the Family Practitioner Services) and to make recommendations on how to make better use of resources by improving these arrangements, with particular regard to the proposal to establish a Supply Board."

GROUP PRACTICE PREMISES

Dr Gerard Vaughan, Conservative Party health spokesman, in an interview with the Pharmaceutical Society, is reported to have said: "I should like to see a reversal of the trend towards health centres, which have in too many cases damaged the close relationship which should exist between patient, general practitioner, and pharmacist. I believe this would mean that a Conservative Government would have to make it easier financially for general medical practitioners to set up group practices outside health centres. This might even involve giving them help towards staffing."

Reference

The Pharmaceutical Journal (1977). **219**, 368.

LEVONORGESTREL

The World Health Organization and the British Pharmacopoeia Commission have officially adopted the name 'Levonorgestrel' for the active isomer of the progestogen, norgestrel, which was formerly known as D-norgestrel. For products containing both the active and inactive isomers of norgestrel the term DL-norgestrel is used.

Reference

Family Planning Association (1977). *Reviewed List of Contraceptives 1977-1978*, p.2. London: FPA.

COMPLAINTS AGAINST GENERAL PRACTITIONERS

The number of appeals by patients to the Secretary of State for Social Services against decisions adverse to the patient by family practitioner committees were as follows: 1975—65, of which three were successful; 1976—52, of which six were successful.

COST OF THE NHS

Mr Roland Moyle, Minister of State (Health) reported that Government spending on the NHS in England per head of population has been as follows:

	£ p
1970-1	35.75
1971-2	40.19
1972-3	45.57
1973-4	51.44
1974-5	72.06
1975-6	97.69

Reference

Hansard (1977). *Official Report*. No. 1074, **931**, col. 450.

PATENT FOR MICRO-ORGANISMS

The United States Appeal Court on 6 October 1977 allowed the Upjohn Company to patent the micro-organism *Streptomyces vellosus*.

This organism is used in the production of lincomycin. It had been argued previously that forms of life did not conform to the United States' patent law categories.

The Appeal Court ruled, however, that micro-organisms had become "important tools" in the pharmaceutical industry and there was no reason to deprive such a tool's "creator or owner" of the protection and advantages of the patent system.

Reference

Pharmaceutical Journal (1977). **219**, 370.

LETTERS TO THE EDITOR

MEDICATION FOR THE MENOPAUSE

Sir,

We read with great interest your editorial on "Medication for the Menopause" (October *Journal*, p.579). However, we should like to clarify one point regarding the effects on blood clotting of hormone replacement therapy.

The only published double-blind trial on the effects of oestrogen replacement therapy at the menopause on blood clotting has been our own report on 'Premarin', to which you refer (Coope *et al.*, 1975). This indicated that there was acceleration of certain blood clotting tests after three months. Your other reference to clotting studies was to a letter by Aylward *et al.* (1976) which appeared in the *British Medical Journal*. This contained the interesting and important suggestion that piperazine oestrone sulphate ('Harmogen') might not accelerate these clotting tests.

As a result of this preliminary communication, we began, 12 months ago, a double-blind cross-over trial on this preparation in menopausal patients. Meanwhile, we would suggest that your readers should regard the absence of accelerating effects on blood clotting by piperazine oestrone sulphate as a possibility which has not yet been proven.

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References

Aylward, M., Maddock, J. & Rees, P. (1976). *British Medical Journal*, **1**, 220.
Coope, J., Thomson, J. M. & Poller, L. (1975). *British Medical Journal*, **4**, 139-143.

Sir,

In your editorial (October *Journal*, p.579) you state that the General Practitioner Research Group (1977) found no clinical difference in effective treatment of menopausal symptoms between piperazine oestrone sulphate ('Harmogen') and ethinyl oestradiol; yet it concludes that the former is clearly preferred on the grounds of safety.

For over 20 years I have prescribed ethinyl oestradiol in doses of 0·01 mg (one fifth of the amount in the majority of contraceptive pills) per day or alternate days, and have found it to be effective in controlling menopausal symptoms. The minute dose has yielded tremendous dividends in terms of relief to the patient and gratitude at minimum cost, and no adverse effects have been reported.

The commonest, most embarrassing and uncomfortable symptom of 'flushing' is easily controlled and the dose

regulated downwards to alternate days or less as flushes are reduced to isolated attacks only, which is a useful criterion.

No proprietary preparation can better this record—and they all cost a great deal more.

The General Practitioner Research Group used double my dose of ethinyl oestradiol, giving 0·01 mg twice daily, yet the difference in reported adverse effects (28 per cent against 24 per cent) between the two drugs was marginal. This hardly justifies the conclusion in favour of the far more expensive proprietary preparation.

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Reference

General Practitioner Research Group (1977). *The Practitioner*, **218**, 573-579.

BALINT REASSESSED

Sir,

Dr Sowerby's paper (October *Journal*, p.583) made fascinating, if difficult, reading. However, I simply cannot accept his conclusions that general practice "must return to a primarily scientific orientation". It could hardly "return" anyway, because it never was "scientific". Undisputedly, many practitioners have added enormously to our scientific knowledge. However, an important aspect of general practice in the past was to listen to patients' problems and prescribe the only available treatment—a placebo.

One of Balint's contributions in this respect was to develop our insight into the relatively covert, but equally important aspects of these consultations; he taught us to observe our patients in *all* respects—not just their large livers, broken legs, or depression. Our reactions to these observations are surely relevant to the patient's condition both because other people in his environment are likely to react in a similar way to ourselves and because we can learn to use our understanding of the patient to help him understand himself better. Such statements may be unscientific, and irrefutable, but does this matter when they help us clarify the process of the consultation and hence dramatically increase the interest of our work?

I also believe that there is ample evidence both from Balint's work and, say, that of Freeling and Browne (1976), that such an approach often helps patients feel better. At the same time Dr Sowerby can be assured that Balint did not think all cases were suitable for his type of psychotherapy. In the seminars I attended he often adopted a 'scientific' approach and suggested physical treatment for the more severe depressives. In general, though, avoidance of such 'scientific' diagnosis is surely healthy. What use would it be, for example, to label case 12 of *The Doctor, his Patient and the Illness* (Balint, 1975) as anorexia nervosa as Dr Sowerby would have us do? I could not see it helping her swollen legs, her dependence on numerous doctors, or her skin rash. Indeed, it would be more likely to stop all attempts at understanding her as a person. Similar arguments could apply to most of the cases that Dr Sowerby would have us consider as depressive illness. The possible benefits of antidepressant therapy in these patients could be totally negated by a doctor's lack of insight into the 'whole patient'.

Of course, Balint often exaggerated—any revolutionary has to—and at times refused to consider a 'medical' diagnosis when one might be appropriate. But let this not divert us from his central contribution. He treated the whole patient, 'general practice'. He made it conscious of itself and its potential. In so doing he helped to lay a firm foundation for our discipline which can now be built upon, not only by those extending his own approach, but also by those with important scientific contributions to make in the epidemiological field. Balint may have confused art with science but this, I submit, is wholly irrelevant to our future course.

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References

Balint, M. (1975). *The Doctor, His Patient and the Illness*. London: Pitman.
Freeling, P. & Browne, K. (1976). *The Doctor-Patient Relationship*. 2nd edition. London: Churchill Livingstone.

Sir,

I have some comments on Dr Peter Sowerby's article (October *Journal*, p.583). Balint was a psychoanalyst but the method which he devised was quite different from psychoanalysis, and much more useful. The results of psychotherapy of any kind, even by physical means, depend on the patient reporting feelings which are not quantifiable. Any psychiatric theory is therefore hard to refute (p.584).

Surely all doctors are articulate enough for a Balint seminar: they all had to present cases when they were students. Also, they had to withstand criticism. If practising doctors were no longer articulate about feelings or able to accept criticism, that would be an argument for catching them young, as students (p.587).

To judge from reports of actual seminars, no two leaders are alike and a "uniform conception" is unlikely. Nor do I think that general practice will ever depart from its "primarily scientific orientation", because the patients' needs compel it. They also compel an emotional response, which Balint seminars help us to handle (p.588).

The good old 'intuitive' doctor has the same behavioural skills as a good Balint-trained doctor, but the latter achieves them more consciously and, above all, more *quickly*. Formal education is more efficient than the school of life.

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MONITORING THE DOSE OF DIGOXIN

Sir,

I was most interested in the article by Drs Brown and Manning (August *Journal*, p.470) on "Monitoring the Dose of Digoxin" and would like to make some comments about the concept of this type of audit and the design of the study.

The use of a drug, particularly one that is employed relatively infrequently in practice, is an excellent 'tracer' method for undertaking audit in general practice. The advantages include:

1. The drug selected can be one which is important both therapeutically and because of its toxicity or side effects, for example, systemic steroids, anticonvulsants, and certain psychotropic drugs.

2. The small number of patients involved allows an audit to be taken with minimal disturbance to paramedical staff or physicians.

3. Case retrieval is made easy by simple prescription checks.

In my own study on long-term digoxin treatment, which concerned 42 patients (1·2 per cent of the total practice population), an audit method was used which applied certain pre-set management criteria to the records of patients on digoxin as well as the biochemical studies and the digoxin assay used by Drs Brown and Manning (Curtis, 1975). A total of six hours was required for this work: a very manageable proposition for any practice.

The higher percentage of patients in