reasons why family doctors have had, and are still having, such an uphill task in their struggle to be taken seriously by their specialist confrères.

On the subject of acute otitis media, I will say only that it is important to examine the ears of febrile children because a child of two years of age or less will frequently not be able to localize his discomfort and actually complain of pain in his ear. No one can distinguish between acute otitis externa, involving only the external auditory canal, and otitis media without looking in the ear. The treatment of both conditions is not the same, but the practical approach to diagnosis is.

If we are to consider that "skilled hands" ever knowingly hand out unnecessary prescriptions, then I suggest to Dr Smith that he should leave a dispenser containing signed blank prescription forms in his waiting-room so that his patients might help themselves and write the prescription themselves. They are already doing almost that.

I might also suggest that the only aspects of the doctor-patient relationship that have been neglected by Dr Smith are those relating to the doctor's duty to examine always and prescribe only when necessary.

There are techniques which one can learn readily to enable examination of the ear in an unwilling child without undue disturbance and I suggest that Dr Smith learn them.

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HOW MANY PATIENTS?

Sir,

We were very interested in your editorial "How many patients?" (January *Journal*, p. 3) and in your comments on Marsh and Kaim-Caudle's analysis of team care in general practice.

Preliminary analysis of our research data collected by a primary care team over a four-year period does not wholly support Marsh's findings.

For a practice population of about 7,000 we recorded detailed information for every face-to-face consultation made with each member of the practice team of three doctors, a trainee general practitioner and fully attached district nurse, health visitor, and social worker from 1970 to 1973. The consultation rate for the whole team was 4·1 per patient-year at risk in 1970 before the social worker joined the team, rising to 4·3 per patient-year from 1971 to 1973, whereas the consultation rate for doctors only was 3·4 per patient-year throughout the four years. Similarly, the visiting rates per patient-year for the team were 1·1 in 1970, 1·2 in 1971, and 1·3 in 1972 and 1973, while the corresponding rate for doctors only was 0·5 per patient-year in each year studied.

We suggest that two of the most important factors affecting the general practitioner's consultation rate will be his clinical interests and his perception of his role, for both these factors influence what he permits his patients to consult him about. Some evidence can be presented to support this view from a comparison of the proportion of diagnoses falling into broad diagnostic categories in Marsh's data and in our own 1972 data (Table 1).

As regards individual diagnoses, Marsh records URTI in 9·4 per cent of diagnoses, whereas the Liverpool team figure was 5·4 per cent and the Liverpool doctors recorded 6·6 per cent. Marsh recorded "anxiety" in 3·9 per cent and "depression" in 6·8 per cent of contacts, whereas the Liverpool doctors recorded 6·0 per cent of contacts as "anxiety" and 2·4 per cent as "depression". Antenatal care accounted for 2·9 per cent of Liverpool doctors' diagnoses compared with 5·8 per cent for Marsh, but they also recorded 3·4 per cent of diagnoses for contraception, an item not recorded by Marsh.

These figures suggest that workload studies from specialized practices may not be sufficient to make judgements about the overall provision of primary medical care in the community, and that much work remains to be done on the influence doctors themselves exert on shaping the demands of their patients.

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Sir:

Your editorial, "How Many Patients?" (January *Journal*, p. 3) has added to the current controversy over medical manpower *(British Medical Journal*, 1977). The much quoted figures of Fry (1972) who has reported caring for 4,000 patients in his practice, and the more recent publication of Marsh and Kaim-Caudle (1976), showing surgery consultation and home visit rates of 1·9 and 0·4 respectively, have to be interpreted with caution. These are results from *individual* practices and despite the apparent fall in consulting rates in other practices, (RCGP, 1973) a number of questions arise:

1. Patterns of morbidity and patients' consulting habits are often drawn from practices where practitioners are members of the Royal College of General Practitioners. Are these doctors and practices truly representative?
2. To what extent has the fall in demand for general-practitioner services been related to the growth in deputizing

Table 1. Rank order of diagnostic categories according to percentage of diagnoses in each category.

Marsh *et al.*			Liverpool team			Liverpool doctors only		
Rank		%	Rank		%	Rank		%
1.	Respiratory disorder	25	1.	Respiratory disorder	19	1.	Respiratory disorder	23
2.	Mental disorder	14	2.	Prophylactic procedures	12	2.	Mental disorder	13
3.	Cardiovascular disease	12	3.	Mental disorder	11	3.	Prophylactic procedure	10
4.	Central nervous system including eyes and ears	10	4. &	Central nervous system including eyes and ears	7	4.	Central nervous system including eyes and ears	8
5.	Musculoskeletal Digestive disorder	8	5.	Social problems	7	5.	Cardiovascular disease	6