EUROPEAN SYMPOSIUM

A symposium on "The Preventive and Medical Care and Social Security of Elderly People in the Country" will be held on 24 to 26 May 1978 at Baden, near Vienna, Austria. Those interested should apply to Dr Gustav Zimmermann, Sozialversicherungsanstalt der Bauern, Wiedner Gürtel 10, Vienna A-1041, Austria.

CORRECTION

In Dr K. D. Hudson's article in the August *Journal* it was stated that in patients with arterial disease fenfluramine raised serum glucose, cholesterol, and beta-lipoproteins, but this should have read: "Bliss, Kirk, and Newall showed that when fenfluramine is taken by patients with peripheral arterial disease there is a reduction of abnormal serum glucose, cholesterol, and beta-lipoproteins."

HEREFORD AND WORCESTER FAMILY PRACTITIONER COMMITTEE

In their *Annual Report* for the year ending 31 March 1977, the Hereford and Worcester Family Practitioner Committee reports that among 232 doctors on the list there were 17 doctors approved as trainers and there were seven vocational trainees in post.

There were 13,166 changes by patients from one doctor to another within the same area out of a population on the combined lists of the doctors practising in the area of 614,455.

During the year 35 complaints were received, of which in two the contractor was found to be in breach of the terms of service.

The total cost of the family practitioner services was £11,985,230, of which general medical services formed 34·2 per cent. The cost of services per person registered with doctors under the NHS was 6·86p per person for general medical services.

Reference

Hereford and Worcester Family Practitioner Committee (1977). *Annual Report.* Worcester: Hereford and Worcester FPC.

LETTERS TO THE EDITOR

BALINT REAPPRAISED

Sir,

I read with interest the article by Dr P. Sowerby (October *Journal*, p.583). As one who had the interesting experience of working in one of his seminars, I am sure that the effect has been to make me constantly question my role as a general practitioner.

The objective of scientific medicine is to make a traditional diagnosis. From that follows the treatment and, we hope, the prognosis. Balint took this a stage further, for an essential part of the diagnosis lies in the communication between the patient and the doctor. This used to be termed "the art of the practice of medicine". Balint attempted to discover a scientific basis (i.e. measurable features) for this interaction. Patients not only have diseases but also by their behaviour demonstrate their reactions to the disease. It is the appreciation of this fact that enables the Balint-trained doctor to enlarge his therapeutic possibilities.

However, this does not seem to satisfy Dr Sowerby. He seems to assume that the diagnosis must be in traditional terms. But is a diagnosis of depression, or psoriasis, or even rheumatoid arthritis, any different from the diagnosis as formed in Balint terms? None of these diagnoses necessarily increases our understanding of the aetiology of the illness—they are simply descriptive terms which have to be supported by clinical observation. So it is in Balint's approach. Furthermore, there is no reason at all why the significance of the Balint-type diagnosis cannot be compared with other similar cases, and the results of 'treatment' also compared. This is an essential part of the scientific method. The danger is the age-old one of separating psyche from soma. If Balint did nothing else, he demonstrated to doctors that the two were inseparable and needed to be treated as such.

STANLEY ELLISON
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Sir,

How refreshing it was to read Dr Sowerby's article (October *Journal*, p.583). As a young principal in general practice who has been through vocational training and had the ideas of Balint expounded to him at length, I was delighted to read such a clear exposition of objections to his theories—objections with which I fully agree.

I have never been happy that Balint's theory or practice was ever anything more than another contribution towards further understanding of some of the difficulties in general practice. Of course Dr Sowerby is right; some of general practice is intuitive.

The other component of my vocational training is that I am myself a third generation general practitioner who has watched my family at work. I know that a lot of their skills are intuitive and I realized during the course of my medical training that the population I could serve best was that that I knew best. The patients I knew best were those people of similar character to myself—that is, the natives from the belt of the country from which I originated. Having come back among them I find that my communication with them is much better than it has been with the population I have served elsewhere, even within the British Isles, and I certainly feel that my patients understand me better here. It has also proved true that some of my communication, at least with my patients, is non-verbal.

I must finish by saying that I did participate in Balint-type seminars but I leave it for others to judge whether I contributed fully or showed signs of the emotional insecurity suggested to be the reason why not all of us can fully subscribe to Balint's methods.

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Sir,

Whether we like it or not, patients come to us with tensions and distress of all kinds. We may say that this is not part of our work, or we may try to un-