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 |

services? Although the percentage of visits performed by these services is still small, it is still growing and delegation of home visiting is undoubtedly a feature of general practice in cities in the UK.

3. The statistics provided by Fry and Marsh do not always identify patients registered in their practices who may have sought primary care services from other sources. What is the incidence of self-referral to other doctors and to casualty departments in practices with low consulting rates?

4. Are the low consulting rates of some doctors purely a reflection of patients' habits, or also a measurement of doctors' methods of practice changing through time? It would seem reasonable to propose that reduction in workload is not quite so simple as suggested and will depend on a combination of patient behaviour and a doctor's experience, personality, and style.

5. Are we making a mistake by using consulting rates as the main indicator of general practitioners' activities? If list sizes were to be increased, general practitioners may have less time to spend consulting with their nursing colleagues, visiting patients in hospital, and supervising vocational trainees.

Before accepting the arguments for increased lists and reduction in medical manpower, factors other than consulting rates have to be taken into account when discussing the organization of primary medical care.

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## EMPLOYMENT OF MENTALLY HANDICAPPED PEOPLE

Sir,

The report on the "Employment of Mentally Handicapped People" (January *Journal,* p. 53) implies an unjustified criticism of Remploy Ltd.

You quote: "If Government agencies like Remploy take only a tiny percentage, any official criticism of industry which is not nearly as well informed on trainees' capabilities as Remploy should be muffled". I find it difficult to understand these remarks and I wonder from which source the statistical data have been obtained.

I am responsible for the medical supervision of the Sunderland factory of Remploy Ltd. This factory has 19 per cent of disabled employees who could be classified as mentally handicapped. These include the mentally subnormal with those suffering from psychoneurosis and psychotic illness. The majority of these, 15 per cent of the total disabled employees, are mentally subnormal. Also there are a number of other disabled employees who have some degree of mental handicap in addition to their primary cause of disablement, for example, epilepsy or cerebral palsy. In March 1976 Remploy nationally had 8,484 disabled employees. Of these 908 (10·7 per cent) were classified as mental subnormality with 798 (9·4 per cent) as psychoneurosis and other mental illness; a total of 1,706 (20·1 per cent). Again there will be many with a mental handicap in addition to their primary disability. These figures do not correspond with the report's "tiny percentage".

At local level the majority of Remploy factory medical officers are general practitioners who are well aware of the problems of the mentally handicapped, both in the community and in employment. Remploy exists to provide sheltered employment for all categories of disabled people who cannot be employed in open industry but who can, under suitable conditions, make a significant productive contribution. There is no question of "allocating only a small percentage of places to mentally disordered people". One of the functions of the factory medical officer is to advise on the suitability of an individual for employment within the factory. Over the last few years an increasing trend in the number of mentally handicapped employees has been noticed, and this was dicussed at a recent meeting of northern factory medical officers and senior staff.

It is the policy of Remploy to disseminate knowledge of the work and conditions in the organization. General practitioners are welcome to come and see for themselves the conditions under which their disabled patients are employed.

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#### Reference

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## FAMILY PRACTITIONER COMMITTEES

Sir,

Many of my colleagues are producing reports of the work of family practitioner committees similar to that produced at Avon (February *Journal,* p.71) giving statistical information about the number of professionals who are under contract and some useful information about family practitioner services.

I enclose the report for the Surrey Family Practitioner Committee for the year ending 31 March 1976.

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## PROPORTIONS OF FELLOWS

Sir,

Dr D. R. Wilson's interesting letter in the February issue of the *Journal* (p. 122) strengthens my conviction that our system of promotion to the fellowship leaves much to be desired and prompts me to offer a few comments.

No system of advancement is perfect, but any form which depends on the goodwill or good memory of one's colleagues must, at best, be haphazard and at times be associated with disappointment, if no more. At worst, it may give rise to feelings of discrimination, to bad blood, and even to resignations. On the other hand, automatic promotion at the end of a period of time or on passing an examination, although it has the merit of simplicity, has its critics. It would seem to me, therefore, that compromise is called for.

First of all, our rather grandiloquent method of nomination should be revised and simplified. At present it is time-consuming, expensive and off-putting. Three equal sponsors completing three identical and over-comprehensive forms are responsible for much reduplication. I would suggest that one sponsor responsible for one form suitably pruned and provided with a section for the signature and brief additional comments of one supporting sponsor is quite enough.

Secondly, we should introduce a statute which would give any member of say, 20 years' standing, provided he was