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Your correspondent Jill Thistlethwaite[1] asks the question: 'If we learn the techniques of "patient-centred" consulting and demonstrating empathy without really liking patients or agreeing with patient partnership is this a problem?'. I would suggest that it is not a problem at all, that it would be unreasonable to expect a GP to like or feel empathy towards every single patient at every consultation, and that we are required as GPs to behave in a professional way at all times even if it does not come naturally. The evidence comes from sociology and our colleagues in the acting profession.

In 1959, the American sociologist Erving Goffman[2] wrote about his enquiries into how motivation manifested itself as behaviour. He concluded that it was quite possible to explain behaviour as a set of 'fronts' — pieces of behaviour that people use in order to pursue relationship objectives. The use of such fronts becomes internalised so that they become part of unconscious normal behaviour. He argued that all people in all aspects of their interpersonal interactions use behaviour in a way designed to bring about the required result.

Does this mean that behaviour that is not 'from the heart' is immoral or unethical? Not at all. Dr Thistlethwaite also mentions the 'method' school of acting, which was prompted by the writing of Constantin Stanislavski[3] even longer ago. It was he who also wrote of 'emotion memory' — if an actor is trying to express a particular emotion, his advice was for the actor to search his own life experience for a situation when he felt that emotion for real, and then to duplicate the behaviour. The behaviour used is accordingly an accurate demonstration of how that actor would behave when genuinely in that emotional state. If the portrayal is to be convincing, then an actor must be acutely aware of his own life and behaviour and not just that of his character.

Even longer ago, a certain William Shakespeare was moved to include in *As You Like It*:

> *'All the world's a stage,*
> *And all the men and women merely players:*
> *They have their exits and their entrances;*
> *And each man in his life plays many parts ...'* (Act two, scene seven.)

So there is not a problem. People, including GPs, cannot on occasion avoid behaving in ways that are inconsistent with how they feel at the time. The problem is when this fact is not accepted, and when the motivation becomes more important than the delivery.

ED WARREN
General Practitioner, Sheffield.
E-mail: ed@warren1952.fsworld.co.uk

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Chaotic consultations

The authors of 'Complex consultations and the edge of chaos' (Innes *et al*)[1] are to be congratulated on making complexity theory accessible and on linking it so clearly with the consultation process. In these times of over-rationality and managerialism any explanatory model that helps GPs to acknowledge and make use of the inherent uncertainty of front-line encounters is to be applauded. However, I couldn't help but feel that this was just another way of conceptualising the importance of the unconscious in human behaviour and interaction, as understood through a basic knowledge of psychoanalytic theory. The 'edge of chaos' of complexity theory may be the same as the 'flash' of insight that the psychoanalyst Michael Balint and his colleagues taught previous generations of GPs to generate and use in short consultations.[2,3] This is not a criticism of complexity theory; indeed, if several different theoretical perspectives all point to the importance of working with uncertainty and non-rational behaviour this not only highlights the importance of such interventions, but allows general practitioners to base it on the theory that they feel most comfortable with. Having at last grasped what complexity theory is, I look forward to the deepening of understanding that will come about as it is tested out in practice.

CHARLOTTE PATERSON
Research Fellow, University of Bristol.
E-mail: c.paterson@bristol.ac.uk

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Buprenorphine versus methadone — safety first?

I was concerned that the otherwise very thorough review by Simoens *et al*[1] gave little emphasis from their findings as to the superior safety profile of buprenorphine as a maintenance agent. It would have been useful to have some comments in the review as to the comparative overdose and mortality statistics in the studies examined.

Methadone has gained notoriety in the medical press on many occasions in the past, on account of the substantial mortality associated with it, and the Advisory Council on the Misuse of Drugs report, *Reducing Drug-Related Deaths,*[2] confirms our suspicions. However, for many years methadone has been the

only pharmacological option open to GPs. As a result, most have lost interest in trying to help heroin addicts — or at worst use the safety argument as a handy excuse to refuse to help, despite the impressive evidence base to support maintenance prescribing of methadone.

Buprenorphine is undoubtedly much safer in practice, for reasons that were only touched on in the review. However, this is one of the most important factors that would lead GPs to consider prescribing it. The research base regarding community buprenorphine prescribing in the UK is still scanty and there is a pressing need to expand the available options for the treatment of opioid addiction beyond methadone. I have had extensive experience prescribing buprenorphine in primary and secondary care over the last 3 years and have found it simpler, quicker and safer to titrate and stabilise patients than by using methadone.

DAVID DAVIES
General Practitioner, Oakview Family Practice, Bromley.
E-mail: David.Davies@gp-g85716.nhs.uk

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Research governance

I read with interest Chris Salisbury's article in the January edition of the *BJGP*.[1] I should declare interest in the issues raised as research manager for three PCTs and a researcher with long experience in both health and social care.

Research governance became my responsibility in April 2002 as a result of national directives. While the areas that had to be covered were made clear, we started with virtually nothing in the way of detailed procedure and guidance. This has gradually improved, and the work not only of the NHS R&D Forum, but also local support from Trent Focus has been very welcome in bringing in what has often been a complicated and sometimes stressful process. This appears to be in total contrast to the major changes in the running of ethics committees, where detailed procedures and timescales have been the order of the day.

Research governance is still a long way from being a system that minimises bureaucracy while also ensuring that research of a reasonable quality takes place. Your writers' comments about the amount of time it takes for research staff are well founded; however, the same applies to those given the responsibility for giving management approval. Research in the NHS is a crucial activity for the improvement of patient care, which can absorb significant amounts of patient and staff time.

Quality, and to some extent quantity, appear to me to be the key issues. We have to remember that the origins of research governance are in some very questionable research practices in places such as Alder Hey Children's Hospital. Ensuring that PCTs know about all research being carried out in them and that it has management approval is something I would hope most of your readers would support. Local experience, particularly in the field of commercial drug trials, suggests that there is room for improvement not only in the quality of some projects, but also in carrying out work where benefits to patients outweigh the potential side effects. We do, however, want to support good research — be it commercial, academic or in-house in origin.

It is a pity that a lack of central guidance and support has led to the bureaucratic minefield that research governance can be. Its existence in a less onerous form is something we should all support.

MICK BOND
Research Manager, North Derbyshire Public Health Network.
E-mail: mick.bond@chesterfieldpct.nhs.uk

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Where there's smoke ... there's council tax valuation band A

Cigarette smoking, more than any other known factor, reduces healthy life expectancy;[1] so smoking cessation is a supremely important health-promotion target. How this is best achieved is the thrust of a massive report by West[2] and colleagues in 2000. Although it included not a single 'journeyman' GP, this panel of 'experts' saw primary care clinicians as best placed to intervene effectively and recommended that, during routine consultations, GPs should be advising smokers to stop. But even before the report appeared, the practicality of this edict was being questioned: smoking habit is discussed in only 20–30% of everyday GP consultations with smokers.[3] Merely urging GPs to advise smoking cessation seems unlikely to succeed; the gulf between 'symptom-led' activity and 'population-based' interventions is too wide. How, then, should we close the gap between ambition and reality? The obvious answer would seem to be for GPs being primed — to know, in advance, which patients are most likely to be smokers and for this additional burden in consultations to be embarked on only where relevant. After all, consultations in UK general practice are events that are already uncomfortably overcrowded.

We wondered whether the council tax valuation band (CTVB) of patients' addresses might provide a means of so 'spotting' smokers, and tested the hypothesis that CTVB is associated with household smoking rates. Four-hundred and fifty practice households were randomly selected from our practice list, and were telephoned during the summer of 2003. Responders were asked: 'Are there any cigarette smokers living at your address?'. Responses were recorded, categorically, as either 'yes' or 'no': no attempt was made to identify individual smokers nor the number of cigarettes smoked. CTVBs of the responding