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

the qualification would be diminished. In addition, assessment would mean a much more subjective decision for the examiners than the awarding of marks for say, a multiple choice paper.

I would like to suggest a compromise: the awarding of the MRCGP(E) for those who pass the examination, and the MRCGP(A) for those who pass by assessment. In this way, the two qualifications could be distinguished, and each would have its own cachet.

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Outcome in smoking cessation

Sir,

The recent review of determinants of outcome in smoking cessation (June *Journal*, p.247) was informative and interesting. Dr Lennox succeeded in addressing issues of practical importance as well as recent research findings and theoretical hypotheses.

It is known that many psychiatric patients smoke. Psychiatric outpatients have been demonstrated to be more likely to smoke than a matched control group comprising people from the general population.[1,2] Similarly, it has been reported that 69% of psychiatric inpatients smoke.[3] There are many possible explanations for this. Dr Lennox indicated the importance of stress and coping skills in influencing attempts at smoking cessation; however, the importance of major depressive illness was not discussed.

There is evidence to suggest that people with a major depressive illness are more likely to smoke, and less likely to succeed in an attempt at cessation, than are people in good mental health or with an alternative psychiatric diagnosis.[4,5] The use of doxepin as an adjunct to smoking cessation has provided encouraging, but not conclusive, results.[6] The concept of self medication to alleviate symptoms, in which there is much current interest,[7,8] may in part account for these findings.

Hence, in a small proportion of people, failure to stop smoking may be symptomatic of a specific psychiatric disorder. For this group, benefit would be gained from specific antidepressant intervention. Indeed, Glass[7] has indicated that patients who smoke and who are unable to maintain cessation should be asked about depressive symptoms. This may become an essential aspect of the doctor's role in dealing with this problem.

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Treatment of non-melanoma skin cancers

Sir,

Readers should not be carried away by Dr Henry's letter (June *Journal*, p.261). Curettage and cautery may be largely a disregarded technique in Dr Henry's environment but it is not so in my environment or that of others.[1,2]

Histopathologists recommend tumour-free margins when lesions are excised and I would totally agree with this. With curettage this is not possible, but it is still an acceptable form of treatment for selected lesions, as stated in one of Dr Henry's references.[3] In the same article, it is stated that reported cure rates for primary basal cell carcinomas are in the range 90–100% regardless of the therapy used.

In another of Dr Henry's references curettage and cautery is a recommended treatment for keratoacanthoma.[4]

As regards a squamous cell carcinoma, it may be primary and if small, would be suitable for curettage. Alternatively, it may arise in lesions of Bowen's disease or solar keratosis. In these cases, where diagnosis may be in doubt, curettage is also suitable. In these types of lesions metastasis is virtually unknown.

In summary, I can state that careful and selective curettage and cautery is a very useful and highly effective form of therapy for non-melanoma skin cancers.

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GPs and work in the third world

Sir,

I agree with Dr Pearson that cooperation between the Royal College of General Practitioners and the Royal College of Surgeons to give those with the MRCGP additional surgical expertise before going abroad would be useful (letters, June *Journal*, p.260). However, I would suggest that the best way for a general practice trained doctor to be competent to treat surgical emergencies abroad would be to work on a supernumerary basis for approximately one month at the hospital where he or she will work or at a large district general hospital near where he or she will eventually work. This would also allow initial adaptation to the different culture, and the opportunity to learn about the local practice of primary health care.

While working in a large non-government managed rural hospital in Chogoria, Kenya, I arranged such training for expatriate doctors who were to work in smaller units and it was always greatly appreciated. In this way caesarian sections (the most commonly performed operation) and surgery for ectopic pregnancy could be learnt as well as general surgery.

Furthermore I am glad to report that having returned to work in Scotland I have been accepted on the relevant minor surgery list.

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