care for depressed patients was associated with 'excellent outcomes for both intervention and control groups.'[1]

Our practice, of 6100 patients, has been developing the role of the practice nurse in this area of care. The training consisted of study days covering depression and counselling, with mentorship from the GPs and attached community psychiatric nurse (CPN). Over a 28-month period from September 95 to December 97, a total of 316 patients were seen 1179 times by the nurse, and the number of new referrals from our practice to the CMHT fell from 137 in 1995 to 97 in 1996 and 71 in 1997.

An audit of a typical four-month period showed that 121 patients were seen 164 times (40%) by the GPs and 206 times (60%) by the nurse. The mean number of visits to the GPs in Mann's study was between 3.29 and 3.83 compared with our figure of 1.3. We found that 87% of the patients were suffering depression; 56% were already on antidepressants and 14% started treatment following initial assessment; 76% were monitored entirely by the GP and nurse; 16% were advised to seek help from a voluntary agency; and 8% were referred to the CMHT.

The practice nurse role is complementary to that of the doctor and community mental health resources, acting as coordinator of care (identifying patient needs and facilitating access to relevant community services), gateway to the Community Mental Health Team (CMHT), and supervisor of treatment of depressed patients using the Beck Depression Inventory (BDI) in the assessment and monitoring of response to treatment.

Our experience supports the Mann study view that the training of practice nurses produces a practice 'shift in attitudes and management that is beneficial to the outcome of depression.' However, we have also found this style of management has reduced the burden on GPs by bringing a collaborative approach to managing this problem.

Further research is needed into developing appropriate team approaches to mental health problems in primary care. We believe a nurse acting as coordinator of this extended team provides a valuable extra dimension to the care that we can provide for this group of patients.

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The MRCGP International

Sir,

It was a joy to read Iona Heath's 'Viewpoint' in the new section of the *BJGP* (November *Journal*)[1]. The opportunity for the College to develop an international examination has been obvious for the better part of twenty years and its introduction would provide a major stimulus to the recognition of the discipline of primary medical care, not only in the Third World, but equally in Europe and Scandinavia.

If general medical practice cannot identify a common core of knowledge, skill and culture, then the claims of those who founded the College nearly fifty years ago were illusions of a grandeur reserved for the more specialist branches of medicine. Resistance to the recognition that generalist practice is a branch of medicine for which special training is needed has paradoxically been most evident within the Board of Examiners of the College, who have claimed that postgraduate medical education in general practice is inextricably bound to the system of delivery of medical care within the British National Health Service. It has always been a mystery why the College Examiners should have failed to recognize that there is a core discipline of general practice within a primary care system applicable in any country.

The international influence of the College has not received the recognition it deserves. The founders of the College had an international vision which led to the creation of the Colleges in Australia, New Zealand, South Africa, Kenya, Malta and Zimbabwe. (Canada had established its own College independently.) Currently the International Committee enjoys contacts with an ever-expanding list of countries, including Pakistan, from whom there is a constant stream of requests for advice and assistance in developing primary medical care services. It is now nearly twenty years since the Government of Kuwait requested help from the College in developing primary medical care, and this was to lead to the very successful educational programme under Professor Robin Fraser and to the Kuwait Diploma in Family Practice (RCGP/Kuwait), now recognized as having an equivalence to the MRCGP. Iona Heath's visit to Pakistan followed an earlier visit by one of us (DG) as a member of the College's International Committee, to whom the request was made for assistance.

The status of general practice family medicine in many countries (and therefore the resources allocated to it) would be enhanced by an internationally recognized diploma examination as Iona Heath has understood. We are delighted that, as one of the sceptics suspicious of the College's motives in trying to create an International Examination, she should have been converted, and we hope she uses her influence as Vice-Chairman of the College Council to convert her peers. The rewards for the College, and more importantly for patients worldwide, would be immense.

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Osteopathy and somatic dysfunction

Sir,

In his discussion paper (October *Journal*),[1] Nefyn Williams describes the concept of somatic dysfunction central to osteopathic practice and proposes it as a useful paradigm for non-specific back pain.

Professor Ernst[2] responds by claiming the concept originated in, and is part of, conventional medical thinking, but then seems to misunderstand it by interchanging the term 'somatic dysfunction' with 'functional'. This out-dated term, used when diagnoses wavered between psychosomatic effects and conversion neurosis, may indeed characterize some conventional medical thinking on back pain, but it is quite different from Nefyn Williams's exposition of osteopathic concepts, as a careful reading of the paper would have made clear.

Not only do we not expect the central tenet of a major complementary therapy to be inadequately understood by a university department of complementary medicine, but we also do not expect to find it denigrated as a 'shifty paradigm' without the reasoned discussion that it was hoped the establishment of a university chair in this field would promote.

When an area of science is not progressing, and there is a possibility that this is due to the inadequate range of conceptual models in current thinking, then the

consideration of alternative paradigms may open up new avenues of research, often with the need to divert resources and technology, and re-train personnel. The study of voluntary motor function has been neglected in basic science while clinicians have focused exclusively on abnormalities of structure as a cause for pain and disability. The idea that abnormalities of neuromusculoskeletal monitoring, programming, and control may be crucial in this field is stimulating some university departments to develop equipment and test hypotheses previously not deemed relevant to the orthopaedic and rheumatological clinicians with whom they usually work. We should remember that it is not data collection that is the foundation of science, but the 'bold conjecture' that Popper,[3] among others, advises should come first lest investigation flounder aimlessly.

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Sir,

Dr Williams's article (October *Journal*)[1] suggested that osteopathic principles could provide a new clinical paradigm for the management of back pain. It was disappointing that a professor of complementary medicine, in his response in the December *Journal*, appears to have overlooked a key point. Without a change in the current paradigm we shall continue to be unable to correctly identify problems presenting with no pathology, nor will we be able to select and validate therapies to which so many patients now turn for help.

The current approach to clinical problems is still essentially based on the principle of causality. We search for pathology. Where we find it, we assume it is the direct cause of the complaint. Where we do not, the problem is categorized as being a functional disorder generated by the mind. However, physiologists have made great strides in advancing our understanding of the complexities and interactions of the nervous system, and have long pointed out the inadequacy of a diagnostic terminology entirely expressed in terms of tissue pathology.

Osteopaths have used the terms 'neuromusculoskeletal system' and 'somatic dysfunction'. These terms indicate both the complex interactions between structures and the nervous system, and the possibility that these relationships may be disturbed to cause dysfunction without apparent pathology. Such disturbances may be considered generally to involve a shift or breakdown in signal processing within the system.

Unfortunately, the commitment to tissue pathology continues to prevent consideration and, ultimately, recognition and use of therapies that are not solely dependent on investigative procedures, such as radiography or readings on a goniometer.

A paradigm shift is long overdue. Only a small one is required. I suggest that, if applied to a biological system with a known non-linear response, its effects may well appear to be beyond belief.

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How should NHS primary care be restructured?

Sir,

The recent White Paper *The new NHS: modern and dependable* presnts an opportunity to reconstruct NHS primary health care (PHC) as a system of 'virtual polyclinics'. Although hospital-focused, the 1991 NHS 'reforms' had considerable implications for PHC. This White Paper offers scope to remedy the adverse consequences while salvaging some positive aspects. Among the latter, diverse models have emerged both from fundholding (total fundholding, multifunds, community fundholding) and from non-fundholding but PHC-led approaches to commissioning secondary care (locality purchasing, GP consortia, practice-sensitive purchasing). Fundholding has apparently stimulated the substitution of primary care for hospital care and strengthened GPs' positions in relation to hospitals.[1] A primary care led NHS has become policy.[3]

Those assumptions recommend implementing 'stage 4' of the White Paper comprehensively, with primary care groups (PCGs) both commissioning hospital services *and* providing PHC. This would at last put the commissioning of hospital services on a single, coherent footing. PCGs should be so constructed that fundholders who wish to can still participate in commissioning secondary services while patients of those who do not can still gain the apparent benefits of fundholding. This implies organizing PCGs around clusters of general practices, as multifunds and GP consortia have been. But GPs, fundholders, and NHS community trusts could also combine as primary care trusts to provide PHC, both directly by managing community services and employing salaried GPs, and indirectly by subcontracting other providers, including independent-contractor GPs. That would create a system of PHC 'virtual organizations' or 'virtual polyclinics', which are in some ways like group health maintenance organizations but without insurance functions,[4] and in other ways like Leningrad-experiment polyclinics but better resourced and more clinically sophisticated.[5]

This approach would create stronger, more coherent PHC providers with GPs playing a central, but not a monopolizing, role. Primary Care Act pilot schemes and health action zones are opportunities to experiment with ways of doing this. Over time, 'virtual polyclinics' could develop into real polyclinics as they acquire buildings, equipment, and other infrastructure of their own, extending recent trends in capital planning for PHC.[6] That would retain the merits of fundholding while reducing fragmentation, and possibly the transaction costs, in commissioning secondary care. Then the attentions of health authorities would have to focus on commissioning PHC, on intersectoral activity, on collaboration with local government, and on consumer advocacy — exactly where it should focus anyway.

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