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 30	55 30	14
Total treatments	1,782	2,721	13

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

Yet today, probably the principal objection to the Balint thesis is found in the existence of large and ill-defined groups of patients who require a great deal of attention from practitioners, hospitals, and community services. They include patients who never feel well, patients with personality problems, and social isolates—people with little or no ability to cope with life's simple demands and who lack adequate social (community and family) support. Recognition of their existence is not new in general practice but has only recently been recognized in clinical psychiatry, which was previously preoccupied with well-described major mental illnesses. They are now an increasing problem to psychiatric departments and hospitals. There are many of them, their condition is usually chronic, they are costly in terms of help and resources, and poor in terms of result. Furthermore, there is no evidence that either drugs or psychotherapy have anything to offer at all. They tend to stay longer in hospital than other groups, are more likely to relapse and be readmitted, and cannot easily be discharged without community support. They offer a major problem to the health service, which seeks to make admissions as brief as possible.

Was Dr Fry (1969) simply being pessimistic when he wrote: "The cause of many mental illnesses depends on unalterable personality and environmental characteristics and although it may be possible with treatment to make the two factors more compatible with fewer symptoms, less personal suffering and family distress, permanent cure is unlikely"? I do not believe so. I believe what he said to be acutely observed. This has nothing to do with sympathy, only with effectiveness and what we believe we can really do.

It would be nice to believe that we could radically alter the environmental aspect, that without even greater growth of the social services, communities could develop solutions within themselves which older and more primitive communities sometimes had; but the massive social intervention required might not be beneficial even if it were within our disposition.

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Reference

Fry, J. (1969). *Medicine in Three Societies: a Comparison of Medical Care in the USSR, USA and UK.* Aylesbury: Medical and Technical Publishing Co.

Shepherd, M., Cooper, B., Brown A. C. & Kalton, G. (1966). *Psychiatric Illness in General Practice.* London: Oxford University Press.

AGE-SEX REGISTERS

Sir,

I thought you would be interested to know that, following your interesting editorial about age-sex registers (September *Journal,* p. 515) when you drew attention to the fact that a family practitioner committee had made use of the Government's Job Creation Scheme to establish age-sex registers for family doctors, I decided to see if there was sufficient support for a similar scheme in Cheshire.

The Manpower Services Commission were sympathetic to our ideas and we subsequently wrote to all the practices in Cheshire asking if doctors were interested in the proposal. The response from family doctors has been very encouraging and to date we have received firm applications from 66 practices (170 doctors), with 440,000 patients, for age-sex registers. A number of practices have already introduced age-sex registers themselves and when we have completed our scheme we estimate that over half of our practices and about 60 per cent of our patients will have the facility of age-sex registers.

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DEPUTIZING SERVICES

Sir,

In the December *Journal* (p. 753) you reported a meeting of the Council of the College held on 17 September 1977, at which deputizing services were considered.

Two points strike me as questionable. First, paragraph four of the Report states: "It was felt to be important that the professional advisory committees were adequately representative of all general practitioners in the family practitioner committee area, so that the views and experience of general practitioners who do not use deputizing services could be readily available constructively to promote higher standards of patient care." Is it the opinion of the College that only practitioners who do not use deputizing services are in a position to give advice which would promote higher standards of care for patients?

Secondly, in paragraph two of the Report it appears that Council concluded that deputizing arrangements made within a practice among a small number of practitioners were preferable. This, however, fails to acknowledge the fact that arrangements within a small group can never reduce the practitioner's commitment from 168 hours to anything approaching the national basic week of 38 to 40 hours. Of all of the protests from the grass roots of general practice regarding the problems of our contract, this point often causes great concern.

It seems possible that the only way to meet the requirements of these practitioners is to provide a tightly closed 40 hours per week contract, probably on a salaried basis, or alternatively to maintain the 168-hour commitment but assure, or indeed encourage, them to reduce their personal working and on-call hours to a level which is comparable with the national working week norm; and this can be done only by the use of large groups, or by deputizing services.

One would not question the need for a good communication system and good relationships between deputy doctors and principals, whether this be in a group or deputizing organization.

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ETHNIC MINORITY GROUPS

Sir,

Some speakers at the Annual Symposium of the College on 20 November 1977 reluctantly used the term 'immigrants', and rightly so. There is a significant change in the use of this word which has previously been widely used.

The Race Relations Board in the UK has suggested the term 'ethnic minority groups' and has warned that the term 'immigrant' or 'coloured population' may cause problems.

The pattern of disease may vary considerably in ethnic minority groups. Such groups now make up a sizeable part of the labour force of the UK.

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