interested parties to write to me giving me their views.

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DOCTORS AND SOCIAL WORKERS

Sir,

It has taken me eight years to find and read *Helping the Aged. A Field Experiment in Social Work* (Goldberg, 1970) which was recommended to me by an academic social worker. It is strange that in the same week that *World Medicine* (1978) lampooned the social workers because of their recently formulated job description I should find myself with a good word to say for a group of people of whom I am usually fiercely critical.

However, it was a delight to read this study, which was the first controlled field experiment in Britain. Although there may be some minor criticisms with regard to the method, the study was extremely sophisticated and its findings, although a surprise to the authors, will confirm the suspicions that general practitioners have had over many years.

The study was led by a social worker and included a physician and statistician. Its aim was to assess the social and medical conditions of 300 old people in a local authority area and determine their need for help. Half of these people were randomly selected to receive help from trained case workers; the other half, also randomly chosen, remained with experienced local authority welfare officers.

Three general and seven specific hypotheses were formed and a separate group of assessors was used who at no time were in contact with social workers. Two examples of hypotheses in the general group were as follows:

1. That more clients in the special group will show positive changes in their social and medical conditions than the comparison group. This was only partially upheld.
2. That fewer clients in the special group will be admitted to institutional care than in the comparison group. This was not upheld.

Examples of the specific hypotheses were:

1. That fewer clients in the special group will deteriorate in ability for self-care and household capacity than in the comparison group. This was not upheld.
2. More people in the special than in the comparison group will develop interests in activities such as clubs, work groups, holidays, home, library, church contacts, and hobbies. This was upheld.

We talk a good deal these days of audit, and the discipline and care shown in this attempt to assess the effectiveness of social work is both instructive and salutary to any of us who are at present involved in measuring our own performance. It is therefore a book which I feel, although eight years old, deserves to be read or re-read.

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JAMES MACKENZIE LECTURE

Sir,

May I congratulate Dr D. J. Pereira Gray on his Mackenzie Lecture 1977 (January *Journal,* p. 6), especially for emphasizing the importance of knowing the patient, from personal contact, in his home environment. One hesitates to comment but I have a fear that in placing emphasis on the behavioural aspect of general practice he does a disservice to medicine, and general-practice medicine in particular, in apparently underrating the importance of a knowledge of pathology and the basic medical sciences.

He speaks of pathology as "the behaviour of organs, tissues, and micro-organisms", but pathology is the study of disease processes, and the organs and tissues in which these take place are those of our patients for whom we seek to make the earliest possible diagnosis. Unless we enter the patient's home with full medical knowledge, including the basic medical sciences, we will find ourselves unable "to care for many patients with coronary thrombosis, acute heart failure, strokes, croup, pneumonia" and other conditions which he quotes, and, what is perhaps more important, we will be unable to differentiate those whom we should not attempt to care for at home. Similarly, we will find ourselves at a loss in explaining to a patient the nature of his disease, the need for further investigation or surgical interference, or even be unable to supervise the healing of the tissues he has damaged in his home accident.

It must be about one hundred years since Osler said, "As is our pathology so is our practice". I believe we should regard this statement to be just as true now as it was then and that it is right that we should first be taught human anatomy, physiology, and pathology in order that we can begin to understand the symptoms later to be presented to us.

I do not believe our task is "to concentrate on those symptoms which are most common in our patients today" but, in our aim to practise total medicine within the framework of general practice, to appreciate the importance of any symptom or set of circumstances which is presented to us at any time. A knowledge of scientific medicine does not prevent us from looking under the bed to see whose shoes are there.

May I also express the hope that with a better shared knowledge of medical care in the patient's home we will reach a greater liaison and understanding with all our hospital-based colleagues and stop this terrible schism which is being allowed to develop in some quarters.

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EMPLOYMENT OF PRACTICE NURSES

Sir,

Our practice nurse recently showed me an article which appeared in the September 1977 issue of the *Nursing Standard,* the official newspaper of the Royal College of Nursing. This article commented, amongst other things, on the position of nurses employed for treatment room work in health centres. This article implied that whilst a state registered nurse works in a health centre, her employer would be the area health authority (AHA) and her salary would be at the staff nurse grade. Similar provisions would apply to non-state registered nurses.

It is, of course, open to the general practitioners working from health centres to employ their own ancillary staff, and this includes nurses, and there is no obligation for such nurses to enter into a contract with the AHA. Furthermore, the Royal College of Nursing itself recommends that state registered nurses employed by general practitioners as treatment room or practice nurses should be paid at ward sister rates—considerably more than a staff nurse employed by the AHA. It is true that the nurses employed by the AHA can contribute to the NHS superannuation scheme and in due course receive a pension, whereas, at present, nurses employed by general practitioners may not.

However, any difficulties in pension arrangements may be modified next April by the implementation of the Social Security Pensions Act. This would allow (or compel, depending on circumstances) nurses employed in general practice (and ancillary staff) to contribute to a State scheme, to which general practitioner employers would also have to contribute. The latter sums would be wholly reimbursed following recent negotiations with the Department of Health and Social Security.

In addition, the AHA may exercise control over the nurses in their employ by transferring them from the surgery to other duties, which may be administratively convenient in spreading the workload but only disturbs the rapport when nurses are attached to one group of doctors.

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Reference

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HEALTH AND THE HOME

Sir,

It may be of interest to know that the balance of nursing care between patients' homes and general-practitioners' premises is also changing, at least in England.

Area nursing officers make returns to the DHSS annually which include the number of new cases (expressed as "first treatments") begun by district nurses and between 1972 and 1976 the location of these treatments has changed, the trend being continuous throughout these years. Table 1 shows that despite a small annual increase in the number of new cases treated at home (almost entirely among the elderly) the balance between patients' homes and general practitioners' premises has changed so that area health authority nurses now see the majority of their new cases in general practitioners' premises. This change appears to be due almost entirely to the extraordinary growth of nurses' activities in the health centres and we have data which suggest that they are taking on more of the 'technical' as opposed to the 'caring' activities which formed the core of district nursing in the old days.

I draw attention to this trend simply to remind us that changes in the activities and deployment of the members of the medical profession seem unlikely to occur without parallel changes in the work of related professions.

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BALINT REASSESSED

Sir,

Dr Sowerby's reappraisal of Dr Balint (October *Journal,* p. 583) and a book review in the same issue by Dr Steel (p. 631) illustrate opposing views of the task of the general practitioner in handling his psychiatric workload. There *is* a critical difference of opinion among us, although until now the College has appeared to adopt and promote the Balint hypothesis.

Like Dr Sowerby, I acknowledge a debt in terms of 'attitude' and agree that the claims of analysis and therapy are untested, a subjective matter for doctor and patient alike.

According to the review, 1966 was the year in which the Balint seminars began. It was also the year of publication of *Psychiatric Illness in General Practice,* in which Shepherd and his colleagues reported the 1961/2 enquiry of the General Practice Research Unit and sought to bring order into the confusion of data on categories and highlight the size of the problem. If ignorance and disregard for the psychiatric component of illness both in cause and effect are somewhat less today, perhaps both of these events contributed.

Before Shepherd's report general practitioners writing on the topic varied between the two extremes of failure to identify any psychiatric problem at all and of finding one in every consultation. Too many doctors still tend to the latter extreme: I sometimes wonder whether depression may not become the most commonly over-diagnosed disease to the detriment of essential clinical enquiry!

Whatever its merit in terms of approach, I think that in terms of effective management the Balint method has considerably less force and attraction than it may have had in 1966.

I am not suggesting that we have no concern for the potential suicide, the recently bereaved, the batterers and the battered, the recurrently depressed, the chronically anxious, and those who require a simple explanation of why their mental state is producing physical symptoms.

In psychoanalytical terms, the 'suitable case for treatment' is often someone whose education has led him to expect this type of approach; and for such I have no other answer and seek none. It is a matter of suiting the doctor to the patient.

Certainly the major formal psychoses are better understood today and better treated as disturbances of neuronal and synaptic amine metabolism than by analysis. This applies whether the disturbance is thought to be primary or secondary, whether the patient is in hospital or general practice, and I believe that few would dispute the precedence of pharmacology here.

There are some conditions (apart from smoking and over-eating) in which altering a pattern of behaviour may be useful. These include family problems centred around children; problems between couples and sexual problems; phobias and other distressing problems associated with undesirable behaviour. It is characteristic that a change of attitude (understanding) *follows* rather than presages the change of behaviour. Again, simple action to effect change has more to offer than comprehensive analysis.

For all of these conditions, and for the large number displaying a natural and inevitable reaction to physical illness, a group responsible for an important and traditional part of general-practitioner involvement, support, a sympathetic hearing, simple explanation, readiness to see frequently, and minimal medication are all that may be needed.

Table 1. Location of first nursing treatments.

Location	1972	1976	Average annual increase (%)
Patients' homes (%)	60	45	4
Health centres (%)	11	25	63
Other general-practitioner premises (%)	41 30	55 30	14
Total treatments	1,782	2,721	13

Source: Department of Health and Social Security, 1978; personal communication.