Correspondence

HOW MANY PATIENTS?

Sir,

Dr John Fry's recent discussion (August *Journal*) on the changing patterns in his practice makes interesting reading. However, I hope that his figures of 30 consultations and two home visits per day for his list of 4,500 are not regarded as the norm for planners of our future.

Of our practice population, about 25 per cent live in the old town and 75 per cent in a rapidly growing new town area. There are six doctors in partnership with average lists of slightly under 2,500. On a typical day recently, with one partner on holiday, the remaining five partners each made an average of 53 consultations, 8·4 home visits and wrote 9·8 repeat prescriptions. Although our practice is by no means an average one, I feel that neither is Dr Fry's practice and that the norm lies somewhere in between. Perhaps other practices could publish their figures so that a true picture can be obtained.

Our permanent health centre opened in October, 1971 and I hope, in due course, to collect figures of work load over the first 12 months. I expect this will show a degree of demand in a rapidly growing area which is not sufficiently appreciated, either by planners or by the Medical Practices Committee. It is our experience that, in such an area, lists even of 2,500 are too large for adequare patient-care, at least in the early stages of development.

P. I. VARDY

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REFERENCE

Fry, J. (1972). *Journal of the Royal College of General Practitioners*, **22**, 521-528.

Sir,

John Fry's article on *Twenty-one years of general practice* (August *Journal*)[1] caused the members of our group to look at our attendance registers. We then asked ourselves why we seem to be working more hours per week than Dr Fry with considerably smaller average lists.

Your editorial[2] raises many of our questions and it is obvious more reports from all types of practice are necessary and may we suggest that additional information is required in the future. For example, how many patients visit other general practitioners or casualty departments instead of their N.H.S. doctor? In London and possibly in other large towns, some people have N.H.S. and private doctors and this is especially common in the middle-class and also with certain groups of immigrants.

Why do patients of doctors with large lists attend the surgery less often than patients of doctors with smaller lists? Do they go to chemists for advice, suffer in silence or not present their "trivial illnesses" to the doctor. It is not necessary in this *Journal* to elaborate on the true meaning of a "trivial illness".

In our practice we have not yet changed to an appointment system except for the antenatal and children's clinics but we often spend 20 minutes or more dealing with a crisis situation which begins with "I'm not feeling too good doctor" or "The children are getting on my nerves". Do all these people ring for an appointment or do only those who get worse come to the surgery when they can present the receptionist with more acceptable symptomatology?

On a more personal note we should like to know how to see 12 children an hour. We normally spend a few minutes talking to the mother or getting the confidence of a child at the developmental assessment clinic and consider this time well spent. We do not repeat any work carried out by our excellent health visitor and would certainly like to know how to get 12 babies and their mothers (who often use the opportunity to bring up a problem about themselves or other members of the family), in and out of a consulting room in an hour.

In conclusion may we stress our genuine interest in these problems because we are certainly not teaching our trainees how to look after 4,500 patients, and if we need to do so we shall certainly have to learn the technique ourselves.

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REFERENCES

1 Fry, J. (1972) *Journal of the Royal College of General Practitioners*, **22**, 521–528.
2 *Journal of the Royal College of General Practitioners*, (1972). Editorial, 491–3.

Sir,

In reply to Dr Brooks (November *Journal*).

1. The practice here is run by two full-time partners only. There are almost 9,000 patients.
2. There is a night and weekend rota with two other practitioners, so each of us is 'on call' every fourth weekend and one or two nights each week.
3. For two years 1961–63, there was an assistant employed in addition to the two partners.
4. The practice is run as a separate unit of 9,000 patients by the two full-time general practitioners. The reason why this number of patients can be registered with two practitioners is that there is a partnership with another unit with two practitioners who have only 2,500 patients between them and so we in our unit can have up to 4,500 patients.

I hope this is clear, namely unit 'A' with two general practitioners has 9,000 patients, and unit

'B' with two general practitioners (in partnership) has 2,500 patients.

My reason for publishing this data was to stimulate further examination of what we can do and should be doing in practice.

JOHN FRY

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Kent.

REFERENCE

Fry, J. (1972). *Journal of the Royal College of General Practitoners*, **22**, 521-528.

GENERAL PRACTITIONERS AND CONTRACEPTION

Sir,

The emphasis of your September *Journal* on contraception is timely. We believe that free contraceptive advice should be available to all within the National Health Service.

Earlier this year we took a practice policy decision that no charge would be made for contraceptive advice for social purposes, and all prescriptions for the Pill would be given on E.C.10. So far the executive council has not asked us to justify our prescriptions.

Surely the time has come to anticipate a universal contraceptive service within the National Health Service? General use of E.C.10 for all Pill prescriptions would help to advance the date when the National Health Service will include contraceptive care for all.

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STUDY OF MEDICAL ETHICS

Sir,

It may be of interest to your readers to know that the Society for the Study of Medical Ethics has recently been established. It is a postgraduate development of the work of the London Medical Group and the Edinburgh Medical Group.

It intends to promote an interest in medico-moral problems by encouraging discussion at student and postgraduate levels; by organising regional conferences; by informing members of lectures and symposia organised by the London Medical Group and similar organisations elsewhere; by the eventual establishment of inter-disciplinary commissions, and by the creation of a library and study centre.

Members will receive *Documentation in Medical Ethics*—a folder of articles, either reprints from journals or originals. Membership is open to members of the medical profession and to others who have a direct professional interest.

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Publicity Officer
Society for the Study of Medical Ethics.
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STUDENT SELECTION

Sir,

I would like to ask the courtesy of this *Journal* to bring to the attention of your readers a very important subject, and to suggest that the Royal College of General Practitioners should pioneer a change in attitude to the selection of medical students, just as they have done during the last decade with the question of vocational training.

During the 1960s the College gave a tremendous lead in initiating a better introduction and education in general practice both for undergraduates and future general practitioners. But what of the 1970s? What should be the aim and direction of the College? I would like to suggest that one of its most important objectives should be to influence and alter the selection of medical students so that by 1980 some sanity and wisdom could be brought to this problem.

Your recent editorial (March *Journal*) and a letter in *The Times*, 27 September, 1972, from the Headmaster of a co-educational boarding school show that this subject is a live issue and something which is of concern to all of us—whether we are doctors or patients.

Opinions obviously vary about what qualities are necessary for a potential doctor, but to judge at present only on chemistry, physics and biology at a certain standard of 'A' level pass is limiting the field to the detriment of both the profession and the patient. It would seem that very few people disagree with this view and yet the universities and medical schools remain impervious to any alteration of the *status quo*. Therefore let the College 'gird up its loins' and attack the entrenched and myopic academics.

JOHN STEPHEN

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Somerset.

REFEERNCE

Journal of the Royal College of General Practitioners (1972). Editorial, **22**, 135-6.

QUALITY IN GENERAL PRACTICE

Sir,

I find myself unable to let the recent article by Frank Honigsbaum (July *Journal*) and your concerned editorial on the quality of care go without comment. I hope you will forgive me as a foreigner from across the sea for commenting on this. As it is a problem with which we all are concerned, and there are many references to North American studies, I thought I would express my feelings.

The overall tone of this article I thought was hypercritical. He seems able to accept any number of studies by all kinds of people outside general practice as valid. He seems to accept assumptions by specialists as true, but casts grave doubts on any comments or assumptions by general practitioners. His orientation is based primarily on hospital illness, e.g. his reference on page 432 to American general practitioners dealing with