HEARING AIDS

Sir,

Like other general practitioners I see a number of people suffering from presbyausis. If I have my definitions right the symptom is deafness, with marked high-frequency loss, which affects the ageing. Whether moderately deaf or very deaf indeed, it is my experience that people suffering in this way get little or no help from hearing aids. It may be that they only rarely get enough help to be thoroughly worthwhile and it is the management of this difficult group which provokes this letter.

It has been my experience that they get into the hands of people who have more salesmanship than science. I can think of three patients who never ever use the very expensive gadget they have bought. When one has given a patient very clear advice that he should be prepared to test a gadget and pay liberally for a test period but on no account buy it, it is indeed rather frustrating to find that he has been persuaded to buy outright.

It may well be that colleagues know of a supplier of hearing aids who is willing to lend apparatus so that patients can find out whether it is going to help them or not. I should very much like to hear of such a firm if it exists.

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SEEING THE SAME DOCTOR

Sir,

I agree with Dr Touquet (August *Journal*) on the disadvantages to patients of a combined list. There are disadvantages for the doctors as well. With a large combined list it is impossible for any partner to know all the patients. This must mean he is a poorer doctor for anyone who sees him. If the patients ' chop and change ' between doctors, they allow the doctor to evade his responsibilities, and a job without responsibility is a boring job.

The partnership can suffer. When a patient consults his doctor's partner, the partner is flattered. He will be reluctant to refer back the patient, thinking it a kindness to solve a medical problem for his partner. But he may see the patient as a failure and come to resent his partner. Worse, he may get delusions of excellence about his own capabilities. He may not observe his own patients changing partners and will forget to ask himself why they have done it.

The reputation of the practice is damaged. If a patient is referred to a consultant, how is the reply to be addressed? To the referring doctor? To the partnership? To the doctor with whom the patient is registered? To the doctor with whom the patient thinks he is registered? If it is not clear who the patient's doctor is, the consultant may feel the doctor is only vaguely interested in the patient. This might also apply to other people with whom the partnership communicates—the health team, employers, union, solicitors, and so on.

Balint wrote about the effects of the dilution of responsibilities between family doctor and consultant. It can also happen inside a shared list group practice. Like Dr Touquet, I favour group practice, but the shared list is not a feature which notably contributes to its great advantages.

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JARGON

Sir,

In reply to Dr C. W. L. Smith's letter (August *Journal*), my letter (May *Journal*) was written more in response to Graham and Sher's paper (February *Journal*) than to Brook and Temperley's.

I was expressing what I think is a fairly widespread concern about the dangers of introducing ideas and particularly jargon from another discipline into our own, where they may act as a smoke screen for the passage of new methods, or simply cloud the issue; hence my comments about propaganda and brain-washing, and betraying the principles of our respective disciplines.

I was not convinced that the techniques of psychotherapy or the use of the sociological concepts described had themselves significantly altered the outcome for the patients. I suspect it was the enthusiasm, the continuing contact, and the compassion of the workers that largely benefited the patients—as was the case in the teams that once gave insulin coma therapy to schizophrenics.

We all have our particular enthusiasms and fantasies which may quite legitimately enable us to help our patients more effectively. In the case of the writers of an article in a medical journal, however, the onus of proof is on them, particularly if their ideas are going to be applied more universally.

In the case of Mrs A. (Brook and Temperley) we are not told whether the black woman lodger did in fact have a terrible temper. This could be important in enabling readers to judge whether the clinic worker had recognised correctly the unconscious meaning of Mrs A's preoccupation with her dangerous black lodger—that she " had within herself another, a black and violent side . . . ."

At the risk of being speculative myself, I suggest that the worker's technique may be merely an