

only pharmacological option open to GPs. As a result, most have lost interest in trying to help heroin addicts — or at worst use the safety argument as a handy excuse to refuse to help, despite the impressive evidence base to support maintenance prescribing of methadone.

Buprenorphine is undoubtedly much safer in practice, for reasons that were only touched on in the review. However, this is one of the most important factors that would lead GPs to consider prescribing it. The research base regarding community buprenorphine prescribing in the UK is still scanty and there is a pressing need to expand the available options for the treatment of opioid addiction beyond methadone. I have had extensive experience prescribing buprenorphine in primary and secondary care over the last 3 years and have found it simpler, quicker and safer to titrate and stabilise patients than by using methadone.

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REFERENCES

1. Simoens S, Matheson C, Bond C *et al*. The effectiveness of community maintenance with methadone or buprenorphine for treating opiate dependence. *Br J Gen Pract* 2005; 55: 139–146.
2. The Advisory Council on the Misuse of Drugs. *Reducing drug related deaths*. London: The Stationery Office, 2000.

Research governance

I read with interest Chris Salisbury's article in the January edition of the *BJGP*.¹ I should declare interest in the issues raised as research manager for three PCTs and a researcher with long experience in both health and social care.

Research governance became my responsibility in April 2002 as a result of national directives. While the areas that had to be covered were made clear, we started with virtually nothing in the way of detailed procedure and guidance. This has gradually improved, and the work not only of the NHS R&D Forum, but also

local support from Trent Focus has been very welcome in bringing in what has often been a complicated and sometimes stressful process. This appears to be in total contrast to the major changes in the running of ethics committees, where detailed procedures and timescales have been the order of the day.

Research governance is still a long way from being a system that minimises bureaucracy while also ensuring that research of a reasonable quality takes place. Your writers' comments about the amount of time it takes for research staff are well founded; however, the same applies to those given the responsibility for giving management approval. Research in the NHS is a crucial activity for the improvement of patient care, which can absorb significant amounts of patient and staff time.

Quality, and to some extent quantity, appear to me to be the key issues. We have to remember that the origins of research governance are in some very questionable research practices in places such as Alder Hey Children's Hospital. Ensuring that PCTs know about all research being carried out in them and that it has management approval is something I would hope most of your readers would support. Local experience, particularly in the field of commercial drug trials, suggests that there is room for improvement not only in the quality of some projects, but also in carrying out work where benefits to patients outweigh the potential side effects. We do, however, want to support good research — be it commercial, academic or in-house in origin.

It is a pity that a lack of central guidance and support has led to the bureaucratic minefield that research governance can be. Its existence in a less onerous form is something we should all support.

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REFERENCES

1. Salisbury C, Leese B, McManus RJ. Ensuring that research governance supports rather than stifles research. *Br J Gen Pract* 2005; 55: 4–5.

Where there's smoke ... there's council tax valuation band A

Cigarette smoking, more than any other known factor, reduces healthy life expectancy;¹ so smoking cessation is a supremely important health-promotion target. How this is best achieved is the thrust of a massive report by West² and colleagues in 2000. Although it included not a single 'journeyman' GP, this panel of 'experts' saw primary care clinicians as best placed to intervene effectively and recommended that, during routine consultations, GPs should be advising smokers to stop. But even before the report appeared, the practicality of this edict was being questioned: smoking habit is discussed in only 20–30% of everyday GP consultations with smokers.³ Merely urging GPs to advise smoking cessation seems unlikely to succeed; the gulf between 'symptom-led' activity and 'population-based' interventions is too wide. How, then, should we close the gap between ambition and reality? The obvious answer would seem to be for GPs being primed — to know, in advance, which patients are most likely to be smokers and for this additional burden in consultations to be embarked on only where relevant. After all, consultations in UK general practice are events that are already uncomfortably overcrowded.

We wondered whether the council tax valuation band (CTVB) of patients' addresses might provide a means of so 'spotting' smokers, and tested the hypothesis that CTVB is associated with household smoking rates. Four-hundred and fifty practice households were randomly selected from our practice list, and were telephoned during the summer of 2003. Responders were asked: 'Are there any cigarette smokers living at your address?'. Responses were recorded, categorically, as either 'yes' or 'no': no attempt was made to identify individual smokers nor the number of cigarettes smoked. CTVBs of the responding

households (96%) were obtained from the Council Tax website.⁴

It is clear from the findings (Table 1) that CTVB locates smokers and could be used to flag those consultations in which discussion of smoking habit would more often be time-effective. Though daunting, it is a simple task to append registration details of patients with the CTVB of their current address using the website.⁴ Armed with this information, one knows the likelihood of being with a patient from a smoking household to be 50% for those living in CTVBs 'A' or 'B', as opposed to a 20% chance for their CTVB 'D' and above counterparts. Thus, GPs and nurses in primary care can know when smoking advice is more likely to be needed and make time for it; and UK general practices 'loaded' with many patients in lower CTVBs can justify enhanced resources for smoking cessation activity.

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REFERENCES

1. Woodward M, Oliphant J, Lowe G, Tunstall-Pedoe H. Contribution of contemporaneous risk factors to social inequality in coronary heart disease and all causes mortality. *Prev Med* 2003; **36**: 561–568.
2. West R, McNeill A, Raw M. Smoking cessation guidelines for health professionals: an update. *Thorax* 2000; **55**: 987–999.
3. Coleman T, Wilson A. Anti-smoking advice from general practitioners: is a population-based approach to advice-giving feasible? *Br J Gen Pract* 2000; **50**: 1001–1004.
4. The Valuation Office Agency. Council Tax Homepage. http://www.voa.gov.uk/council_tax/index.htm (accessed 11 Feb 2005.)

Table 1. Percentages of homes, categorised by council tax valuation band, inhabited by smokers.

Council tax valuation band	Households with ≥1 smoker (%)
A	26 (55)
B	58 (45)
C	30 (28)
D	11 (16)
E+	16 (22)

χ^2 , 4 degrees of freedom, 34.27, $P < 0.001$

Palliative care in end-stage COPD

Thank you for publishing the two studies^{1,2} which provide some thought-provoking evidence on the patterns of care provided to COPD patients in the last year of their life, as compared to cancer patients in a similar situation.

A terminal phase of an illness can generally be recognised when the shared decision-making forum of patients, nurses, doctors and carers acknowledges the prospect of an early and inevitable death. Disseminated cancer and motor neurone disease are generally recognised by the lay population for what they are: processes that, barring miracles, inevitably kill and against which doctors have no effective weapons. Without the pressure to perform futile life-prolonging heroics, doctors are free to concentrate on what they can do to help the patient under these circumstances.

End-stage patients who do not have these diagnoses quite possibly perceive themselves, and are perceived by their carers, as potential candidates for interventions that might prolong their life, irrespective of whether or not this is actually the case. Because of the uncertainty and the non-inevitability of death in these patients, I suspect that doctors are altogether more fearful of being seen to 'write patients off', which is what a palliative-based agenda might be seen to do, and instead pursue a policy of 'doing what they can' even if this might be less comfortable for the patient concerned. I think this is particularly likely in cases in which influential relatives live at a distance, or appear infrequently, professing strong views. I also think it more likely among patients from lower social classes (among whom deaths from COPD are more prevalent anyway), where cultural barriers prevent empathic communication and might undermine a clinician's confidence in embarking on an effective-palliative, as opposed to an ostensible-curative, policy.

The recent spate of cases, reported in the media, where agonised parents of terminally-ill babies have fought to compel paediatricians to prolong their lives, should serve as reminders to us that this area of

medicine is fraught with potential ethical challenges. Careful evidence-based strategies will be needed to get patients and their relatives clearly on board, so that doctors can act in the interests of their patients without fear of serious complaint.

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REFERENCES

1. Halliwell J, Mulcahy P, Buetow S, et al. GP discussion of prognosis with patients with severe chronic obstructive pulmonary disease. *Br J Gen Pract* 2004; **54**: 904–908.
2. McKinley RK, Stokes T, Exley C, Field D. Care of people dying with malignant and cardiorespiratory disease in general practice. *Br J Gen Pract* 2004; **54**: 909–913.

Correction

Jepson R, Weller D, Alexander F, Walker J. Impact of UK Colorectal Cancer Screening Pilot on primary care. *Br J Gen Pract* 2005; **55**: 20–25.

On page 24, paragraph two, it incorrectly states that:

'... practice staff members in Scotland were more likely to think that it would substantially impact on workload than practice staff in England: 44.7% (95% confidence interval [CI]= 20.6% to 32.6%) versus 26.6% (95% CI = 38.3% to 51.2%) in Scotland.'

The authors would like to amend this to:

'... practice staff members in Scotland were more likely to think that it would substantially impact on workload than practice staff in England: 44.7% (95% CI = 38.3% to 51.2%) and 26.6% (95% confidence interval [CI]= 20.6% to 32.6%) respectively.'