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

medicine, has existed for 40 years, the same length of time as the RCGP. But the political and commercial influences referred to in the editorial have resulted in only a small minority of medical practitioners in the UK becoming members of a Balint group. Yet in the rest of Europe, and in other continents, there has been great use and further development of the Balint techniques.[4]

The editorial refers to the important principle of the doctor–patient relationship. This is not merely a matter of how the doctor deals with each patient, but also how patients respond to their doctor. Balint frequently reminded doctors that the word doctor originated from the word teacher. However, before teaching patients, we should try to learn from them, not just about them.

We were educated in a tradition of curative medicine; but, as Balint stated, we should aim to 'cure sometimes, relieve often, comfort always.' 'There is nothing wrong in prescribing a tonic; what is wrong is giving a tonic and nothing else.' We were trained to regard all patients as bearers of disease, and to decide if they are genuinely ill; but there is more to medicine than medicines, and more to patients than their signs and symptoms. We have all been taught: 'Don't just sit there, do something'; but what can often be as helpful is: 'Don't just do something, sit there'. Finally, Balint reminded us to 'regard your patients as human beings; while never forgetting they are still your patients.'

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Health promotion: time for a new philosophy?

Sir,

There are philosophical differences between public health and personal care. While the editorial by Kelly and Charlton (June *Journal,* p.223) may be a valid criticism of public health policy it lacks understanding of the important issues of family medicine. As general practitioners we do not see health promotion as an alternative to management of illness, but integrated into medical care.

Health promotion, from the perspective of the general practitioner, is a valuable resource for individual health. The 1981 report of the Royal College of General Practitioners[1] discussed areas of importance in preventive medicine, and promotion of health was seen as an integral part of the consultation.[2] Even the Ottawa charter for health prevention presented at the international conference on health promotion in Ottawa, Canada in November 1986 enshrined the provision of personal skills as one of the key areas in health promotion.

Health promotion should be subjected to scrutiny but it is incorrect to say that this has not occurred. Many interventions have been validated in primary care and some have been proven to be ineffective.[3] Even if, as suggested by Kelly and Charlton, health promotion were limited to helping our patients to stop smoking, to reduce drinking and to increase physical activity, it should remain an important component of the consultation. The editorial also suggests that we consider a healthy human being to be 'a rare and delicate organism'. Surely this concept has always been the cornerstone of personal doctoring?

There are limitations to mass intervention and it is questionable whether lifestyle intervention and social engineering are either appropriate or wanted, but while general practitioners relate to patients as individuals, there should be no problem tailoring health promotion to individual need and priority. The problem is not in the philosophy of health promotion but the imposition of public health doctrine on personal care.

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Continuing medical education

Sir,

We read with interest the two articles on continuing medical education by Dr Murray and colleagues (April *Journal,* p.157, May *Journal,* p.194). Our colleagues from the west of Scotland should be congratulated on their ability to attract general practitioners to courses that they organize but we fear that their success has not been experienced in other parts of the country.

We have shown previously the difference in behaviour between trainers and non-trainers in general practice[1] and the preference of many general practitioners for the courses provided by drug companies.[2] Our concern is that, under the current arrangements for the postgraduate education allowance, obtaining continuing medical education of the right quality is becoming a lower priority for many general practitioners than the desire to collect their complement of postgraduate education allowance sessions at the lowest possible cost. If this situation continues then we fear for the long term future of postgraduate education.

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Membership of the RCGP by assessment

Sir,

I qualified in 1950 and I passed the membership examination of the Royal College of General Practitioners in 1976. I found it rather difficult to start studying again, after some 25 years or so. But I did and I felt a great deal of pride and satisfaction when I was successful. During the necessary revision I realized how much I had forgotten over the years.

The advantage of the examination is the revision that is necessary. I feel this advantage would be lost if membership were awarded 'by assessment', and the value of