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

vouched for by two fellows, the right to apply for, and indeed expect, election to the fellowship.

Such amendments would, I believe, provide a substantial safeguard against the more than occasional oversight.

To return to Dr Wilson's letter, may I suggest that the figure he quotes for Wales of approximately one fellow to four members, although perhaps a little generous at present, does indicate that Welsh fellows are well aware of their obligations to members with qualifications for the fellowship. Further, I see nothing wrong with his figure of 72 new fellows for England. Why not indeed?

Those who fear a cheapening of our fellowship if its basis is broadened may take comfort from the example set by the Royal College of Physicians of London. Half a century ago, able provincial physicians, often of considerable repute, had little hope of attaining to their fellowship, and few ever did. Since those days, however, and particularly since the coming of the NHS, the London College has markedly liberalized its fellowship policy so that its ratio of fellows to members is now one to three. Yet I much doubt if there is any feeling that its currency has been debased in consequence.

We are a young and, thus far, a successful College, thanks to our founders and many later loyal and devoted workers, but we still have many more friends to make and adherents to acquire. Let us go our own way and see to it that it is a liberal way, and let others do what they will.

S. F. MARWOOD

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Alveston
Bristol.

Sir,

As Provost of the South-West Wales Faculty I have taken the precaution of checking the figures given by Dr D. G. Wilson in his letter (February *Journal*, p. 122). His mathematics are a bit shaky in that his faculty of Bedfordshire and Hertfordshire has 5·05 per cent of members as fellows and mine has 16·05 per cent. The proportion of fellows in England is 8 per cent, in Scotland 10·53 per cent, in Wales 17·3 per cent, and in Ireland 11·74 per cent, which agrees with his figures. The average for faculties in Britain is 7·3 per cent with a standard deviation of 2·4 per cent.

Even with these corrected figures it appears that there is no statistical significance in the number of fellows in Dr Wilson's faculty, while we in South-West Wales have rather more than one would expect by chance. We are too modest to attempt an explanation of the disparity but I suggest perhaps not enough fellows are put up by the English faculties.

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## WHAT KIND OF COLLEGE?

Sir,

I have just been shown your February issue and hope that you will allow me to comment on the letters from Drs Stephen and Woolley and from Dr Donald Irvine (p. 121).

I did not compare a weighing machine to the MRCGP, as stated by your correspondents, but rather to the MRCP, a quite different animal! In an exercise where total marks were apparently of import Dr Irvine gave the weighing machine six marks and the MRCP two marks, and I note that Drs Stephen and Woolley regard the scoring system as manifestly ludicrous.

For 13 years I was a member of your College and thought that it sought to improve practice by illustration and example. Recently I felt that the College might be trying to impose doctrine by means of sanctions and this, the real point of my article, was conveniently ignored by Dr Irvine. I make no apology for trying to reflect the views of a body of local opinion and I note that Ian Capstick, FRCGP, has expressed disquiet at the image presented by the College (Capstick, 1977).

Sadly, I feel that power politics will prevail and meanwhile Dr Irvine is free to indulge in his own brand of sniping at my expense. I am not "where the action is". Apart from clinical satisfaction I envy him the action of the university, the postgraduate centre, the press interview, the DHSS consultation, the medico-political conference, the overseas commitments . . .

I wonder if there is more than one way to give up general practice?

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**Reference**

Capstick, I. (1977). *British Medical Journal*, 1, 373.

Sir,

I read with great interest Dr Donald Irvine's reply to Drs Stephen and Woolley on the subject of the selection of training practices (February *Journal*, p. 121). I would, however, question his assertion that "the personal qualities of the trainer carry the greatest weight" and add my fears about college control of vocational training and compulsory college membership to those of Dr Brian M. Goss (February *Journal*, p. 120).

Some five years ago I was accepted as a trainer in Dr Irvine's own region. At that time I worked in a ten-man group in a new, purpose-built group practice centre. Subsequently, for reasons both personal and professional, I moved to a small, single-handed practice in a rural area in a different part of the same region. Within two years a vocational training scheme was set up in my present area and I attended all the preliminary meetings and introductory courses on teaching methods, following which I made a formal application to become a trainer. I received a reply which indicated that my application would be considered *when I had taken the college examination.*

These events lead me to two possible conclusions: firstly, that my "personal qualities" which had been satisfactory three years earlier were no longer satisfactory; and secondly, that there is discrimination against single-handed practices in the selection of trainers.

Like Dr Goss I care about standards and have organized my practice so as to give as high a standard of personal care as possible. In addition I have always taken an interest in the academic side of general practice and for several years I have participated in the undergraduate teaching programme of the University of Leeds. With increasing experience and the scope offered by my present practice to devote more time to each patient I find it difficult to conclude that my "personal qualities" are no longer acceptable.

The second conclusion would imply that successful training for general practice can take place only in the setting of a group practice. While realizing the advantages of group practice, particularly in an urban area, I do not consider it desirable that trainees should experience only one style of practice and cannot agree with the implication that only this type of practice can achieve a sufficiently high standard. Furthermore, I was assured by Dr Irvine and his colleagues that such discrimination against single-handed practices does not take place.

The only other conclusion which I can draw is that the college examination is now considered to be more important than the personal qualities of the trainer or his style of practice, which I find far more disturbing. Dr Irvine's final paragraph echoes my own belief that "good teaching and training in general practice has its foundation in good patient care". While I realize that the college examination is one method of assessment of standards in general practice, I cannot accept it as the chief criterion of good patient care for teaching or any other purposes. If this is the College's intention, Dr Goss's fears are well-