already registered, they are often willing to do so. The local specialist services have long been clogged by stable users on low-dose maintenance who can be appropriately treated in the community. We are attempting to return the prescribing for stable drug users to the community. This can also allow specialist services to focus on the more complex interventions and the stabilization of patients prior to GP management.

Our experience has been that, with the right support and encouragement, primary care can respond 'to the challenge of treating this disenfranchised group'.[5]

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Weighting for GMS cash-limited allocations

Sir,
The appropriate basis of remuneration in general practice has been debated since the original GP contract in 1965.[1,2,3] While an appropriate remuneration system should be related to effective performance,[4,5] specifying outcome in primary care is difficult,[6,7] and most commentators have therefore focused on the measurement of workload.[1,4,8] The introduction (in 1985) of the Jarman deprivation payment[9] was indeed intended to reflect the presumed greater workload engendered by patients' lists drawn from deprived areas — although the basis of the Jarmen index is hotly disputed.[10]

Although this debate preceeded the advent of the new GP contract in 1990, the issues are even more pertinent today because the basis of the general medical services cash-limited allocations has recently been changed to reflect the different casemix presented by different age groups based on estimates of the average lengths of consultations with GPs in the different ICD (International Classification of Diseases) chapters.[5] This is a curious procedure because the bulk of that component of the budget (70%) is for practice nurses; to adjust that proportion of the budget for workload it would seem better to examine the casemix presented to nurses.

However, there are good grounds for querying the whole approach. One could argue that the basis of any package should be need and not raw demand or (unadjusted) utilization so that, for example, a male adolescent from a deprived environment (a 'putative' low and brief consultor) may have greater 'needs' than an introspective middle-aged woman from suburbia (a 'putative' high and lengthy consultor) for whom regular visits to the surgery are part of her 'routine'. This is the approach adopted elsewhere in the resource allocations literature and is the basis for the other formulae implemented or proposed by the Executive.[5] The departure from this generally agreed approach, which is implied by this weighting, should be re-examined.

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Depression screening instruments

Sir,
We are aware that depression still represents a significant public health problem in general practice, and that screening instruments designed to detect symptoms of depression could have important benefits for recognition, greater patient well-being, and cost savings. A number of self-rated questionnaires are available that could act as screening instruments for depression, but they have not lived up to their promise. Some questionnaires require additional assessment after screening to ensure the diagnosis is correct, some are long and are not sensitive to somatic presentations of depression, and none give specific guidance on management.

We have been reviewing the literature concerning these screening measures during our development of a new self-rated 'brief depression scale' (BDS) specifically designed for use in primary care. Although a number of excellent reviews are available,[1] there are still difficulties to be overcome in using these instruments to detect depressive illness in the surgery. Specifically, many of these questionnaires, although showing good validity results, still do not make it possible to predict with reasonable certainty a diagnosis of depression by current diagnostic criteria. This is essential in order that patients with a reasonable chance of showing improvement after treatment will be detected as suffering from a definite depressive illness. Many of the currently used screening instruments, including the well-known Beck depression inventory and the Zung Sscale, were not designed as screening instruments at all, but as measures of the severity of depression once recognized. This has led to problems of interpretation in a number of research studies.

Notwithstanding many practitioners' efforts in improving detection of depression in their surgeries,[2] we offer the following guidelines for the future use of these scales in primary care:

- Screening scales should be easy to administer and use and should be able to detect clinically relevant depressive disorder as opposed to unhappiness.
- It is important that scales are able to detect somatic symptoms of depression as this is the most common way in which the illness presents to the general practitioner.
- Scales should be detection or diagnostic instruments rather than severity measures.
- Scoring should enable relevant management decisions to be considered, perhaps by the use of protocols used

by the GP, whereby ranges of scores point to the use of different treatments and management plans.

We are currently validating our scale in a number of general practices in Leeds, and we hope that our work will provide answers to these questions as well as enable university departments and primary care practices to work together in the improvement of this pressing problem.

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Art for art's sake?

Sir,
Sweeney's exemplary Mackenzie lecture (February *Journal*) highlights exactly why this type of perspective is an absolute necessity to today's undergraduate students. Here at the Royal Free Hospital School of Medicine we are about to embark on special study modules which aim to 'tell it how it is' in the areas of cancer, oncology, and palliative care. Indeed, the focus of our intended course is as much on living with as on dying from cancer, and is aimed at students at the beginning of their second clinical year.

One of the reasons why I do not think that competency will be neglected[1] — a characteristic that patients expect from their doctors — is that current training does not prepare students well for a whole host of conditions that cannot be cured but merely controlled (diabetes, arthritis, HIV-infection, some cancers). MacNaughton cites a single randomized controlled trial which supposedly indicates that patient-centredness may be incompatible with 'quality care'. My interpretation here is that patients are people, and to separate out an individual's medical care from their 'whole person' care is a false dichotomy that undermines that very fabric of the doctor–patient relationship. Thus, for example, in a beautifully crafted set of interviews of people with chronic pain syndromes, Brodwin points to the absurdity of trying to divide the medical care of a person from their ordinary social background. This surely is the point of a wider understanding of the humanities — something that enhances the understanding of students about the real lives of their patients.

The challenge for us as doctors, teachers, people, and, yes, patients is to integrate humanities teaching into the curriculum such that it complements the more traditional biomedical learning that is a necessary and fundamental aspect of medical training. However, at the same time, let us not forget that medicine without the humanity is reduced to mere technicalities. The General Medical Council is keen to inculcate attitudes that befit the profession, and a wider, deeper, understanding of people's lives as reflected in poetry, books, articles, and film can only enhance this understanding.

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Primary care research and development (R & D)

Sir,
We read with interest the three editorials concerning primary care R&D in the January edition of the *BJGP*.

We are concerned that, while the editorials quite rightly discuss the strategy, national importance, and development of primary care research, no mention is made of primary care development or dissemination.

Research is of little value to the general practitioner on the 'Clapham omnibus' unless it can be put into normal clinical practice and therefore improve clinician behaviour. The skills associated with developing and disseminating research findings are quite different from those that are required to undertake the original research. These skills are often undervalued by grant givers, medical schools, and research institutions.

We are concerned that the current direction of the R&D strategy is dominated by academic departments of general practice, which are under pressure from their host medical schools to 'perform' by measuring their activity through research articles published and, more importantly, grants received for research. Thus the general direction of R&D is towards research and not to the development and implementation of that research. One example is the recent guidance from the Department of Health about section 36 funding: this is the guidance that allows health authorities to develop new 'item of service' payments, funded by HCHS funds. This guidance is the most important piece of development that the NHS has seen since the 1990 contract. However, the editorials make no mention of this, presumably because it is perceived to be 'contractual' rather than pure 'academia'.

While such a division continues between research and development, research will continue to be seen by the majority of GPs as an isolated activity of little relevance to normal practice, and of even less use to their patients.

We would encourage those responsible for developing the strategy and direction of primary care R&D not to omit the development issues; research and development are two side of the same coin, one cannot have the one without the other. If high calibre people are to be attracted to the field of developmental work, a proper career structure parallel to that of the GP academic needs to be constructed by the institutions and those who accredit institutions.

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Nurse detection and management of depression in primary care

Sir,
Mann *et al*[1] and the editors of the *Journal* are to be applauded for reporting and publishing important findings in the challenging field of mental health (January *Journal*).

The authors' conclusion appears to imply that participation in a study on depression was sufficiently influential on individual practitioner attitude and clinical behaviour