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

to create an altered outcome of depression, regardless of research trial group or professional status of carer. This is not surprising, however, given the natural remission of depressive symptoms coupled with the Hawthorne effect. It would have been useful to report findings on longer-term follow-up, when an environment of heightened awareness of depression had decreased.

A more central question in practice is that of the 'natural' management of depressive symptoms by primary care professionals, especially in the context of screening activity. Such findings, however, can only be elicited by a different methodology, which establishes the care pathways of individual patients in a naturalistic setting.[2] There is also a concern that the study (like many others) specifically excludes the elderly, where depression is known to be both more likely to be chronic and undertreated. Studies ongoing in Sheffield (Philip I, McKee K, Newton P, *et al,* unpublished ms, 1997) are attempting to understand the consequences of primary care givers (lay and professional) suspecting depression in elderly patients, and to what extent those workers would liaise with a GP, encourage prescription, make referral, or simply define sadness as a natural consequence of life circumstances. Such studies may shed light on the elements of intervention that are truly critical therapeutically, and which therefore would benefit from maximal attention in any educational input or guidelines for good practice.

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A pilot study of the role of echocardiography in primary care

Sir,

Echocardiography is an essential investigation in the assessment of patients with suspected left ventricular systolic dysfunction. There was a 2.5-fold increase in the requests for echocardiography between 1988 and 1993, with a 12-fold increase in the number of requests for assessment of left ventricular systolic dysfunction.

We assessed the role of echocardiography in a primary care setting to determine whether such a service could complement existing hospital-based echocardiography services. The service was based in the surgery of a five-partner practice in Dundee and set up in collaboration with the local cardiology department. Indications for echocardiography included a history of dyspnoea, previous or recent myocardial infarction, hypertension and cardiac murmur. Echocardiography was performed using a Hewlett Packard Sonos 1000 by an experienced echocardiography technician and two of the partners. Each patient underwent a full echocardiographic study to access left ventricular function. Following each study a formal report was produced and a treatment recommendation was made by the medical staff. The main echocardiographic diagnoses are summarized in Table 1. Twenty-two patients had their treatment altered as a result of echocardiography and eight patients were commenced on an angiotensin-converting enzyme inhibitor.

This is the first reported use of echocardiography in primary care. Primary care based echocardiography is a potential way of complementing hospital-based echocardiography services as the majority of requests here were for the assessment of left ventricular function. A key issue is the quality of the images obtained and their interpretation. GPs willing to run an echocardiography service should be trained in accordance with the British Society of Echocardiography.

This pilot study demonstrates that it is possible to set up and run a primary care based echocardiography service. It is essential that operators are fully trained and that there is collaboration with the local cardiology unit on locally agreed guidelines. Further work is required to evaluate the cost-effectiveness of such a service, the validity of assessments, and whether primary care echocardiography is a suitable alternative to open-access echocardiography.

Table 1. Main echocardiographic diagnosis.

Diagnosis	Number
Left ventricular systolic dysfunction	14
Left ventricular hypertrophy	16
Aortic valve disease	
aortic stenosis	1
aortic sclerosis	10
aortic incompetence	2
Mitral valve disease	
mitral stenosis	1
mitral incompetence	10
Normal echocardiography study	29

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HRT use

Sir,

Townsend (January *Journal*[1]) has established that the present use of HRT is over 20% for women aged 40 to 64 years in Britain. This huge increase in expense and workload must be a cause for concern as most of the prescriptions are patient-led and are reaching the well-fed, exercising, and non-smoking classes 1 and 2, rather than poorer women who are more likely to smoke and less likely to eat well.[2]

All the evidence on risks and benefits is derived from observational studies and, until the results of large randomized controlled trials are published, we will have to make decisions using the insufficient evidence now available.

We should target the vulnerable groups who have risk factors such as early menopause, fragility fractures, adverse family history, and long-term use of high-dose corticosteroids. A dedicated clinic is preferred by patients,[3] and referral within the practice, with bone density estimation only where the result makes a difference to the decisions on treatment, is economical and feasible.

Prevention cannot be cost-effective: a fracture prevented at the age of 60 may still occur years later at a greater cost to the NHS. Yet the postponement of disability could greatly improve the quality of life of the individual. Every woman needs counselling about the menopause.

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