about from the significant loss of power within these particular medical encounters.

Clinical implications

As a result of this demedicalisation and de-labelling of depression in cases of demonstrated ineffectiveness of medication, patients appeared to lose access to a range of other services such as counselling and psychotherapy services as well as losing usual access rights to their GP in that some GPs have reported restricting or closing down consultations. This loss of access is particularly significant at a time in the UK when CBT is being targeted at those labelled as depressed or anxious, leaving little on offer for anyone without the right diagnostic label. Furthermore, the drive to provide large quantities of CBT is driven by economic imperatives for patients on benefits to return to work. The ultimate conclusion of demedicalisation of depression in primary care contexts could therefore arguably lead to significant financial disadvantage for patients in a climate in which rights to welfare support are increasingly and more explicitly linked to the provision of basic psychological treatments channelled through primary care and based on a simplistic diagnostic framework for referral.

On the other hand, it could be argued that some patients who become demedicalised in this way gain access to a new form of help via their GP in the sense of the non-medical interventions discussed above, which provide an ad hoc form of social or community support and intervention. However, these advantages come at a cost since as Parsons (1951) originally argued, providing a label for an illness can give the physician their authority and the patient their access to the sick role. In this study the demedicalisation of the patient, the pill and the GP seem to lead to the loss of power and authority of the GP which appears to lead in a circular fashion to GPs feeling frustrated and less willing to engage with these 'difficult' patients. Marcum (2008) argues that Medicine ought to reincorporate the humane and empathic elements associated with its ministerial past and it is conceivable that this could be achieved through the relaxation of the evidence based practice rubrics in primary care and a re-examination of the ethics of confidentiality for the physicians at the coalface between Medicine and society. It remains unclear however whether this would allow the physician to regain their power and authority in the context of demedicalisation.

Conclusion

In comparison with lay views of 'depression', the medical label is believed to engage with an underlying psycho-pathology that transcends individual patient's accounts of misery. In an important way the existence of this underlying psycho-pathology is validated by the fact that such patients usually respond to a common intervention in the form of anti-depressant medication. But when asked to consider patients for whom this intervention does not work, GPs drew upon lay labels and notions in the absence of medical ones that could work for them. The effect was to construct an implicit diagnostic label that drew on lay notions of social deviance rather than medicalised psycho-pathology. Medicalisation therefore seems like a dynamic process at the coalface of clinical practice: patients are no doubt medicalised but also sometimes demedicalised. It is possible for a group of patients to slip through the medical classification process and, in so doing, illuminate the way in which medicine frames disease for others.

Appendix. Theme list

Anti-depressant properties	Doubt Confidence
Explanatory & contributory models	Causal models Descriptive models Mutual exacerbation models Grasping for explanatory model Not 'depression'
Hopelessness	Ceiling on potential improvements Patients who won't get better GP hopelessness
Burden	Mental burden Burden of somatising General burden
Skills and support	Learning resources System support Direct support Managing own feelings

Social care	Problematic involvement in benefits & forms Focus on social & community interventions Involvement with family & home life
Long term management	Generic strategies Interactional issues
Referral decisions	Psychology & counselling Psychiatry Alternative interventions Patient choice Lack of control Waiting times Lack of clarity about options
Patient interaction	Influencing factors Patients with unrealistic expectations GP responses

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