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Your correspondent Jill Thistlethwaite¹ asks the question: 'If we learn the techniques of "patient-centred" consulting and demonstrating empathy without really liking patients or agreeing with patient partnership is this a problem?'. I would suggest that it is not a problem at all, that it would be unreasonable to expect a GP to like or feel empathy towards every single patient at every consultation, and that we are required as GPs to behave in a professional way at all times even if it does not come naturally. The evidence comes from sociology and our colleagues in the acting profession.

In 1959, the American sociologist Erving Goffman² wrote about his enquiries into how motivation manifested itself as behaviour. He concluded that it was quite possible to explain behaviour as a set of 'fronts' — pieces of behaviour that people use in order to pursue relationship objectives. The use of such fronts becomes internalised so that they become part of unconscious normal behaviour. He argued that all people in all aspects of their interpersonal interactions use behaviour in a way designed to bring about the required result.

Does this mean that behaviour that is not 'from the heart' is immoral or unethical? Not at all. Dr Thistlethwaite also mentions the 'method' school of acting, which was prompted by the writing of Constantin Stanislavski³ even longer ago. It was he who also wrote of 'emotion memory' — if an actor is trying to express a particular emotion, his advice was for the actor to search his own life experience for a situation when he felt that emotion for real, and then to duplicate the behaviour. The behaviour used is accordingly an accurate demonstration of how that actor

would behave when genuinely in that emotional state. If the portrayal is to be convincing, then an actor must be acutely aware of his own life and behaviour and not just that of his character.

Even longer ago, a certain William Shakespeare was moved to include in *As You Like It*:

*'All the world's a stage,
And all the men and women merely
players:
They have their exits and their
entrances;
And each man in his life plays many
parts ...'* (Act two, scene seven.)

So there is not a problem. People, including GPs, cannot on occasion avoid behaving in ways that are inconsistent with how they feel at the time. The problem is when this fact is not accepted, and when the motivation becomes more important than the delivery.

ED WARREN

General Practitioner, Sheffield.
E-mail: ed@warren1952.fsworld.co.uk

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Chaotic consultations

The authors of 'Complex consultations and the edge of chaos' (Innes *et al*)¹ are to be congratulated on making complexity theory accessible and on linking it so clearly with the consultation process. In these times of over-rationality and managerialism any explanatory model that helps GPs to acknowledge and make use of the inherent uncertainty of front-line encounters is to be applauded. However, I couldn't help but feel that this was just another way of conceptualising the importance of the unconscious in human behaviour and interaction, as understood through a

basic knowledge of psychoanalytic theory. The 'edge of chaos' of complexity theory may be the same as the 'flash' of insight that the psychoanalyst Michael Balint and his colleagues taught previous generations of GPs to generate and use in short consultations.^{2,3} This is not a criticism of complexity theory; indeed, if several different theoretical perspectives all point to the importance of working with uncertainty and non-rational behaviour this not only highlights the importance of such interventions, but allows general practitioners to base it on the theory that they feel most comfortable with. Having at last grasped what complexity theory is, I look forward to the deepening of understanding that will come about as it is tested out in practice.

CHARLOTTE PATERSON

Research Fellow, University of Bristol.
E-mail: c.paterson@bristol.ac.uk

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Buprenorphine versus methadone — safety first?

I was concerned that the otherwise very thorough review by Simoens *et al*¹ gave little emphasis from their findings as to the superior safety profile of buprenorphine as a maintenance agent. It would have been useful to have some comments in the review as to the comparative overdose and mortality statistics in the studies examined.

Methadone has gained notoriety in the medical press on many occasions in the past, on account of the substantial mortality associated with it, and the Advisory Council on the Misuse of Drugs report, *Reducing Drug-Related Deaths*,² confirms our suspicions. However, for many years methadone has been the