

associate or member of the College.

The closing date for receipt of final reports for adjudication will be 25 September 1978.

NEW EXAMINERS

Dr R. L. King, MRCP, General Practitioner, Bath, and Associate Adviser in General Practice, Wessex Region, and Dr J. A. C. Terry, FRCGP, General Practitioner, Isle of Wight, have been appointed new examiners for the membership examination of the College.

MRCGP EXAMINATIONS

The dates for the next MRCGP examinations are as follows:

November/December 1978

Written papers: Thursday, 2 November 1978.

Orals: In Edinburgh and London during the week ending 16 December 1978.

Closing date: 21 September 1978.

May/July 1979

Written papers: Thursday, 17 May 1979.

Orals: In Edinburgh during the week ending 30 June 1979 and in London during the week ending 7 July 1979.

Closing date: 5 April 1979.

The written papers will be held in London, Birmingham, Leeds, Newcastle, Manchester, Edinburgh, Aberdeen, Cardiff, Belfast, and Dublin. These and other centres may be used as required, subject to a minimum (and in some centres a maximum) number of candidates. It may be necessary to limit the total numbers and candidates are therefore advised to apply well in advance of the closing dates.

The application fee is £50 and the reapplication fee £25.

PRACTICE ORGANIZATION ROOM

The Practice Organization Study has been reorganized to provide two components.

First, it offers a register of innovations in general practice so that practices which have new buildings or a new approach to buildings, new methods or modifications of old methods of organizing staff, or innovations in filing and screening systems may be identified. The information comes from college faculties and individual general practitioners through a questionnaire which is available from the College.

Secondly, it offers the results of a more detailed questionnaire whose purpose is to show the internal running of a practice in all its aspects. This register contains much information which is interesting but because it is tedious to record it is being used to a much lesser degree.

The current exhibition shows examples of both types of questionnaire and how they are used, and also shows examples of the kind of information we are endeavouring to achieve. The exhibit will subsequently be available for loan to faculties as are all the other exhibits in the College. Arrangements for loan may be made with Mrs J. Mant, Secretary to the Practice Organization Committee, at 14 Princes Gate, London SW7 1PU.

It is of great importance that the College should record current methods of organization in general practice, since advance in general practice can be achieved only by a mutual learning process. It is for this reason that the Practice Organization Study needs to succeed and we would be delighted to receive more completed questionnaires in order to achieve this aim. It does not matter if the innovation is slight or if the general practitioner is not certain whether it is worth inclusion as all information is useful to this study.

The Practice Organization Room also contains demonstration tapes and slides from the Graves Medical Audiovisual Library, a number of monographs on different aspects of practice organization, and various other exhibits.

BUTTERWORTH GOLD MEDAL

The Butterworth Gold Medal is awarded for the best essay relevant to general medical practice from a list of five selected subjects. The subjects for 1978 are:

1. The primary health care team is in danger of 'relegation'.
2. The doctor and not the illness dictates the therapy.
3. The place of development surveillance in general practice.
4. The care of the elderly in general practice.
5. The management of hay fever in general practice.

This competition is open to all fellows, members, and associates of the College. Entries, which must be in essay form, should consist of not more than 10,000 words, be typed on one side of A4 paper only, and be entered under a 'nom de plume' accompanied by the author's name and address in a sealed envelope. They should be marked 'Butterworth Gold Medal Essay Competition' and sent to the Secretary, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

The closing date is 1 August 1978.

LETTERS TO THE EDITOR

BALINT REAPPRAISED

Sir,
Dr Sowerby's provocative article on Balint (October *Journal*, p. 583) has produced some predictably interesting correspondence. However, I detect in

both the article and some of the letters assumptions that a discipline is either a science or it is not and also that science is 'good' and its absence 'bad'.

Examination of the history of science reveals that the growth of any scientific method of enquiry has an evolutionary

development. This makes it unrealistic and over-simplistic to consider general practice in such exact terms as being a science or not a science (Kuhn, 1970). Furthermore, I think that it would help our academic growth if we were more keenly and honestly aware of our

present stage of development and Dr Sowerby's excellent paper raises important questions that are central to this issue. With regard to the second assumption I feel that although we should strive for improved methods of scientific enquiry, and I have found Popper's philosophy of great value in this respect, great contributions can be made to our struggle to establish general practice as an academic discipline by those among us who state their views and observations without necessarily being able to prove or refute them. I think the value of this type of contribution is eloquently supported by Marshall Marinker's recent review of *Doctors Talking to Patients* (February *Journal*, p. 113).

CHARLES B. FREER

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Reference

Kuhn, T. S. (1970). *The Structure of Scientific Revolutions*. London: University of Chicago Press.

Sir,

I should like to thank all those who wrote to you for their kind words and valuable comments on my paper (October *Journal*, p. 583). I should also like to clarify one issue on which I seem to have expressed myself badly.

Dr Ellison, Dr Manasse (January *Journal*, pp. 56, 57), Dr Sackin, and Dr Scott (February *Journal*, p. 110) all rightly point out how concerned Balint was to understand the patient as a whole person. In this I am in full agreement with Balint. My paper should be regarded as a plea to understand that to do so is more difficult than even he believed. Balint thought that his approach to understanding the person was as scientific as our approach to understanding physical disease, and that he had gone some way towards achieving the most desirable goal of intellectually unifying our understanding of body and mind. I applaud and admire the goal and the effort but alas I think the aim was not always true. It was true, as I said in my paper, so long as he stuck to descriptions of behaviour. It went awry when he tried to interpret that behaviour. In the continuing absence of any substantial "science of persons", as Laing (1960) described it, we must make do with what understanding we have, which is intuitive. I have the greatest sympathy with those who think I have enlarged the gap between psyche and soma and sincerely hope that this is a

mere intellectual illusion. I wrote the paper in the belief that the clearer we see the boundaries of this divide, the better we shall be able to bridge it.

P. R. SOWERBY

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Reference

Laing, R. D. (1960). *The Divided Self*. London: Tavistock Publications.

JAMES MACKENZIE LECTURE

Sir,

The 1977 James MacKenzie Lecture (January *Journal*, p.6) stressed the importance of home visiting and your readers may be interested to know the visiting rate in our practice.

Between November 1976 and 30 November 1977 in an NHS practice with five partners and an average of 2,742 patients, our total practice visiting rate was 0.64 visits per patient per year.

Our practice uses commercial deputizing services only to cover periods of sickness and holidays, and we have one of our own partners in reserve when the deputizing service is being used so that it is possible to attend conditions needing urgent or specialized care.

I. L. WILKINSON

The Surgery
Chapel House Lane
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W. Midlands.

Sir,

May I add a small round of applause for your superb James Mackenzie Lecture (January *Journal*, p. 6)?

I think the basic philosophy that you clarify in the early part of the paper is particularly important, as are the data that you have collected in support of it.

Sometimes in Canada we find the rest of the medical profession resistant to such ideas; indeed, even some of the academic departments of general practice find this kind of thinking difficult, and it is helpful to read a paper which sets out these ideas so clearly.

JAMES A. COLLYER

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Sir,

The James MacKenzie Lecture (1977)

delivered by Dr Pereira Gray elaborated in a most perceptive manner many of the unspoken feelings and ambivalent attitudes held by family physicians with regard to their role in caring for the patient at home. There cannot be many who will disagree that better knowledge of family history, family psychodynamics, the home environment, and local cultural conditions form an important backdrop in both understanding and preventing illness.

Unfortunately, the "vacuum of care" against which Dr Gray warns forms yet another task among the many which family physicians are currently exhorted to undertake lest they relinquish their status. In recent years their objectives have included more effective practice organization, health team management, reducing hospital outpatient visits by improving and increasing the scope of care, health education and preventive medicine, arranging adequate time for themselves and their families, maintaining continuity of care, increasing their commitment to hospital care, and regaining the practice of obstetrics. I wonder if family physicians can really expect to attain all these objectives as well as maintain the pattern of home care and visiting.

Dr Gray's comments about the lack of controlled studies on home obstetric deliveries can be applied in the same way to home care itself. The value of the knowledge of home and family as it affects the progress and outcome of disease is not established. In other words, there is no evidence that family doctors, through this knowledge, can effect any added benefits to their patients. Are the costs, in time and money, of purposefully acquiring this knowledge and implementing it by home care amply rewarded by improved outcomes?

From the American point of view, home visiting appears to have been priced out of the market, yet there also seems to be some reversal of this trend and most of the family practice training programmes have used home visits at least as an educational exercise (Curtis *et al.*, 1977). Home visiting in the US may have been partially replaced by telephone medicine. This is an economic form of care in which the patient consults from home with the doctor. Most Americans have a telephone and there is evidence of high consulting rates after hours of up to 500 calls per 1,000 patients per year as opposed to an average of 9.2 calls per 1,000 patients per year in Britain (Cargill, 1976; Hogg, 1976). Primary care paediatricians may spend up to three hours a day consulting on the telephone with mothers (Perrin and Goodman, 1978).

The direct costs of medical care to