

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.

T. H. H. GREEN

Group Practice Centre
50 The Village
Wallesey.

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.

PAUL SACKIN

The Surgery
School Lane
Alconbury
Huntingdon PE17 5EQ.

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.

J. R. SCOTT

Cornwall House
Cornwall Avenue
London N3 1LD.

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

the practice on digoxin (1.2 per cent compared with the 0.73 per cent of the authors' study) could be explained by the significant number of cases in my own study who clinically did not justify treatment with digoxin at all!

I am surprised at the authors' concern to establish the value of blood urea and serum creatinine levels in determining renal function as a guide to digoxin dosage. This has already been well documented by several others who consider creatinine clearance to be the most sensitive test of poor renal function. It is known that the digoxin clearance may be depressed before any elevation of blood urea nitrogen level (Bloom and Nelp, 1966; Mason, 1974; Hulka *et al.*, 1975; Brady, 1977; Dobbs *et al.*, 1977).

Drs Brown and Manning state that in their study the patients were weighed but no further mention is made in relation to specific doses of digoxin in the article. Yet weight is regarded as an important guide to dosage (particularly lean body weight) and a change in weight is often an indicator of early cardiac failure. The reduction in weight that elderly people experience with the passage of years may lead to digoxin toxicity, if they have been on the drug over a long period, owing to decreased muscle mass (the major depository of digoxin).

A further question concerns the presence of other disease entities and the use of other drug therapies among the authors' patients taking digoxin. They discuss taking drug histories from the patients but do not indicate if any other drugs were prescribed for different medical conditions. They do mention potassium supplements and diuretics, including furosemide, which is not only well known for its potassium depleting activity, but also for its tendency to produce hypokalaemic alkalosis (Frohlich, 1977). It is a powerful drug which probably should not be used with digoxin at all. There are, however, other products which affect the absorption and toxicity of digoxin. Alumina gels, magnesium trisilicate, kaolin-pectin mixtures, high fibre cereal, and cholestyramine absorb the drug while gastric uptake is affected by anticholinergic agents (Brady, 1977). Digoxin toxicity manifested by arrhythmias and symptoms can be precipitated by adrenergic drugs, reserpine, hypomagnesia, and hypercalcaemia. Phenytoin, propranolol, and procainamide enhance the action of digoxin.

Drs Brown and Manning also state that certain decisions were taken with regard to maintaining or altering digoxin dose, based on clinical judgement. This 'clinical judgement' is not defined in the article, although I have

the impression that it was related to the apical and radial pulse rates. A range of pulse rates regarded as clinically satisfactory by the authors would have been valuable in reviewing their analysis of the results.

I am concerned that the doses of digoxin were increased in a number of patients based on "sub-therapeutic" levels of digoxin in the serum in spite of the fact that some patients had reasonable pulse rates and were clinically normal. Recent evidence (Mason, 1974) has shown that there is a linear therapeutic dose to contractile response relationship, so that even small amounts of the glycoside provide therapeutic activity. This contradicts earlier opinions that there was minimal contractile benefit to the heart until a specific digitalising dose had been reached. One should not therefore be too closely bound by the so-called 2.6 n mol/l when assessing the clinical response of the patient and estimating the dose of digoxin.

(Incidentally, it is interesting to note that the cost of a serum digoxin estimate at this university hospital is £12 as opposed to £.085 by the authors of this article.)

I fully support the authors' conclusions resulting from their investigations. It would be interesting to speculate whether the results of creatinine clearance studies on all patients involved in this study would have led to further adjustment of the dosage of digoxin in their cohort of patients.

PETER CURTIS

Department of Family Medicine
University of North Carolina
Room 738, Clinical Sciences Building
220 H
Chapel Hill
North Carolina
USA.

References

- Bloom, D. M., Nelp, W. B. (1966). *American Journal of Medical Science*, **251**, 133-144.
Brady, E. S. (1977). *Drug Therapy*, 71-82.
Curtis, P. (1975). *British Medical Journal* **4**, 747-749.
Dobbs, S. M., Kenyon, W. I., Dobbs, R. J. (1977). *British Medical Journal*, **1**, 749-752.
Frohlich, E. D. (1975). *American Heart Journal*, **89**, 1-3.
Hulka, H., Sheiner, L. B., Peck, C. C. *et al.* (1975). *Clinical Pharmacology and Therapeutics*, **17**, 385-394.
Mason, D. T. (1974). *Annals of Internal Medicine*, **80**, No. 4, 520-534.

INNER CITY PRACTICE

Sir,
Judging from the response to a brief

assertion I made at the College symposium, there is some support for my views. I wish to elaborate these points now.

So far as I am aware there has always been difficulty in attracting professionals to areas of great need. The attractions of life away from the inner city are felt not only by doctors but by teachers, lawyers, administrators, architects, and for all I know dustmen and dishwashers too. Where general practitioners differ is that the others may live in the commuter suburbs and do their jobs just as well, while we are thought to be shirking our responsibilities if we do so. If we do live in and serve slum areas then we must usually send our children to slum schools and run the risk of seeing their childhood blighted by being at best social outcasts, at worst juvenile outlaws.

We must compete for housing with the richest members of society whose efforts at 'gentrification' have raised the cost of buying and rehabilitating even the worst housing beyond our pockets. If practice premises are available we are unable to pay the prices which other businesses can. If they are not, then we must hope for the dubious benefit of health centre premises. Recent experience of arbitrary increases in health centre charges and the declared intention of one recent Secretary of State to deprive health centre doctors of rights of tenure puts me, and I am sure many others, off health centres.

Our staff too will expect city rates of pay and perks. Our ability to arrange this is limited both by our own income and the willingness of the family practitioner committees to accept their part of the burden. I know of two contemporaries who have left the profession to better themselves; both are vocationally trained, one is a member of our College. One deals in second-hand cars, the other runs a pop music recording studio. They both wanted to live in big cities and that is their solution to the cash-flow problem.

I do not know the solution but I am sure that it will have to be more than a simple diversion of funds into the health centre and district nursing budgets. Financial incentives to practise in deprived areas have failed because they are not high enough to pay for a decent house, let alone for private education. Until they are those who are attracted to city practice will not come.

It seems that the College has generally held itself aloof from the matter of personal incomes. When this was merely a question of deciding our level of luxury I think that this was correct. Now that income prevents us from buying houses and practice premises in ever-widening areas of our large towns I