more thoughtful use of primary care services. It is likely that an out of hours centre open between 19.00 hours and 22.00 hours could cover an area with a radius of five miles or more and reduce the out of hours workload of general practitioners in the area by about 60%.

Many of the doctors who were not sure about primary care out of hours treatment centres could become more positive if they were more familiar with the idea, and if they knew that funding was available. However, it is clear that not all general practitioners see this as the solution to the problems of 24-hour general practitioner cover.

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Treatment of drug misusers

Sir,

Research can change that which it purports to be studying. That described in the paper by Tantum and colleagues (November *Journal,* p.470) did exactly that; their work undermined rather than supported traditional patterns of general practitioner behaviour.

I write from Rochdale district. I suspect Rochdale is the mill town described in the paper. I have had drug misusers on my list ever since I started practice 20 years ago. Several times in their paper the authors describe intensive promotion of the project among doctors. At the sharp end I am certain that they worked hard and saw mountains of paper disappear from their office. However, at the coalface I was vaguely aware that something was afoot at the nearby tertiary care regional centre. I did receive a pad of their multi-coloured forms which were of no direct benefit to me or my patients. Always willing to help, I filled them in, probably more assiduously at first than later. This tail-off phenomenon is well known and documented.[1] I do not believe that it corresponded with any tail off in treating patients.

I can confirm that our local psychiatrists suddenly developed heightened sensitivity to patients with problems of drug misuse, following contact with the tertiary care centre. Similarly, I received a protocol for the treatment of drug addicts. Top down dissemination of protocols is notoriously inadequate.[2] This protocol was for uncompromising withdrawal and was unsatisfactory as it failed the acid test of usefulness.

The matter was further complicated by the inception of drug teams. They had closer links to the regional centre, greater resources, and were willing to supply greater amounts of methadone than was customary among general practitioners. This served to undermine general practitioners' confidence at the very time this piece of research was taking place.

I believe the Rochdale drug team has the following composition: a manager, a social worker, a psychiatric nurse, a child care worker, a probation worker and sessional input from two local general practitioners. I understand that they have a load of between 80 and 100 clients. In my own single-handed practice of 2700 patients in adjacent Heywood I have 18 registered opiate addicts who I treat with maintenance/withdrawal therapy. The money I received for a drug dependency health promotion clinic has now been withdrawn.

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Teaching the art of medicine

Sir,

Bruce Charlton (November *Journal,* p.475) is to be applauded in his discussion of humane medicine, both for his consideration of the philosophy of medical education and for his comment on the science of medicine.

To most doctors medicine is seen as a science both in its frame of reference and in its practice, and to many it now assumes a commercial dimension. In many ways, however, it is appropriately classed with the arts, considering its background and expression, and this is seldom recognized either in training or in practice. The result often breeds a pseudo-science which is compelled to analyse everything with familiar 'scientific method' even when this may be inappropriate,[1,2] and which rejects innovations not conforming to these constricting regulations.[3]

Science is concerned with the discovery and exploitation of data on repeatable patterns in isolated units with maximum precision.[4] Medicine (certainly general practice) has to consider disease (which is different in each case) in patients (who vary infinitely) in physical, psychological, social and spiritual contexts, by different doctors (who have the same variability as patients); and each variable and the response to it differs with time. Without the recognition of this we would not have made much of the progress which the Royal College of General Practitioners has helped to foster in recent years. Although each of these variables may be measured scientifically, the whole may not.

While we may base our practice on the soundest scientific principles we can find, it is often valid to look to the arts to help us to function optimally. Like medicine, the arts are concerned with the uniqueness of the individual and of an individual's responses.[4] We should already be aware of books, poems, films or paintings which have helped us to form our responses to experiences our patients have had but we have not. Much of Plato's philosophy is based on the premise that art is a search for the recovery of perfection or wholeness;[5] the same could and should be applied to the active process of healing[6] ('heal' is derived from the Old English meaning 'whole').

The *British Medical Journal* recently published an article by a schoolgirl, a prospective medical student, on her experience shadowing a house officer.[7] In it she described her reaction on witnessing death: 'I think it could be hard to remember that each death can never happen again and that each person's grief is different and cannot just be given a prepackaged response.' An artist has no difficulty with this, nor have most doctors. But science could only provide a 'prepackaged response', and most of us have been guilty of considering death only in scientific, statistical, or even commercial terms. I hope the writer of this article will not lose her insight as a result of scientific training at medical school.

A shift from purely scientific towards a more artistic medical training (or education[8]) would demand a philosophical sea change. At the very least it is important that doctors realize the proportion of their profession which is art rather than science.

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Burnout

Sir,

I was interested in Ruth Chambers' editorial about avoiding burnout in general practice (November *Journal,* p.442). The pressures on general practitioners can be divided into a number of different areas. First, there is the stress of providing a readily accessible service, day and night, to the patients in the practice. That is what most of us anticipated as we entered medical school, and regard and welcome as our proper professional role. Incidental and vital to such a service is the establishment of good relationships with colleagues, both medical and non-medical, in the practice and the setting up of a well organized management structure. Naturally, indispensable to all this is a satisfactory, fulfilled and supportive domestic ambience. In addition, we must all, as individuals, ensure that we take steps to keep up to date across the whole spectrum of general practice.

Primary care in the 20th and 21st centuries requires a considerable input into the organizational structures above individual practices, to the benefit of all. It is only fair, therefore, that general practitioners should take their turn in representing their colleagues on National Health Service committees, and play their part in running postgraduate training and education, and generally pulling their weight in the organization of the Royal College of General Practitioners, the British Medical Association and local medical societies.

I think the general public acknowledges that the obligations of general practice outlined above constitute a full, even overburdened existence — far more so than those of, for example, lawyers, accountants, bankers and most business people. No wonder some of us burn out. Those of us that do not often do so at the expense of our cultural and social lives, with much less time for recreational reading, visits to the theatre or generally playing our part in the community.

You will recognize, of course, that the huge additional burdens of the new contract for general practitioners have not yet been listed. There is no need to enumerate them, for we are all only too well aware of them. It seems to me extraordinary that no reference was made to them in the editorial. Burnout is a concept of the last few years, and is clearly getting more common. If a vessel is full to the brim, and more is added to it, it can accommodate the extra either by overflowing or by springing a leak. Put another way, our reaction to trying to cope with the intolerable stresses of the last three or four years is either to burn out or to water down our erstwhile professional standards, in addition to encroaching on our domestic and social life. A critical difference between a general practitioner in the NHS and those in the professions mentioned is that the latter are able to limit their workload, and we clearly cannot.

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Sir,

Ruth Chambers is right to remind us of the stresses from the kind of work that general practitioners do (editorial, November *Journal,* p.442). My departure from general practice at the age of 55 years has resulted in many general practitioners opening their hearts to me about their frustrations. This self-selected group rarely express as their main problem frustration 'by working in a partnership that is resistant to change or unwilling to invest in more practice resources'. These doctors, like me, suffer from stresses outside the practice. The year on year underfunding of the National Health Service, hugely increased in the last decade, means that we cannot get for our patients the services that we see that they need.

Mr X may cause us 'heartsink' but all too often it is not Mr X that is the problem, but the fact that he has been found on the floor again and is unable to get up unaided, incontinent and needs to be admitted to hospital. The heartsink is the awful knowledge that there are either no hospital beds available for Mr X, or that one will be found for him but that bed will be the one that was being kept for Mr Y, another patient who was booked in for the following day for the third time to have his triple bypass operation.

The enthusiasts for the NHS reforms may genuinely believe that the internal market will improve services. One certain effect of them, however, has been to shuffle the responsibility for the effects of underfunding from the shoulders of the government onto local doctors and managers. It is the helplessness that general practitioners feel when landed with the responsibility for telling patients that they cannot have treatment because it has been cut by the government, which is the source of the burnout, as well as the source of other symptoms of stress such as heart attacks, nervous breakdowns or addiction.

Virginia Bottomley tells us general practitioners that we are responsible for preventing heart attacks. Well, I have taken her advice and prevented my own heart attack by leaving general practice.

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Chronic pain

Sir,

I read the paper 'Evaluation of a cognitive behavioural programme for rehabilitating patients with chronic pain' (December *Journal,* p.513) with interest and admiration. Management of chronic pain is a daily challenge for the rank and file general practitioner and this stimulating original paper made a lot of sense.

It is surprising that behaviour therapy, so well established in Sweden and the United States of America has not caught on in the United Kingdom for the management of chronic pain. This is despite the fact that the role played by perception and belief in the aetiology of chronic pain is not disputed.[1-3]

For some reason this paper has remained low profile; it has escaped the radar screens of the lay media especially the women's magazines which often provide advice on such matters. Despite this I believe that if these results could be substantiated by others, we could be observing the signal of a new dawn in the management of patients with chronic pain.

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