with the doctors enabled patients from all walks of life to accept help with their social problems. It demonstrates clearly that patients do consult their doctors with problems that frequently have a major social component, for 1,000 patients were referred to the social worker during a four-year period and this figure by no means represents the total need. A considerable proportion of these 1,000 patients was not known to the local social work agencies.

General practitioners are acutely aware of the social problems associated with bad housing, psychiatric illness, poverty, loneliness, old age and terminal illness. It was precisely in these difficult areas of practice that the social worker was able to demonstrate her skills in assessing need: offering information, advice, practical help, and providing essential therapy in the form of short-and long-term casework. The book provides an excellent description of the social worker's role and methods of working which will be particularly valuable to doctors unfamiliar with the subject.

The book shows how after the resolution of initial difficulties over the respective roles of the social worker and the health visitor, the inter-disciplinary group settled down to work as a closely knit team. In her introduction, Dame Eileen Younghusband says "The quality of the casework and the ability to work as a member of a team are more important than previous experience in a particular setting." In the final analysis it is the quality of the interpersonal relationships in any group practice team that will determine the effectiveness of care provided.

The authors show that a social worker has a valuable contribution to make to a general-practice team and that general practice is a very acceptable setting for social work. They recognise however that formal attachment may not be the only way in which social workers and general practitioners may collaborate. It may be that many patients could be adequately helped at the area office of the local social services department. One of their most important conclusions is that, "Whether clients have to knock at one or more doors to receive the medical and social help they need is perhaps less important than that the rooms they enter should interconnect."

This book is clearly written and is immensely readable, it is particularly recommended to vocational trainees and their teachers and to all general practitioners wishing to keep abreast of this important and rapidly expanding field of practice.

L. RATOFF

A Sociology of Medical Practice. Cox, Caroline and Mead, Adrianne, pp. 318. London: Collier Macmillan. Price: £2.75.

My undergraduate education contained no mention or recognition of the existence of sociology. In my middle age, sociology seems to be not only important, but a subject whose importance to me as a practising doctor grows.

The foreword, written by Margot Jefferys, is dated November 1972, and most of the papers which it contains, were published in the 1960s. Very few of them, one of the exceptions being Julian Tudor Hart's *The Inverse Care Law*, were familiar to me before I read this book. Most of them I found extremely stimulating and readable. I. K. Zola on *Medicine as an Institution of Social Control*, not only antedates Illich, but is more balanced, and at least as eloquent. Ernest Becker on *Socialisation, command of performance and mental illness*, has made me aware of the value of being articulate. In most civilised societies this results in articulateness being positively correlated with leadership: a correlation which may not be desirable.

E. Th. Cassee is excellent on *Therapeutic behaviour, hospital culture and communication.* Erving Goffman on *The inmate world*, paints a picture which is as frightening as anything I have ever read.

In the space of a brief review, it is not possible to draw attention to all the good things in this book. Perhaps I can best give an idea of its flavour by quoting a little at length from Zola: "This paper is not an attack on medicine so much as on a situation in which we find ourselves in the latter part of the twentieth century; for the medical area is the arena or the example *par excellance* of today's identity crisis—what is or will become of man. It is the battleground, not because there are visible threats and oppressors, but because they are almost invisible; not because the perspective, tools and practitioners of medicine and the other helping professions are evil, but because they are not. It is so frightening because there are elements here of the banality of evil so uncomfortably written about by Hannah Arendt. But here the danger is greater, for not only is the process masked as a technical, scientific, objective one, but one done for our own good. A few years ago a physician (G. S. Myers) speculated on what, based on current knowledge, would be the composite picture of an individual with a low risk of developing atherosclerosis or coronary-artery disease. He would be:

> . . . an effeminate municipal worker or embalmer completely lacking in physical or mental alertness and without drive, ambition or competitive spirit; who has never attempted to meet a deadline of any kind, a man with poor appetite, subsisting on fruits and vegetables laced with corn and whale oil, detesting tobacco, spurning ownership of radio, television, or motorcar, with a full head of hair, but scrawny and unathletic appearance, yet constantly straining his puny muscles by exercise. Low in income, blood pressure, blood sugar, uric acid and cholesterol, he has been taking nicotinic acid, pyridoxine, and long term anti-coagulant therapy ever since his prophylactic castration.

This I fear with Freidson: "A profession and a society which are so concerned with physical and functional wellbeing as to sacrifice civil liberty and moral integrity must inevitably press for a

'scientific' environment similar to that provided laying hens on progressive chicken farms—hens who produce eggs industriously and have no disease or other cares."

This book is a must for all teachers in general practice, all practising doctors, and I hope, all undergraduates.

J. S. McCORMICK

Dutch Balint groups. Le phenomene Hollandais. (1973). STEEL, ROBIN. Pp. 37. St John's House, 28 Bromyard Road, Worcester. No price.

Dr Robin Steel is an English general practitioner with a particular interest in the educational role of Balint groups as part of professional preparation for general practice. On learning that in Holland 15 per cent of its family doctors had experience of such groups (compared to one per cent in Great Britain) he decided to visit that country to study the movement first hand. He obtained a Council of Europe Travelling Fellowship which allowed him to spend a fortnight in June 1973 visiting Dutch practices, clinics and universities and conferring with family doctors, psychoanalysts, professors, researchers and administrators.

He has entitled his report, *Le Phenomene Hollandais*, unnecessarily obscure, if exotic, and thereby creating a passing problem for reviewers and a major headache for medical librarians. The account was intended to be an individual one and succeeds in being idiosyncratic. It is written in a racy style, and though the sentence structure is sometimes disconcertingly unwieldy it is totally without pomposity.

The "phenomenon" he describes is the vigorous and sustained growth of Balint and kindred groups throughout Holland, and their acceptance as part of the normal scene in Dutch general practice. This is in contrast to the situation here where the movement, though very active, has about it the air of a minority cult ("The Tavistocracy" it has been called), and where furthermore it is geographically restricted to London and its environs. True, the impact on British medical practice has been out of all proportion to the small numbers taking part. Yet the demand from general practice for fresh groups has until now been disappointingly modest, though it may receive a fillip from the formation of the Balint Society and from the International Conference held in London.

This study explores two facets of integration. There is the practitioner's need to integrate the separate pieces of information he has about his patients and their families—physical data, psychological, and social. And there is the problem of integrating the varied educational resources available, of harnessing them to meet this need. How the Dutch have tackled this is well described in the pages of the report. They seem to have gone for a less hot-house atmosphere, have not been afraid to experiment and to improvise, and are not over-concerned with keeping the strain pure; it is not always clear whether the term "Balint" denotes a format, a group process, or a task orientation.

In Holland the demand for groups usually emanates from local general practitioners and the organisation is not centralised. A "network" ensures close collaboration with interested Dutch psychiatrists, whose fees and travelling expenses are met by the practitioners. The normal arrangement is for groups to meet fortnightly with a specialist "Advisor" (not "Leader") who is usually a psychoanalyst or a dynamically orientated psychiatrist, but who may be a clinical psychologist, a physician with interest in psychosomatic illness, or a social worker experienced in group work. The natural life of such groups appears to be about two or three years but some continued as topic-centred groups, teaching, research, or as social affairs.

According to Dr Steel the Dutch show more interest than their British colleagues in the knotty problem of evaluation, and he quotes a fascinating account of a study which involved a peripatetic actress tape-recording her way through a series of consultations with Balint-trained doctors. Naturally, there were matched control groups of "role-play trained" and "non-trained" general practitioners.

J. NORELL