local resources. As a single-handed general practitioner with 2100 patients, of whom at least 100 have serious chemical dependence, I work closely with the local statutory and voluntary drug counselling agencies to provide care for this group. There seems to be little practical information about how general practitioners should manage large numbers of drug addicts coming to their surgery for primary care and for help with their dependence.

Perhaps it would be useful if those practices which have experience of between 50 and 100 chemically dependent patients at any one time on their list could pool their combined experience. With the Royal College of General Practitioners acting as facilitator a forum could be established enabling this information to be available to a wider audience. I would, of course, be pleased to hear directly from any other practices involved in this sort of work.

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Sir,

The article by Ronald and colleagues on the problems of drug abuse, human immunodeficiency virus (HIV) infection and the acquired immune deficiency syndrome (AIDS) (June *Journal,* p.232), highlights that much of the responsibility for therapeutic care and ongoing support for individuals and families with these problems now lies with primary health care facilities and in particular with the general practitioner and the primary health care team.

The team with its individual skills is potentially ideally suited for this work, but recognition of the need for increased resources for primary care is vital if an already stretched workforce is not to become overwhelmed. It seems to us that it is often small inner city practices with limited resources and personnel who are struggling to cope with the highest workload. The potential not only for therapeutic input but for health promotion and harm minimization is great, in liaison with other community agencies, but this will not be achieved without additional help. Essential to the general practitioner is the provision of adequate back-up specialist secondary care agencies for referral, advice and support. The provision in some areas is still patchy and variable.[1]

General practitioners often feel they have inadequate knowledge to cope confidently with the problems associated with addictive behaviour.[2] The subject is noticeably underrepresented in most undergraduate curricula. Recognizing this, the department of addictive behaviour at St George's Hospital Medical School in London has for the past eight years given priority to a comprehensive training package for general practitioners. The one year diploma course covers the range of substances and behaviours involved in addictions, including gambling, eating disorders and smoking cessation. The course offers theoretical training and education in clinical management skills and basic audit and research skills. Emphasis is placed on strategies for use within general practice by regular discussion of cases from the participants' own practices. The course is now linked to a new multidisciplinary diploma course for other professionals working in the field, thus providing an opportunity to explore and develop wider perspectives on primary health care strategies.

In addition, a special interest group for general practitioners, the SIGMA group, has recently been established at the medical school. The group meets quarterly and provides a forum for information, discussion, research and support, and any general practitioner with an interest in addictive behaviour is welcome to join.

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Patient-centred doctors

Sir,

I was interested to read the article by Howie and colleagues relating doctors' attitudes about patient care to their levels of stress (May *Journal,* p.181). I am concerned, however, about the use of the term 'patient-centred doctors'.

The description 'patient-centred' is generally assumed to apply to consulting styles or clinical methods in which the doctor pays particular attention to understanding the patient's expectations, feelings and fears.[1,2] Operational definitions have been described and used, enabling consultations to be classified as patient- or doctor-centred.[1,3,4] Of particular interest is the positive association between patient-centred consultations and their outcomes.[5]

Howie's team used the instrument designed by Cockburn and colleagues[6] to classify doctors as patient-centred or not. As far as I am aware, the scale has not been validated in terms of showing that those with patient-centred attitudes also perform in a patient-centred manner. The difference between what doctors say they would do and what they actually do has already been described.[7] It seems that there is not yet sufficient evidence to describe those with patient-centred attitudes as 'patient-centred doctors' and the implications in terms of outcomes are important to our discipline.

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The importance of the generalist

Sir,

The editorial (June *Journal,* p.222) by His Royal Highness The Prince of Wales, president of the Royal College of General Practitioners, provides excellent advice to members of the College, reminding us to be generalists not multi-specialists.

Much of the message of the editorial resembles the important lessons which medical practitioners have derived from Balint groups.[1-3] The Balint movement, which originated in the United Kingdom and is devoted to patient-centred