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**

*Nursing Standard* (1977). Editorial. September, p.2.

## 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<br>30 | 55<br>30 | 14 |
| Total treatments | 1,782 | 2,721 | 13 |

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