

Sir,
Despite your recent editorial (January *Journal*, p. 3) I still feel there is a place for the "collecting of figures in general practice". I enclose our workload figures for the past six years in a two-man urban practice, with a relatively static population and an admitted bias to the younger age groups (Table 1). We have attached, part-time midwife, district nurse, and health visitor. We work a rota with three other doctors and the actual hours that each of us works in the practice is 60½ hours a week, which includes night and weekend duty in rota. As well as this work I am a member of our local district management team, which takes up a considerable time out of ordinary hours. I am collecting accurate figures for this work too. When Dr John Fry talks on the motion, "Each general practitioner is capable of looking after 5,000 patients", at the Annual Spring Meeting of the College, I hope that figures such as these will indicate the true workload that we are already handling.

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Table 1. Workload

Number of patients	1970	1971	1972	1973	1974	1975	1976
	3,726	3,736	3,686	3,726	3,882	3,928	4,438
Transfers							
X (within area)	124	155	192	185	143	218	145
R (changed area)	98	75	108	69	84	76	71
C	9	5	21	1	1	14	—
N	31	22	13	—	2	1	—
E (emigration)	12	5	17	4	9	6	4
D	23	6	17	14	16	20	18
S	5	9	19	5	9	—	6
Notice by doctor							
Adoption	2	2	5	5	1	14	6
	1	2	2	—	—	—	1
Total	305	293	394	283	267	349	251
Surgery attendances							
Antenatal consultations	10,270	11,031	11,229	10,367	11,512	11,088	11,839
Total consultations	438	413	345	212	332	295	333
Total consultations	10,708	11,444	11,574	10,579	11,844	11,383	12,172
Consultation rate per 1,000 patients per year							
	2,874	3,063	3,140	2,839	3,051	2,898	2,743
Home visits							
Home visiting rate per 1,000 patients per year	2,772	2,852	2,729	2,019	2,366	2,226	2,552
	744	763	740	541	609	567	575
Total direct doctor/patient contact rate (consultations plus visits) per 1,000 patients per year							
	3,618	3,826	3,880	3,380	3,660	3,465	3,318
Repeat prescriptions							
				2,253	2,912	3,549	
Laboratory tests							
Bacteriology	468	519	521	315	872	965	660
Pathology	49	110	232	129	177	174	255
X-ray	64	80	142	76	75	87	100
'Planotest'	53	64	98	132	264	88	90
Cervical smear	55	106	149	230	124	334	365
ECC		not available	20	25	30	13	14
MSU							325
MSU positive							43
Cervical smear claims							45

Sir,
We found your editorial "How many patients?" (January *Journal*, p. 3) to be astounding in its omissions and conclusions. Surely, if ten minutes were spent on each patient and if the patient-consultation frequency per year were 1.9, then 2,500 patients would be adequate? But this is not stated. Nor is it stated that there are published figures or that in some practices the patient-consultation frequency is up to six a year. In our own practice it is 5.1 (including antenatal and baby clinics).

It is of vital importance to consider such questions as how many consultations were initiated by the doctor, whether the area was urban or rural, whether it was a shifting population, and whether any antenatal or child welfare clinics were run. These are all crucial yet they are not even mentioned.

If we did no follow-up visits or extra clinics, no doubt we could get our figures down also and look after 4,000 or 5,000 patients, as Dr Fry appears to suggest in his article (January *Journal*, p. 9).

We cannot see that the question "how many?" is answered at all and are amazed at the suggestion that "general practitioners are reluctant to look at this variable". What evidence is there for this? Could it be because we are too busy, or is it perhaps because no one has actually asked us? Surely the College with its nationwide organization could circulate us with a questionnaire and find out at a stroke?

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GENERAL-PRACTICE WORKLOAD

Sir,
In his article on "General Practice Workload, Needs and Resources in the National Health Service" (December *Journal*, p. 885) Dr Tudor Hart examined ways of relieving general-practice doctors of their high workload. When he considered the possibility of turning nurses into doctors he made the assumption that there are "no untapped reserves of nurses". Despite this he is able to cite experimental evidence which shows that nurses can offer a diagnostic service if they have specific training in primary care. It appears that the argument against nurses doing this is not their inability to perform medical tasks, as may have been implied earlier, but

the problem of their demanding high wages and status.

Apart from the discontinuity in the logic of this argument, this is surely an outrageous expression of professionalism. If a nurse should not be encouraged to offer a medical diagnostic service because she might "share the same social ambitions as doctors" is this to be deplored because doctors have an ascribed right to guard their elitism, or because these social ambitions are not beneficial for society? If the latter is true then this is unlikely to be helped by training more doctors who have the luxury of six years' socialization into the medical milieu.

The other problems that Dr Hart tackles are those of maldistribution and malorientation. Both doctors and nurses will choose to work in the same geographical areas which are already favoured in terms of medical resources. The training of more doctors will by itself not alleviate maldistribution. His suggestion for "proper distribution" for doctors can and should equally apply to nurses.

As far as malorientation is concerned, it is possible that doctors might be helped by examining new techniques developed in nursing. The nursing process which will provide the future basis for the SRN syllabus consists of a systematic evaluation of patients' needs and care. The patient is the focal point for the nurses' interests, and his co-operation and involvement is seen as essential for his wellbeing. As with problem orientated recording, social as well as medical and psychological problems are seen as relevant to patient care. Also, nurses are more likely than doctors to come from the same social class as their patients and may therefore be more efficient at identifying and understanding their patients' problems.

There is only one way of determining how care should be distributed between different health care practitioners. This is by a vigorous assessment of who most effectively deals with the patient's problems in terms of clinical efficiency and patient satisfaction.

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AETIOLOGY OF MULTIPLE SCLEROSIS

Sir,
Multiple sclerosis commonly begins as retrobulbar neuritis. If multiple scler-