urgently treatable problem (coronary stenoses) must be solved without delay. Other causative levels (that is, risk factors) can be addressed later. In this and many other situations, the spiritual needs of the patient may require addressing but are not a priority.

The hypothetical scenarios also imply that holism can have its limits, for example, when the patient does not cooperate. In real life, this frequently seems to be the case. Mr Nash was not fully compliant with dietary measures and did not want to talk about his family problems. Holistic health care is an ideal that many clinicians subscribe to, but it does not work if patients do not want it.

It could, of course, be argued that the scenarios I have created here are exaggerated caricatures of reality and that the conventional approach is a rather optimistic description of what might happen to a patient in the current NHS. This may well be true. My aim was not to depict 'real life' but to tease out potential problems with the current misuse of holism. Caricatures can make certain features more obvious than reality. If nothing else, my approach implies that naïve holism may be attractive to many patients, but that it can be a dangerous distraction from the most important issues in health care. Yet I do believe that holism is important — too important to be delegated to alternative practitioners! Those who agree with this view should consider ways of reintroducing it into modern medicine where it may have gone missing.

In conclusion, good health care is likely to be holistic but holistic health care, as it is marketed at present, is not necessarily good. The term 'holistic' may even be a 'red herring' which misleads patients. What matters most is whether or not any given approach optimally benefits the patient. This goal is best achieved with effective and safe interventions administered humanely — regardless of what label we put on them.

Edzard Ernst

Personal profile on pain

Living with constant pain is a problem not only for the sufferer, but also for their family, friends and indeed everyone who touches their life. We all have a threshold of pain where one can endure no more without medication, or any of a variety of treatments. With the assistance of these it is hoped that one can enjoy life as near normal as is possible. Beyond that level is the great unknown, of side effects from increased medication, and in some cases mood swings on a daily basis. These side effects vary greatly depending upon pain threshold, specific case history, and medication prescribed solely for the individual; in extreme circumstances there can be dramatic consequences.

It was while at the limit of my personal pain threshold, and a resulting discussion with my GP, that my quest for knowledge about the long-term use of opioid medication began. Put simply I have a desire to know what lies ahead of me, with regard to quality of life and how best to assist my ailing body in order to cope as best I can in the future.

I have led a full and varied life for 56 years. Occupations have spanned professional football, civil service scientific work and hard manual labour. From a very young age, sport of all kinds, competition and a desire to be the best, with along the way injury, wear and tear, as well as broken and damaged bones, have all contrived to place me in my current condition. Mine is either a case of bad luck or inevitability, but deal with matters I must, as there is no alternative. Hence my discussion with my GP, which followed many years of excellent care from the NHS.

With the Honiton Surgery being a Research Practice, the idea of tackling my circumstances and fears through the mechanism of a fully accredited research project for the community appealed to my GP, because as well as being of benefit to me personally, it could also be a worthy subject to apply for funding to see if my situation was common among others taking strong opioid medication for chronic non-cancer pain. With the guidance and help of my GP I was invited to attend a course on research methodology in Exeter with the assistance of the Folk.us organisation. On the course I studied grounded theory, qualitative and quantitative research, phenomenological study, as well as the basics of research in the wider community. It was necessary to do this to satisfy the stringent requirements of the ethics committee in order to be granted an honourary research contract to assist the research team at the Honiton surgery under the guidance of the Exeter Primary Care Trust. The whole process was of great interest, reward and fulfilment to be among professional dedicated people and be allowed to take a small part in their never ending efforts for the community.

The project took the form of compiling knowledge in a qualitative approach from interviews with people suffering and coping, on a daily basis, with pain management in their own individual circumstances to try and determine, by thematic analysis, any recurring details or patterns common to all sufferers of pain who are taking strong medication. The interviews were transcribed and the research team met periodically to discuss and evaluate the relative merits of the individual interviews. The overall results produced really interesting and in some cases surprising points of similarity, which could be grounds for further professional investigation on a wider basis.

Brian Ruel

The results of this study are presented on pages 101–108.