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

Remploy Report/Accounts (1976).

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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Reference

Surrey Family Practitioner Committee (1977). *Statistical Review of the Work of the Committee for the Two-Year Period ended 31 March 1976.* Surrey: FPC.

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