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.

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REFERENCES

1. Simoens S, Matheson C, Bond C *et al.* The effectiveness of community maintenance with methadone or buprenorphine for treating opiate dependence. *Br J Gen Pract* 2005: **55**; 139–146.
2. The Advisory Council on the Misuse of Drugs. *Reducing drug related deaths.* London: The Stationery Office, 2000.

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.

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REFERENCES

1. Salisbury C, Leese B, McManus RJ. Ensuring that research governance supports rather than stifles research. *Br J Gen Pract* 2005; **55**: 4–5.

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