LETTERS TO THE EDITOR

CONSULTATION RATES

Sir,

We read John Fry's James Mackenzie lecture "Common Sense and Uncommon Sensibility" (January *Journal*, p. 9) with interest. We were concerned however, by the stress laid on the falling consultation rate which was echoed in the editorial "How many patients?" in the same issue (p. 3).

We work from a main surgery where we provide full services, including an appointment system, antenatal, and well-baby clinics, a practice nurse, an attached health visitor, and district nurse. The surgery is open throughout the day for 6,500 patients. We also work from a branch surgery where we provide a less complete service for 2,100 patients. There is no appointment system and no clinics are held. The surgery hours are from 09.00 hours to 10.00 hours and from 17.00 hours to 18.00 hours. The same doctors work in each surgery, but we feel less committed to our work at the branch surgery. Our consultation rates are 3·4 consultations per year per patient at the main surgery, excluding special clinics, but only 1·75 consultations per year at the branch surgery.

Our contention is that the better the service provided, the more likely it is to be put to use, and therefore we view the emphasis on low consultation rates with concern.

While we are interested in developing the idea of audit in general practice, we think that a low consultation rate is not necessarily a measure of good practice, and may be the reverse.

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Sir,

I venture to question the statement in John Fry's James McKenzie lecture "Common Sense and Uncommon Sensibility" (January *Journal*, p. 3) that there is no definite relationship between the high consultation rates in Scotland and morbidity.

The figures in Table 1 were issued by the Scottish Home and Health Department. Scotland's poor showing may be due either to different uses of the death certificate or to real differences in mortality. The latter explanation seems to be generally agreed and while I am sure that Dr Fry is correct in saying that often consultation rates are in the hands of the practitioners themselves, the Scots do seem to be unhealthier than the rest of the UK, and higher consultation rates would therefore seem to be inevitable. Would not comparison of the morbidity in two similar practices north and south of the border provide a useful basis for research?

Table 1. Standardized mortality ratio (UK = 100) from selected causes 1971.

Cause	Sex	England and Wales	Scotland	N. Ireland
Respiratory TB	M	95	153	98
Ca large intestine	F	97	126	120
Ca bladder and other urinary organs	F	97	136	78
Diabetes	F	96	141	102
Ischaemic heart disease	M	93	119	115
	F	97	126	120
Cerebrovascular disease	F	97	125	121
Cirrhosis of liver	M	96	137	109
Complications of pregnancy	F	98	193	149
Congenital abnormality	F	96	123	152

As always, I read Dr Fry's lecture with admiration for his mastery of information and for his ideas.

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GENERAL-PRACTICE WORKLOAD

Sir,

Some of the points raised by Vivian Turner and Marion Ferguson are already adequately answered if my paper is read carefully (December *Journal*, p. 885), and in particular if my reference to specific proposals on education of mature students is considered (Tudor Hart, 1974).

It seems that the main problem is not my "outrageous professionalism", but the outraged professionalism of Vivian Turner and Marion Ferguson. So far as I know, no one has yet tackled the *principles* of the division of labour between different types of health worker in some future, more rational health service. Even for this, some regard would have to be paid to its roots in our present division of labour.

I believe I have no need to prove that I am an opponent of medical privilege and professionalism as hitherto understood. I think the word is usually a cover for humbug. The sectional problems of job demarcation are quite serious, within professions as well as between them. Patience and tolerance are necessary to avoid becoming too easily outraged by expressions of opinion by contiguous groups of health workers. It is not difficult to stay out of trouble in this area either by keeping one's mouth shut, or by making sure that nothing but platitudes emerge from it; anyone wishing to express original ideas is treading a minefield.

The point I wished to make was that in solving the problem of giving patients an average of ten minutes' consultation rather than five, nurses are likely to be most effective if doctors continue to have responsibility for the initial assessment of all newly presenting problems, especially if the work of nurses is expanded to include the special functions secondary to this, chiefly some specific aspects of examination, history taking, and investigations.

When serious audit is applied to any field of medical work, whether by doctors or nurses, the results are chastening. All of us are working rather badly, and audit is only a beginning towards more effective work. If the initial assessment of newly presenting problems is not a matter for doctors in an advanced industrial society, then this implies a distinction between nurses and doctors that is quite new and should be spelt out. The Burlington Trial was no more than a very crude test of effectiveness, and in fact neither the doctors nor the nurses came out of it very well.

We should not be afraid of thinking and writing mistakes if the alternative is to talk interminably about team work without actually undertaking it, and to pay lip service to the central position of the patient, while in practice suppressing criticism both within and between professions to the detriment of good patient care. If we all behave as though we were sitting on committees of the British Medical Association and the Royal College of Nursing, nothing will ever change.

Marion Ferguson and Vivian Turner live and work only about 30 miles from this practice, and they would be very welcome to come and discuss this important question with my medical and nursing colleagues.

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Reference

Tudor Hart, J. (1974). *Lancet*, ii, 1191-1193.