mothers to offer peer coaching, mainly through groups, was effective in improving breastfeeding rates.[6]

In the current climate it is tempting to see lay interventions as a solution to health service shortfalls rather than opportunities for partnership to improve the quality of care. These process issues deserve more investigation and are likely to arise in other expert patient and lay initiatives.

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A taxonomy of general practice

Kieran Sweeney and Iona Heath[1] try to give some theoretical basis for the enduring features of general practice but don't make it easy because of where they start. In the case history, Mrs B's GP uses the first part of the consultation to rehearse the evidence for various interventions to improve her biochemistry. It would, perhaps, be better to start with the history, which, if it includes something about Mrs B's ideas, concerns and expectations, might lead the GP to comfort and care before considering 'a cure' — or in this case secondary prevention. This could lead to better communication, the patient telling her story and the GP responding appropriately with his, using evidence from research judiciously and sensitively applied.

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Hazardous drinking and a general practice: plenty of optimism but not there yet

I read with interest the editorial in April's Journal entitled *Hazardous drinking and the NHS*.[1] This article does not address the fundamental issue facing our practice with regard to hazardous drinking at the present time.

In November 2004 I attended the RCGP course *Complexities and Controversies — Managing Alcohol Problems in Primary Care*. I came away convinced of the need to take action within our practice. McCambridge *et al* highlight the evidence of the harm moderate alcohol consumption is causing. Similarly, the evidence that brief intervention is effective is overwhelming. The practice incorporated FAST screening into the annual reviews of patients with chronic disease. Our practice nurses undertook brief intervention training and were keen to develop their expertise in this field. Having identified hazardous drinkers with chronic diseases I assumed some would welcome intervention but this has not been our experience. Of the hundreds identified, single figures have accepted brief intervention.

The work with heavy-use and dependent drinkers continues as usual.

The mere mention of alcohol within the chronic disease clinics provokes the defensive reply 'so you think I'm an alcoholic'. Within this setting, measurement of BMIs is acceptable and produces some response, and with smoking, simply asking about smoking status provokes 'I really must give up'.

Using Prochaska's stages of change model, alcohol appears to be firmly within the precontemplation arena. This perhaps explains why with alcohol there has not been a progression from screening into treatment. How is this gap to be bridged?

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The authors have stated that there are none.

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