present stage of development and Dr Sowerby's excellent paper raises important questions that are central to this issue. With regard to the second assumption I feel that although we should strive for improved methods of scientific enquiry, and I have found Popper's philosophy of great value in this respect, great contributions can be made to our struggle to establish general practice as an academic discipline by those among us who state their views and observations without necessarily being able to prove or refute them. I think the value of this type of contribution is eloquently supported by Marshall Marinker's recent review of *Doctors Talking to Patients* (February *Journal*, p. 113).

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Reference

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Sir,

I should like to thank all those who wrote to you for their kind words and valuable comments on my paper (October *Journal*, p. 583). I should also like to clarify one issue on which I seem to have expressed myself badly.

Dr Ellison, Dr Manasse (January *Journal*, pp. 56, 57), Dr Sackin, and Dr Scott (February *Journal*, p. 110) all rightly point out how concerned Balint was to understand the patient as a whole person. In this I am in full agreement with Balint. My paper should be regarded as a plea to understand that to do so is more difficult than even he believed. Balint thought that his approach to understanding the person was as scientific as our approach to understanding physical disease, and that he had gone some way towards achieving the most desirable goal of intellectually unifying our understanding of body and mind. I applaud and admire the goal and the effort but alas I think the aim was not always true. It was true, as I said in my paper, so long as he stuck to descriptions of behaviour. It went awry when he tried to interpret that behaviour. In the continuing absence of any substantial "science of persons", as Laing (1960) described it, we must make do with what understanding we have, which is intuitive. I have the greatest sympathy with those who think I have enlarged the gap between psyche and soma and sincerely hope that this is a mere intellectual illusion. I wrote the paper in the belief that the clearer we see the boundaries of this divide, the better we shall be able to bridge it.

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Reference

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JAMES MACKENZIE LECTURE

Sir,

The 1977 James MacKenzie Lecture (January *Journal*, p.6) stressed the importance of home visiting and your readers may be interested to know the visiting rate in our practice.

Between November 1976 and 30 November 1977 in an NHS practice with five partners and an average of 2,742 patients, our total practice visiting rate was 0·64 visits per patient per year.

Our practice uses commercial deputizing services only to cover periods of sickness and holidays, and we have one of our own partners in reserve when the deputizing service is being used so that it is possible to attend conditions needing urgent or specialized care.

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Sir,

May I add a small round of applause for your superb James Mackenzie Lecture (January *Journal*, p. 6)?

I think the basic philosophy that you clarify in the early part of the paper is particularly important, as are the data that you have collected in support of it.

Sometimes in Canada we find the rest of the medical profession resistant to such ideas; indeed, even some of the academic departments of general practice find this kind of thinking difficult, and it is helpful to read a paper which sets out these ideas so clearly.

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Sir,

The James MacKenzie Lecture (1977) delivered by Dr Pereira Gray elaborated in a most perceptive manner many of the unspoken feelings and ambivalent attitudes held by family physicians with regard to their role in caring for the patient at home. There cannot be many who will disagree that better knowledge of family history, family psychodynamics, the home environment, and local cultural conditions form an important backdrop in both understanding and preventing illness.

Unfortunately, the "vacuum of care" against which Dr Gray warns forms yet another task among the many which family physicians are currently exhorted to undertake lest they relinquish their status. In recent years their objectives have included more effective practice organization, health team management, reducing hospital outpatient visits by improving and increasing the scope of care, health education and preventive medicine, arranging adequate time for themselves and their families, maintaining continuity of care, increasing their commitment to hospital care, and regaining the practice of obstetrics. I wonder if family physicians can really expect to attain all these objectives as well as maintain the pattern of home care and visiting.

Dr Gray's comments about the lack of controlled studies on home obstetric deliveries can be applied in the same way to home care itself. The value of the knowledge of home and family as it affects the progress and outcome of disease is not established. In other words, there is no evidence that family doctors, through this knowledge, can effect any added benefits to their patients. Are the costs, in time and money, of purposefully acquiring this knowledge and implementing it by home care amply rewarded by improved outcomes?

From the American point of view, home visiting appears to have been priced out of the market, yet there also seems to be some reversal of this trend and most of the family practice training programmes have used home visits at least as an educational exercise (Curtis *et al.*, 1977). Home visiting in the US may have been partially replaced by telephone medicine. This is an economic form of care in which the patient consults from home with the doctor. Most Americans have a telephone and there is evidence of high consulting rates after hours of up to 500 calls per 1,000 patients per year as opposed to an average of 9·2 calls per 1,000 patients per year in Britain (Cargill, 1976; Hogg, 1976). Primary care paediatricans may spend up to three hours a day consulting on the telephone with mothers (Perrin and Goodman, 1978).

The direct costs of medical care to