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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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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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