

A survey of the work-load in a general practice

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THE popular image of the overworked general practitioner has existed for many years, and has been repeatedly emphasized with a great deal of anecdote. There is a wealth of factual evidence about work-load, but until the last decade, little attention has been paid to this by the majority of general practitioners. Little thought has been given to his intentions when seeing his patients. Such facts and figures as we do have are often discussed emotionally rather than rationally.

Over the past ten years there have been many more papers dealing with this subject and Fry (1969) aroused critical opposition by asking whether (in view of his findings), we need to increase the productivity of doctors already in the service rather than training large numbers of new doctors.

It is apparent that there are marked variations in different parts of the country, both in regard to patterns of visiting and prescribing, and also in the uses made of the community health services and the hospital service. It is also known that the ratio of consultations to visits varies widely. In a short space of time there has been a remarkable nation-wide decline in home visiting. Visiting patterns are falling into line with those in many other parts of the world. We might ask what this is related to: Size of practice? Pressure of work? Personality and training of doctors? Social pressures? Traditional attitudes of the surrounding doctors and the local population? We believe the most important factors are the attitudes and training of the general practitioner. The findings in this paper emphasize the difficulty of generalizing from one practice to another.

Last year we decided to study in more detail the work of our practice nurse. A preliminary paper on this subject was published in the *British Medical Journal* in 1967 (Smith and Mottram).

We were concerned in gathering information about her work in primary visiting and to what extent each of the partners in the practice made use of her services. As part of this study it seemed essential to have detailed figures about the work-load of the doctors in the practice. Each face-to-face consultation of the doctors was recorded for a period of one year from May 1968 to April 1969. The figures for the nurse's work are being analyzed and are the subject of another paper (Smith, Weston and O'Donovan).

The details of each consultation were recorded by the doctors on 'L' sheets using a simple numerical coding system. The usual baselines of age, sex, marital and social status were noted at each consultation and the diagnoses were coded according to the Classification of morbidity—College of General Practitioners (revized 1963).

The 'L' sheets were those designed by the Records and Statistics Unit of the Royal College of General Practitioners. Their use is described in a *Handbook of research in general practice* (Eimerl and Laidlaw 1969).

The 'L' sheet does not seem to be widely known and is little used, although it has much to recommend it for simple recoding. The resulting figures can be rapidly analyzed

with nothing more complicated than an adding machine. Few of us have access to computers and indeed for simple analysis of this kind, they are hardly necessary. If a well thought out numerical code is used large amounts of information can be collected rapidly and easily.

Method of recording

TABLE I

'L' SHEET CODING

- | | |
|--|---|
| <p>A. DURATION OF INTER-ACTION* (CONSULTATION OR HOME VISIT)</p> <ol style="list-style-type: none"> 1. 0-5 minutes 2. 5-10 minutes 3. 10+ minutes <p>B. MODE OF ACTION OF DOCTOR**</p> <ol style="list-style-type: none"> 1. Medical advice. 2. Refer for laboratory investigation 3. Refer for consultant services 4. Refer to nurse 5. Certification 6. Social advice only 7. Further assessment 8. Medical examination 9. Hospital admission 0. Other (casualty) <p>C. DOCTOR ASSESSMENT OF CASE</p> <ol style="list-style-type: none"> 1. Essentially medical case 2. Unnecessary 3. Nurse could have helped with case | <ol style="list-style-type: none"> 4. Could have attended surgery 5. Non-medical problems 6. Other <p>D. MAIN THERAPEUTIC INTENTION OF DOCTOR</p> <ol style="list-style-type: none"> 1. Specific 2. Palliative or symptomatic 3. Placebo 4. Prophylactic 5. Advisory 6. Other <p>E. PRESCRIBING</p> <ol style="list-style-type: none"> 0. Nothing prescribed 1. EC10 2. Private purchase advised 3. Contraceptive <p>F. 0. Obesity problem</p> <p>G. 1. Antenatal</p> <ol style="list-style-type: none"> 2. Cervical smear 3. Examination of breasts 4. Cervical smear and examination of breasts |
|--|---|

* Estimated only.

** Where more than one mode of action occurs only the main one was recorded.

Practice details

The practice now numbers over 9,000 (January 1970), and there is a high proportion of overspill from Birmingham. The practice is run by three partners from a purpose-built central surgery and one branch surgery. There are direct telephone lines to the branch surgery and to the local hospital.

The partners in addition to practice work assist in the running of the local general hospital (69 general-practitioner beds) and a chronic sick hospital (144 general-practitioner beds). One partner does a number of anaesthetic sessions a week and two of the partners assist in maintaining the casualty service at the hospital. In all about 11 national half days are performed by the partners within the hospital service. The senior partner is largely responsible for the care of the aged sick (belonging to the practice) in the chronic sick hospital.

The practice is widespread (about 90 square miles), and it has been the policy to encourage the patients to be self-reliant, but to always 'phone for advice when in doubt.

Preliminary analysis of the 'L' sheet revealed many interesting facts about the effect of the doctors' attitudes and their methods of work. These are discussed in detail in a later section.

We encountered some difficulties in our recording because we did not run a pilot scheme first. Dr A found it too great a strain to record every item, therefore in September 1968 he decided to record one in every five consultations taken strictly in rotation. For this reason his figures are incomplete.

It is important at this juncture to give a thumbnail sketch of the three partners concerned, for it became apparent that the figures when analyzed not only told us a lot about

the practice and its patients, but also a great deal about the doctors themselves.

Dr A—The senior partner who is due to retire in about four years' time might be described as an 'old-fashioned doctor'. He is very much one of the old school, trained in the physical school of medicine, who regards medicine as a vocation and an extension of the Christian life. He is looked upon by his faithful patients as an omnipotent figure. He does not use an appointment system at all. He has never been known to lose his temper.

Dr B—Middle forties. An extrovert personality who, while agreeing that medicine is a good work, regards the greatest good for the greatest number as being important. He tends to see things and problems in general terms, and is impatient of detail. He tends to establish good or bad relationships quickly and is interested in psychological rather than physical medicine, although he is deeply involved in hospital work. He works by appointment. Most of the newcomers are on his list.

Dr C—Middle forties. An introvert with a liking for clinical medicine, he tends to be a perfectionist, both in his professional work and his life. He is very concerned with detail, both clinical and administrative and dislikes working under stress. He takes longer to establish relations with patients, but they tend to be deeper. It is significant that he allows seven minutes a consultation against Dr B who allows five. He uses an appointment system; joined the partnership two years ago bringing a typical cross-section practice with him and his list has built up extensively over the past 18 months.

The analysis

There was an enormous mass of information and it was difficult to select the most important figures. The patterns of work of the two younger partners showed many similarities despite their differing approaches to medicine. Total direct consultations for each doctor over the year were in the range 6,500 to 7,700. (No form of indirect consultation was recorded). Dr A's figures are not very accurate and for the most part are only complete for eight months of the year (October–May).

Length of consultations were not accurately recorded so no calculations can be made about the length of time spent consulting and the length of visiting times. However, both the younger partners notice a steady increase in the amount of time they spend seeing patients in their consulting rooms and often the early afternoon surgery seems to merge with the evening surgery. In fact there must be a saturation point beyond which any increase in consultation times would lead to a deterioration in the doctors' efficiency. We often feel this point has been reached in our daily work.

The work we do at our local hospitals has not been recorded. Most minor trauma including all suturing, minor surgery and a certain amount of other illness, especially in the evening and at weekends is seen and dealt with in the casualty department of the local general-practitioner hospital by the partner on call. Two of the partners are on the casualty rota and this involves them in a total of two national half day sessions a week. Also many cases, which in other circumstances might have been looked after at home and required much visiting, were admitted to our general-practitioner beds, investigated properly and in our opinion receive a higher standard of medical care. It is difficult to give any accurate figures for the number of patient contacts involved.

The figures in tables IIa and IIb show considerable differences from those of other recent surveys. The total consultation rate was 2,568 per 1,000 patients per year compared with 3,938 for S.W. England (Wright 1968) and 5,456 for S. Wales (Williams 1970).

There was little variation between the three doctors though Dr B showed a lower rate than the other two. This is probably due to his larger share in the hospital work.

We have already noted that no records were kept of the consultations with patients

at the hospital which we estimate to be 5,000 for the three partners.

Our visiting figures are remarkably low especially Dr B's. Visiting habits and how they are affected by the use of a nurse was the origin of the figures used in the present

Consultations and home visits

TABLE II (a)

| Doctor | Total consultations (C) | Home visits (H.V.) | H.V./C. rates as percentage | Antenatal consultations (A.N.) |
|--------|-------------------------|--------------------|-----------------------------|--------------------------------|
| Dr A | 7,572 | 1,400 | 18.5 | — |
| Dr B | 6,677 | 251 | 3.7 | 1,049 |
| Dr C | 7,666 | 791 | 10.3 | 969 |
| Total | 21,915 | 2,442 | 11.1 | 2,018 |

Dr A holds no antenatal clinic.

study. Our nurse did about 1,300 primary and follow-up visits during the year of her study which only overlapped our year of recording for 11 months (April 1968–March 1969).

Dr B has always considered that an inordinate amount of time is wasted in unnecessary visiting and in a previous paper has endeavoured to show how some of it can be effectively carried out by a suitably trained nurse. Dr C was unconvinced when he joined the practice but agreed to use the nurse for a trial period. Dr A felt that little of the work of visiting could be delegated to a nurse. These attitudes are fairly well reflected in the home visiting to total consultations ratio expressed as a percentage in table IIa. Even Dr A's figure including the middle aged and elderly of the practice and making little use of the nurse are low compared with most other surveys.

TABLE II (b)

| Doctor | Total consultations | Consultations rates/1,000 Patients/year |
|--------|---------------------|---|
| A | 7,572 | 2,632 |
| B | 6,677 | 2,233 |
| C | 7,666 | 2,872 |
| Total | 21,915 | 2,568 |

These figures have of course been influenced by telephone requests for advice which are encouraged by all partners and the use of the hospital.

The figures for antenatal consultations reflect the large number of young married couples in the practice, the tendency for the local obstetricians to hand over most of the antenatal work to the general practitioners, and the surprising number of patients who elect to have their second and third babies at home despite the adequate number of hospital beds available.

Hospital admissions

Acute and emergency admissions were only accurately recorded by Dr C. These totalled 74 patients during the 12 months. Some of these patients were admitted to other hospitals in the area. His admission figure represents nearly one per cent of his total consultations and is higher than those in the S.W. England study (0.5 per cent) and the S. Wales study (0.1 per cent) and reflects the use of the general-practitioner beds at the local hospital.

Practice—Size and distribution

The situation in an overspill area has resulted in a steady increase in practice size

from 7,721 patients in October 1967 (when Dr C joined the partnership) to 8,848 in April 1969 at the end of the study. The average number of patients on each partner's list was calculated from the figures for the beginning and end of the year, and it was these figures which were used in our calculations.

TABLE III
PRACTICE NUMBERS DURING YEAR OF STUDY

| <i>Doctor</i> | <i>April 1968</i> | <i>April 1969</i> | <i>Average for year (2)</i> |
|---------------|-------------------|-------------------|-----------------------------|
| Dr A | 2,872 (524) (1) | 2,881 (533) | 2,876 (528) |
| Dr B | 2,877 (67) | 3,101 (68) | 2,989 (67) |
| Dr C | 2,472 (200) | 2,866 (214) | 2,669 (207) |
| Total | 8,221 | 8,848 | 8,534 |

Figures in brackets represent patients over 65 years of age.

The average for the year were used in the calculations for tables IIa and IIb.

The differing numbers of patients over the age of 65 on the list of each partner has had a considerable influence on the work they do. (See tables V, VI and VII).

Dr B has always dealt with most of the obstetric and paediatric work of the practice. In consequence over the years Dr A has had an increasing proportion of the middle aged and elderly patients of the practice to care for. Since Dr C joined the partnership Dr A has continued to look after his own patients and few of them consult the other partners. Drs B and C often see each others patients.

Sex ratios

The figures for consultation rates of male and female patients require some comment. Dr A's figures show a preponderance of males, though one should have expected a slight preponderance of females since he sees a lot of elderly patients.

TABLE IV
ALL CONSULTATIONS (EXCLUDES ANTENATAL CONSULTATIONS FOR DR B AND DR C).

| <i>Doctor</i> | <i>Male patients (M.)</i> | <i>Female patients (F)</i> | <i>M/F ratio as percentage</i> |
|---------------|---------------------------|----------------------------|--------------------------------|
| Dr A* | 3,715 | 1,860 | 66.7/33.3 |
| Dr B | 2,184 | 3,602 | 37.6/62.4 |
| Dr C | 3,099 | 3,598 | 46.2/53.8 |

*Dr A—eight months only (October–May)

Dr C having brought into the practice a normal spread of patients showed a fairly normal male/female consultation ratio, while Dr B whose list has largely been built up of overspill patients during the past ten years, and who has undertaken the gynaecological and midwifery section of the practice for 20 years, shows a preponderance of female consultations; but again these figures may tell us more about the doctors than the patients.

TABLE V
AGE DISTRIBUTION OF PATIENTS—ALL CONSULTATIONS

| <i>Doctor</i> | <i>Under 10 years</i> | <i>Percentage total consultations</i> | <i>Over 60 years</i> | <i>Percentage total consultations</i> |
|---------------|-----------------------|---------------------------------------|----------------------|---------------------------------------|
| Dr A* | 365 | 6.5 | 1,865 | 33.1 |
| Dr B | 1,272 | 19.2 | 297 | 4.4 |
| Dr C | 1,272 | 16.5 | 890 | 11.5 |

*Dr A—eight months only (October–May)

Influence of age

The doctor's attitude and the type of practice he inherits or builds has already been commented on. Dr A sees the older patients and Dr B the younger ones, whereas Dr C has a normal spread nearer the national average. Dr A's certification rate is far higher than the other partners (table X); this probably reflects the tendency for the older man to take or need longer periods of absence from work. It may be that this group of patients think that they have a far more understanding doctor when it comes to their ability to work. It may also be that since Dr A works without an appointment system, men whose main need is certification prefer not to make an appointment. This may apply also to older people as a whole.

TABLE VI
THE 'LONGER' CONSULTATION

| <i>Doctor</i> | <i>Male (M)</i> | <i>Female (F)</i> | <i>Total</i> | <i>M/F ratio as a percentage</i> |
|---------------|-----------------|-------------------|--------------|----------------------------------|
| Dr B | 117 | 314 | 431 | 27.1/72.9 |
| Dr C | 220 | 325 | 545 | 40.3/59.7 |

The longer consultation

It has often been said that if one spends time in a 'longer' consultation at the onset of a doctor/patient relationship, the illness can be organized and time will be saved in the long run (Balint). We recorded the approximate length of consultations as a routine with no prior thought of the possible significance of the resulting figures. In this way the fact of observing could not have changed the doctors' patterns of behaviour with regard to the length of consultations with certain types of patients.

When we came to analyze the sheets we found to our surprise that less than ten per cent of the consultations of Drs B and C were of the longer type, but Dr A rarely noted that his were a longer type of consultation. To what kind of patient were the younger doctors prepared to give this extra time? Dr B allocates a longer amount of time to his female patients, whereas Dr C was consistent with his M/F ratio. When we analyzed the longer consultation patients with regard to social status, it again appeared to us that Dr B apportions a longer time to the patients in social groups 1 and 2, *i.e.* the numbers were approximately equal, although these two groups together only represent about 23 per cent of the practice total. Does this refer to the patient needs of the upper social groups, or does it reflect the doctor's attitudes?

We think that the recording of patients who received longer attention merits further study, and since we are in a position to follow them up we hope in the near future to see them, and assess whether their attendance pattern, the causes of their illness (and their family illness rate) has been affected by their 'long' interview.

Analysis of illness

We analyzed various diagnostic categories of illness during the months of February, May and October.

We selected categories of disease which appeared to show a difference in approach between the doctors. Again one sees the similarity in outlook of the junior partners, but the degenerative conditions and injuries gravitate toward Dr A. One interesting point is that both Drs B and C were convinced that a great proportion of their cases were suffering from psychoneurotic disorders before the analysis, and it came as a surprise to find that in fact only about ten per cent of their cases were considered by themselves to be so. Another point that emerged was the low incidence of contraceptive pill prescribing. We believe that the figures are accurate as we only issue six-monthly

scripts and patients have to see us when their prescription is due for renewal. Dr A does not prescribe the 'pill' at all, and it therefore means that in a practice population of 9,000 only 170 are taking the 'pill'. On the other hand we make a deliberate attempt to encourage patients to have an IUCD fitted, and in the course of three years about 250 have been fitted within the practice.

TABLE VII

| Diagnostic category* | Dr A | | | Dr B | | | Dr C | | |
|-----------------------------------|------|------|------|------|------|------|------|------|------|
| | Feb. | May. | Oct. | Feb. | May. | Oct. | Feb. | June | Oct. |
| ENT and respiratory | 280 | 215 | 175 | 94 | 114 | 96 | 150 | 111 | 92 |
| Psychoneuroses | 50 | 20 | 35 | 61 | 79 | 67 | 55 | 53 | 64 |
| Rheumatic disease.. .. | 140 | 140 | 90 | 24 | 30 | 32 | 37 | 27 | 33 |
| Injuries | 65 | 35 | 75 | 7 | 19 | 36 | 17 | 18 | 23 |
| Skin disease | 25 | 25 | 20 | 30 | 28 | 49 | 35 | 50 | 48 |
| CVS.. .. . | 45 | 70 | 25 | 10 | 8 | 15 | 41 | 39 | 26 |
| Gastro-intestinal | 65 | 60 | 105 | 16 | 35 | 31 | 34 | 15 | 45 |
| Genito-urinary (exc. norm. preg.) | 10 | 5 | 5 | 42 | 37 | 46 | 33 | 31 | 51 |

* College of General Practitioners—A Classification of Morbidity (Revised 1963).

Doctor-patient attitudes

Only rarely was a consultation classified as 'unnecessary', although one or two visits were so assessed and it was thought that a visit by nurse would have sufficed.

Social status

TABLE VIII

| Registrar Generals classification | No. of patients | I | II | III | IV | V |
|-----------------------------------|-----------------|---|----|-----|------|-----|
| Assessment by Drs A .. | 145 | 2 | 11 | 108 | 24 | 0 |
| B .. | 145 | 7 | 36 | 67 | 31.5 | 3.5 |
| C .. | 145 | 6 | 30 | 63 | 36 | 10 |

Social status was often omitted by Drs A and C on the 'L' sheets and Drs A and C did a random week of attendances to arrive at the figures in the table. Dr B's figures are reduced from a total of all his attendances to provide a comparable figure.

On analyzing the social status grouping is much as would be expected. There is a slight shift to the lower social groups in the case of Dr A which would be expected, since he does not use an appointments system and has the older local patients. Newcomers to the town tend to be in social classes II and III.

Dr B thinks there is some evidence that the lower social groups tend to attend on Monday mornings without appointments, but we found it difficult to find completely unskilled patients according to the Board of Trade classification.

We realized at the end of our study that there was a flaw, because our prescribing figures referred to the number of forms (EC10's) rather than to the actual number of items on a prescription. Further, we did not record routine repeat postal prescriptions.

TABLE IX
PRESCRIBING HABITS

| Doctor | No. of EC10 forms issued | EC10 for specific therapy |
|--------|--------------------------|---------------------------|
| Dr A | 5,025 | 4,300 |
| Dr B | 2,974 | 1,311 |
| Dr C | 3,366 | 735 |

It was apparent that there was a difference in the pattern of prescribing habits. The junior partners prescribed on EC10's for about half of the patients seen, the senior partner prescribed for nearly 90 per cent of his patients. The individual doctors varied in their attitudes; Dr B estimated that about 50 per cent of his treatment was specific; Dr C considered that his main therapeutic intention was the advice he gave rather than the prescription he issued. Dr A considered that nearly all the medicines he prescribed had a specific therapeutic purpose ('L' sheet coding—D.1).

We were sent our prescribing figures by the Ministry for the month of July during the year of the study. (Dr C was on holiday during this month and they are not altogether typical.) For the partnership the average number of scripts per person on our lists was 0.290 against the national average of 0.414, and the average cost per person on the list was 39d. against the national average of 59d.

The low rates of consultation for purposes of certification by Drs B and C should be compared with Dr A's fairly high rate. No private certificates for work are issued by any of the local doctors (mutual agreement), and this eliminates a number of unnecessary consultations.

TABLE X
CERTIFICATION

| <i>Doctor</i> | <i>No. of NHS Certificates issued**</i> |
|---------------|---|
| Dr A | 1,735* |
| Dr B | 399 |
| Dr C | 309 |

* Dr A—eight months only (October–May)

** 'L' Sheet Code B5.

Discussion

There is much more to be learnt from the mass of facts which we have recorded. We know now that we have attempted too much, and it is apparent from the consistency of the figures that carefully selected periods of time with meticulously accurate recording would suit most purposes better.

As we studied our figures certain questions arose in our minds. We found that some items, e.g. referral to consultant, referral for further assessment, tended to 'bunch' on particular weeks.

1. Do we refer patients for assessment or other services more on certain days of the week, or when we are particularly stressed?
2. Does our work pattern and methods of treatment alter under stress?

We recognize there is a wide difference in our visiting and consulting figures to those found by other practices, on occasions the difference is extreme. We attribute some of these differences to:

1. Intensive use of the local general practitioner hospital facilities.
2. Extensive use of a nurse not only for usual procedures and re-visiting, but also for primary visiting.

Our figures do not present the traditional picture of the overworked, harassed general practitioner. We feel this is due to our deliberate policy of concentrating on quality in medical care. In the past the service that the general practitioner gave their patients has been based on demands as opposed to needs. As a result a disproportionately large amount of time has been spent on 'trivial ailments'. Patients who have greater needs and patients who make no demand on our services in comparison are comparatively neglected and do not receive the quality or the quantity of medical care that their needs warrant. Eimerl (1966) in a study of "How general practitioners use their working time", discussed the rigidity of practice patterns, the surprising amount of the doctor's time spent on visiting, and the need for individual practitioners to re-appraise how they spend their time. In his study the time spent on each of the doctor's activities was carefully measured and the doctors spent almost as much time visiting as in the

consulting room. However, the time spent on home visits included travelling and only one fifth of this time was in face-to-face contact with the patients. Although we did not make any such accurate time measurements we probably spent rather more time in the consulting room, and considerably less time on home visiting.

It is our impression that our patients bother us less and less for more trivial illness. They have every right to expect an unhurried assessment of the problems they do present and this seems to be reflected in the increasing length of individual consultations.

In the past, and indeed at present, rigid attitudes by general practitioners towards the demands of their patients have led to inefficient medical care. There is a great necessity for practitioners continually to examine the ways in which they work, the ways in which they use their time, what they delegate to other less highly-qualified staff, if they are to continue to give their patients the services that they really need.

It is our experience that if good relationships are maintained with the patients in the practice, and they are continually acquainted with the purpose of any innovations, then it is acceptable to them and they know they are getting a better service.

We agree with Walton's view that the older doctor is less inclined to treat psychoneurotic disorders, but on the other hand though the two younger partners seem to be different, on the basis of Walton's factor analysis they seem to devote very similar proportions of their work to psychiatric problems. We did not find our rate of consultation for psychiatric disorders was as high as Logan and Cushion (1958), who had a rate of 187.4 per 1,000, but this may be because our methods of recording these diagnoses is rather different. The idea that the doctor's attitudes towards illness determined the type of patients he attracts to his practice has to be modified in the light of the shortage of doctors. This means that in the Midlands at any rate patients have often little choice, because many doctors have full lists and they have to go to the doctor who is in a position to take new patients. In these circumstances the doctors' attitudes towards emotional problems and psychiatric illness operates in a different way. New patients who have come from other practices where perhaps these types of problems have either been ignored, rejected or dealt with in a mechanistic fashion are often resistant and even hostile to a different approach by their new doctor. However as mutual confidence grows and a good doctor-patient relationship is established they readily accept a psychotherapeutic approach to their medical and social problems.

One thing that emerges clearly from this survey is that it tells us more about the doctors than the patients. The personality of the doctor, the type of practice he inherits or builds, and the general pattern of local general-practitioner attitudes are reflected in our figures.

It is also clear that figures that quote averages about list size, consultation rates, consultation-home visits, ratios, etc., are often misleading in the study of ways and means of applying medical care efficiently within the general-practitioner service in this country.

This may seem to be a statement of the obvious, but the assessment and analysis of surveys coming from general practice are useless unless this is borne in mind. It may account for the widely differing attitudes of doctors to their problems and the problems themselves throughout the country.

Summary

This paper shows in detail the work-load of a three-man partnership in the Midlands. It stresses the need for up-to-date figures about general practice, and concludes that

work-load and patterns, whilst adjusting to the needs and demands of the patient, more truly reflect the attitudes of the doctors in the practice.

REFERENCES

- Eimerl, T. S. *et al.* (1966). *British Medical Journal*. **2**, 1549.
 Eimerl, T. S. and Laidlaw, A. J. (1969). *Handbook for research in general practice*. Second edition. Edinburgh and London. E. and S. Livingstone.
 Fry, J. (1969). *Journal of the Royal College of General Practitioners*, **17**, 355.
 Logan, W. P. D. and Cushion, A. A. (1958). *Morbidity statistics from general practice*. Studies on medical and population subjects No. 14, vol. 1. London. Her Majesty's Stationery Office.
 Smith, J. Weston and Mottram, E. M. (1967). *British Medical Journal*. **4**, 672,
 Smith, J. Weston and O'Donovan, J. B. (1970). *British Medical Journal*. **2**, 653.
 Smith, J. Weston and O'Donovan, J. B. (1970). *British Medical Journal*. **3**.
 Williams, W. O. (1970). *A study of general practitioners' work-load in South Wales. 1965-1966*. Royal College of General Practitioners.
 Wright, H. J. (1968). *General practice in south-west England*. Royal College of General Practitioners. Reports from General Practice No. 8.

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