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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Practice profiles

Sir,

Frances Hanson and Conrad Harris are to be congratulated on their profile of general practice in an area (April *Journal,* p.165). The findings that interested me were that partnerships of two, and single-handed doctors had low claim rates for items of service, and that older doctors had lower rates of claim and smaller lists.

I work in a two-man partnership with a list size (patients aged under 65 years) of 2900 last quarter. My partner and I decided to compare our data with those of Hanson and Harris. Our claims for item of service payments for the last March quarter were 16.8% of the total income, which includes Seniority L and 111. Furthermore, the highest item of service claim was for contraceptive services, and maternity services were only £12 less. We had a low rate for temporary residents, because South Norwood is hardly a holiday area. All this is the reverse of the authors' findings.

It is probably true that maternity services are given up by older doctors, not necessarily through age, because I still deliver my own domino patients in our unit. It is, however, a demanding discipline, since it is nocturnal. In coping with night calls much depends upon whether one is a mesomorph or a cerebrotonic ectomorph, because increasingly we hear young doctors wishing to have a day off after they do one.

Another aspect that seems to make age irrelevent is the quality and amount of ancillary staff employed. We have made these independent, with a practice manager and two full-time receptionists. Professional book-keeping standards and follow up from the age–sex register, now aided by the family practitioner committee computer mean that performance in these respects is immaterial of age.

I suggest, with humility, that the problem is not associated with the age of the practitioner, as Hanson and Harris argue from all their work, but with management skills, team-work, good premises, and the distribution of the practice population, including mobility and structure. After all, we have the second highest birth rate of any ward in our borough.

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Maternity services: the consumer's view

Sir,

Audrey Taylor's paper on the consumer's view of maternity services (April *Journal,* p.157) is an interesting attempt at quantifying an important question that can be subject to much biased prejudice from both researcher and research population. I feel, however, that a few points of clarification are required, especially with regard to the sample population, which could render her results even more significant. It is not clear why mothers of babies born elsewhere were included in this survey or why indeed they were transferred into the district. Exclusion of these mothers would have reduced the number of variables concerned. A more important point is the omission of the reasons leading to the selection of general practitioner or consultant antenatal care. Were pregnant women given a choice of whom they saw? Was the decision affected by general practitioner or consultant counselling, or were pre-determined guidelines used? Did any of the sample population receive shared care? Were any women from the general practitioner care sample transferred to consultant care (or vice versa)? Finally, it would have been interesting to compare the mode of delivery (not mentioned in the text) and the presence or absence of complications with the mother's view of her antenatal and postnatal care, as a retrospective consideration of an event or process may be greatly modified by subsequent events, and the occurrence of a major life event, such as delivery, may well influence the feelings expressed concerning later events.

It is widely acknowledged that hospital antenatal clinics tend to be impersonal, rushed and subject to long waits. The best way to counteract the 'conveyor belt' system is to increase the ratio of hospital doctors to patients — to this end greater use of general practitioner antenatal obstetric care would be most welcome, in order to reduce the number of women seen in hospital clinics. Personally, I would like to see the consultant obstetrician and the general practitioner working more closely as a team with the pregnant mother as their first concern rather than perpetuating the 'them and us' feeling that is often still apparent.

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Balint and holistic medicine

Sir,

We are members of a group of general practitioners who are at present engaged in a research project with Enid Balint. Our group has been working together for almost two years, studying new ways of understanding the effectiveness of our work in general practice. We would like to comment on Dr Pietroni's article 'Would Balint have joined the British Holistic Medical Association' (April *Journal,* p.171).

There is at present a great deal of confusion about 'holistic' and 'whole-person' medicine, and Dr Pietroni's paper in making a comparison between his Association and the work of Michael Balint, makes a useful starting point to attempt a little bit of unravelling.

Nobody would dissent from the British Holistic Medical Association placing importance on the principle of 'responding

to the whole person'. But Dr Pietroni does not discuss at all how this is to be done; or whether any of us can perceive a 'whole person'; how doctors are to be trained in this work; or indeed how they are to know to what extent they are being useful to their patients.

Dr Pietroni's philosophy seems dangerously like 'a little bit of everything makes a whole'. He is right that we live in a 'relational world', but modern physics only advanced to its present state by the most scrupulous andd detailed observation of the interactions between subject and object. The Balints have encouraged this same kind of observation in helping doctors study how they work with their patients. A Balint group for instance, would want to discuss with Dr Pietroni exactly what he meant by a patient's 'spiritual disease', and how this diagnosis fitted into the pattern of events that had occurred between himself and that particular patient.

This question of method and the need for other doctors' perspectives in the discussion of an actual case is central. One doctor's view of a patient is always, even at best, a partial view. It can never be anything other than this, however much the doctor would like to believe the contrary. It is essential in any work on this subject for the doctor to be included in the field of observation. The patient cannot be considered without considering the doctor. Through this process in a training group a doctor learns that his view of a patient is heavily dependent on his own particular viewpoint.

The question of 'interventions' brings important differences to the surface. Dr Pietroni describes as one of the principles of the 'holistic' approach an 'extended range of interventions'. He seems to conceive the Balints as having added a form of modified psychoanalysis to the doctor's range of 'interventions' and blames them for having prevented the addition of others (such as co-counselling, transactional analysis). This approach of 'adding' things is precisely what the Balints have tried very hard to avoid, preferring instead to use their psychoanalytic skills to help doctors enhance the effectiveness of their work from inside their own framework and not by importing methods from other settings.

Moreover it was never an aim of Balint groups to 'contain some of the wounds of the healer', in other words to provide a therapeutic group for doctors. Of course Balint groups are limited if judged by this aim. It was precisely because their aim was 'training cum research' and not therapy, that they had the limitations described by Dr Pietroni deliberately built into them by the Balints — discouragement of direct personal revelation and not examining the relationships within the group. The limitations, far from being a problem, are what enables them to function. It follows that the leader and the doctors in a group have to be able to bear this necessary frustration.

If, as we have outlined, Dr Pietroni's critique of Balint work is somewhat wide of the mark, part of the responsibility for this lies with the membership of the Balint Society for not having published any significant additions to its work since *Six minutes for the patient.* This book describes the importance of doctors surrendering their central role in the doctor–patient relationship and the discomfort for them in doing this, which may have meant that it has been a more difficult book for doctors to absorb than its major predecessor, *The doctor, his patient and the illness,* which gave them a much more central role. The long pause in published Balint work is one that we hope will soon come to an end. One book has already been prepared for publication which presents the work of a group of general practitioners who worked with Enid Balint from 1980 to 1983 and we also hope ourselves to publish the findings of our present group as soon as the work is completed.

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Sir,

I read Dr Pietroni's article on holistic medicine with interest (April *Journal,* p.171). Two points I feel are worthy for furthering the debate.

First, Bruno Bettelheim's book *Freud and man's soul*[1] has clearly shown that the entire English-speaking scientific community is labouring under a mistranslation of psyche as 'mind' when, in fact, it means 'soul'. Our culture confuses what is a vital and creative distinction; obscured, Dr Bettelheim presumes, by a translator who was unable to cope with the implications of man having a soul. I would propose that unless the holistic doctors stop describing man as body, mind and spirit they are doomed to as sad a demise as psychoanalysis suffered in our proud culture.

Secondly, the holistic focus on innate abilities for self-healing, secure as it is in self-centred existentialist philosophy, nevertheless is a contradiction of the spiritual element they purport to include. The very heart of holism contains the seed of its limitation. If the spiritual aspect of man is his transcendence, then transcendence into a purely humanistic world can only lead to weakness being inflicted on weakness. Transcendence to a pure source of life, to God the creator, is necessary for healing from within despite the persistence of corrupted and harmful relationships in the human community of the world.

To fool the public into a belief that self-healing will be induced by alternative and complementary medicines will open the floodgates to charlatans, deceivers and spiritualists whose purpose is to ensnare the patient into an idolatry of their particular form of private practice.

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Reference

1. Bettelheim B. *Freud and man's soul.* New York: Alfred Knopf, 1983.

Patient participation groups

Sir,

I was sorry to read that Dr Alastair Malcolm's well-intentioned effort to start a patient participation group was not the instant success which he had hoped (Letters, April *Journal,* p.184). He is in good company. One of the most successful 'user groups' in Britain had a similar start, and only got going at the third attempt and using a different approach. There are at least eight ways of starting a patient group[1] and Dr Malcolm had chosen a particularly difficult one.

His suggestion that a group was not needed in his area because of liberal practice policies, would be more plausible if there was evidence to support it. But this evidence could only come from patients. Doctors often have to speak for their patients, but a direct patient voice is more authentic.

I hope that Dr Malcolm will not be so easily deterred. There are many people willing to help him — in particular the National Association for Patient Participation. The honorary secretary's address is: 2 Howard Road, Bristol BS6 7UT.

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Reference

1. Pritchard P. Patient participation in general practice. In: Gray DJP (ed). *Medical annual.* Bristol: Wright, 1983.