Can an optimum list size be estimated?

Sir,

I read with interest Dr A. Jacob's letter (December *Journal,* p.669) on the calculation of an optimum list size, based on an optimal work rate. At the Health Services Research Unit of the University of Kent at Canterbury, we have recently completed a number of surveys of general practitioner trainers in five regions. The surveys were concerned with standards in general practice and included the collection of workload data.[1] We can therefore provide estimates which are more recent and less speculative than the ones Dr Jacob had to rely upon. In four of the regions we asked the receptionists to record the number of surgery consultations at each session for one week. Based on 317 replies the mean number of consultations per session was 15.4 (ranging from five to 42) and the mean number of general sessions per week excluding Saturdays was 8.4 (ranging from four to 11). The number of registered patients consulting per session, that is the consultation rate, was 6.3 per 1000 patients (ranging from 2.6 to 8.5 per 1000 patients).

The search for a commonly agreed optimal work rate, as discussed by Dr Jacob, is indeed a difficult one. In one of the surveys we asked trainers what they considered to be the optimum number of patients they would wish to see in a session. The mean number was 14.6, but individual opinions ranged from five to 25.

How did these findings relate to list size? There was no association between the desired optimum and the actual list size. The number of consultations and the consultation rates showed significant associations with list size. In regression analyses with the list size as the independent variable the beta coefficient was +0.311 for the number of consultations per session, and −0.360 for consultation rates. Neither of these results would justify the prediction that a lowering of list sizes would result in directly proportionate reductions in workload, or increases in consultation rates. Nor did we find sufficient evidence in this study that these quantitative factors had any significant effect on the standards of care.

ROSE KNIGHT

Division of General Practice
St. James's Hospital
Leeds LS9 7TF

References

1. Butler JR, Knight R, *et al.* List size, standards and performance in general practice: a pilot study. *HSRU report no 55.* October 1984. Obtainable from the Health Services Research Unit, University of Kent, Canterbury, Kent.

The irritable urethral syndrome

Sir,

The Medical Research Council's Bacteriuria Committee[1] advised that 'the term urethral syndrome is not recommended because there is no evidence of urethral disease in most of these patients'. Whatever the shortcomings of this report,[2] I feel that its view of the urethral syndrome should be accepted and that Dr T.C. O'Dowd (March *Journal,* p.140) should have made clear why he decided to reintroduce it. The term not only draws attention to the wrong part of the urinary tract, but gives no information as to the state of the kidneys. Indeed, Dr O'Dowd's article fails to mention the kidney at all; a serious oversight when 50% of all patients with inflammatory disease of the urinary tract have renal pain and tenderness.[3]

In women, urinary tract symptoms and psychological symptoms are often associated. This association is common in those women with chronic renal pain and/or tenderness, but uncommon in those with lower urinary tract symptoms only. Furthermore, the psychological symptoms appear to be secondary to the renal involvement and cease when the renal condition is successfully treated. Such treatment may include urethral dilation or sphincterotomy, about which Dr O'Dowd is so dismissive. In fact, these procedures are especially valuable when urethral stenosis is present, and this can often be recognized from the symptomatology.

Dr O'Dowd concludes by advancing the view that this is a psychosomatic problem and in doing so presents us with a false antithesis. He says that 'It is difficult to say if such people are anxious because of their symptoms or that their symptoms are merely a manifestation of their anxiety'. He has clearly overlooked the possibility that both the physical and the psychological symptoms have a common cause as indicated above. In conclusion, I have found that the most useful working hypothesis in approaching the vexed question of inflammatory disease of the urinary tract in women, is that no distinction in principle need be made between those women with and those without significant bacteriuria, and that an anatomical classification, dividing such patients into those with urinary tract symptoms and those with lower urinary tract symptoms only, is of great practical value.

N.B. EASTWOOD

82 Victoria Road
Oulton Broad
Lowestoft
Suffolk NR33 9LU

References

1. A report by the members of the Medical Research Council Bacteriuria Committee. Recommended terminology of urinary tract infection. *Br Med J* 1979; **2:** 717-719.
2. Eastwood NB. Recommended terminology of urinary tract infection. *Br Med J* 1979; **2:** 978.
3. Eastwood NB, Bruce RG, Wren WJ. Prevalence of inflammation of the urinary tract. *J R Coll Gen Pract* 1965; **10:** 257.

Family planning: general practice and clinic services

Sir,

As a general practitioner and also as a family planning instructing doctor, I read with interest the article (April *Journal,* p.199-200) comparing family planning services in general practice and the clinics by Dr Sam Rowlands, whom I know to be an enthusiast in this field.

In Edinburgh, fortunately, the relationships between general practitioners and clinic doctors is usually anything but 'acrimonious or hostile', and communication is good. I do, however, feel that some sort of liaison card for recording cervical smears might reduce unnecessary duplication and this is soon to be introduced by Lothian Health Board.

I must take Dr Rowlands to task about his comments on staffing of family planning clinics. Firstly and unfortunately, the concept of medical gynaecologists has reached stalemate, as I understand this idea does not have the approval of the Royal College of Obstetricians and Gynaecologists. Secondly, why should part-time staffing of these clinics be 'unsatisfactory' and 'unjustifiable'. Why should it necessarily be a good idea to have all family planning doctors working full-time with a consequent seven-fold reduction in their numbers? — an administratively neat concept, but nothing more.

In my opinion the female doctors who mostly staff these clinics have much to offer in their professional interest and often from their personal experience of pregnancy and motherhood. The limited hours of work suit such doctors (and other clinic staff) very well. Should the staffing be made full-time, these women would not work to the subsequent loss of the service. I consider it to be a great deal worse to have these clinics staffed by full-time, possibly male, would-be general practitioners.

PENELOPE A. WATSON

Sighthill Health Centre
Calder Road
Edinburgh EH11 4AU