industries and in practice miners forced out of the industry are having to find unskilled labouring occupations. It is quite clear to me, and other doctors who work in them, I think, that social and medical problems in the present or former mining areas of Britain are very acute and obviously are likely to worsen. In Wales at least these are areas of high mortality and also of high general practitioner work-load, and have been the object of concern by the Ministry of Health. It seems to me most unfortunate that the apparent misclassification of miners by the Registrar General may distort this mortality and other epidemiological data. I do not know whose job it is to try to influence these decisions, but I should have thought that the College could reasonably make representation in the matter as we are certainly an interested body.

I also think that so far as possible the *Journal of the Royal College of General Practitioners* should encourage its contributors to present their work in an objective, definable and if possible measurable fashion, so that hypotheses and conclusions can be discussed in a scientific manner. We have surely long ago left the era of unconfirmable and undeniable subjective speculation and assertion.

Glyncorrwg. J. TUDOR HART.

REFERENCE

1. J. roy. Coll. gen. Practit. (1967).

General practice in South-west England

Sir,

The survey on general practice in South-west England is based on a mass of very interesting and important information devotedly recorded by the 68 participating doctors. Yet the report itself is in some ways disappointing.

Nature carries out research by throwing up occasional variants and selecting those most efficient for the development of the species. In contrast, the results of this survey are presented in such a way as to bury all variants in the means of the groups selected for comparison. This is an excellent technique for presenting information on the *status quo* but provides almost no clues as to how general practice could be improved in the future.

For example, the consultation rate per 1,000 patients at risk annually is quoted as ranging from 1,997 to 8,263 (1:4.14). Yet of all the 23 groups chosen in tables I and II the widest range is from 3,427 (practitioners with 3,000 or more patients) to 4,784 (practitioners with less than 2,000 patients), a ratio of 1:1.40. The report concludes that "this suggests that individual reports from practices are of limited value". What greater value emanates from 23 groups with almost identical average rates? "Plainly the doctor himself is a major factor in the determination of his consultation rate" but no evidence is adduced to support the sweeping and pessimistic assertion that "this appears to be due to subtle and intangible elements in patient relationship rather than to any readily alterable factors". I suggest that the views of "Doctor 1,997" and "Doctor 8,263"

would be germane and more valid. This is a fundamental problem of general practice for "we can no longer afford to dissipate skill upon the haphazard, *ad hoc*, provision of care. . . .".

The home visiting total consultation rate (tables I and II) expressed as a percentage, ranges in these same 23 groups from 23.7 (single-handed practitioners) to 34.6 (dispensing practitioners). One wonders what individual range and modes of practice these figures conceal.

The range of indirect consultation rates for individual doctors is from 20.8 to 1,201 (1:57.7) yet the range amongst the averages of the 18 groups selected in table V is from 223 (practitioners with more than 3,000 patients) to 452 (practitioners with two partners), a ratio of only 1:2.03. What is the significance of these figures?

The repeat prescription range (table V) in these same 18 groups is from 248 (practitioners with more than 3,000 patients) to 837 (practitioners with three or more partners). Do busy doctors cure their patients with fewer drugs and, if so, how?

In tables XI and XII the seven groups selected varied in their regular use of the 12 items of equipment listed from an average of 5.6 items each (doctors in rural practice and doctors over age 50) down to 3.7 (doctors under age 40 years) which affords consolation to age but little else.

In tables XIII and XIV, nine different surgical procedures are listed and the number of these carried out by the doctors is studied. Among the nine groups of doctors selected there is a range of 1.9 (single-handed doctors) to 4.2 (doctors with access to beds). This casts no light on what factors in single-handed practice render these procedures more difficult or less desirable.

Table XVIII shows that 'straight' x-rays, pathology, bacteriology and biochemistry are generally available. Yet, disappointingly, the outpatient and casualty referral rate (Groups III and IV) in table XIX did not bear an inverse relationship to the use of diagnostic facilities (Groups 1 and II). In fact the single-handed doctors who investigated their patients the least (101.9) also referred the least number of patients to hospital (87.9). Further, the doctors with the highest consultation rates investigated their patients the most (293.9) but sent the most to hospital (158.8). Were there no individuals who used the facilities to increase their own scope for diagnosis and treatment and so decrease the need for referring their patients to hospital? It seems unlikely.

I believe that by far the greatest factor governing the quality of general practice is the quality of the individual practitioner and that more could be learnt from exceptional than from average ones. It is likely that an outstandingly good doctor would do outstandingly good work if he worked in any of the 25 groups of doctors selected in this survey.

The survey has gathered a wealth of information on many of the facets of practice which have a profound bearing on its effectiveness. Hidden beneath all the averages quoted for each parameter studied must lie a standard deviation curve of the individual doctors. At the extremes of each curve are the exceptional doctors and in the middle are the great majority who mainly determine the averages quoted in the report. No

doubt the doctors at each extremity vary in most of the studies. I suggest that it would be of great interest to invite each of these unusual doctors to give an exposition of their conflicting rationales and techniques. There is no 'correct' way of practising, but such a series of articles would enable us to select from each contrasting pair of views and methods those we consider the better ones to follow. In this way the survey would play a part in the evolution of general practice.

Wick. J. M. WILKS.

Jenner Museum

Sir,

With regard to the article by Dr G. L. Wylie on the Jenner Museum in the College *Journal* of February 1968, you may be interested to hear of a headstone standing in the churchyard of St. Nicholas' church at Worth Matravers in the Isle of Purbeck, Dorset.

The stone indicates the graves of Benjamin Jesty, a farmer from Downshay, and his wife. He died on 16 April 1816, aged 79 years. The inscription reads:

"He was born at Yetminster in this County, and was an upright honest man; particularly noted for having been the first person (known) that introduced the Cow Pox by innoculation and who, from his great strength of mind, made the experiment (from the Cow) on his wife and two sons in the year 1774."

Apparently this antedates Jenner's vaccination of James Phipps by 22 years.

Bournemouth. J. L. LOAKES.

Fellows

Sir,

While in full agreement that those who have contributed so much to the College in its various activities should become the first Fellows, I feel that those of us, now between 70–80 years of age, and retired, who were, I may say, foundation members, as we joined from the first request to start a college of general practitioners, and had it not been so the College would never have been started, should receive one or two Fellowships. If the number should be too great a ballot could be taken. I know this procedure was done by the Royal College of Surgeons, Edinburgh, when my father and grandfather became Fellows without examination. Also the funds of the College must increase by the £25 required for Fellowship.

Newbury. ALEX G. MACGILLIVRAY.