Scheme 2; Barnet; Blackpool, Victoria Hospital; Davyhulme, Park Hospital; East of Scotland; Halifax; Ormskirk; Paisley; Rugby; and Windsor 1.

All these schemes are recognized by the Royal College of General Practitioners for the purposes of the MRCGP examination.

SIMG CONGRESS

The SIMG Congress on General Practice will be held on 10 to 12 November 1977 in Dresden, East Germany. Those interested should write to Dr Peter Frank, Ash House, Ash Lane, Hale, Cheshire.

CORRECTION

Dr R. A. Savage apologizes for omitting his acknowledgements in the article, published in the June 1977 issue on doctor's attitudes to women in medicine, which were as follows:

We wish to thank the principals, trainees, staff, and patients in both group practices for their co-operation. We received a grant from the Research Foundation of the Royal College of General Practitioners, and invaluable advice and encouragement from Dr R. J. F. H. Pinsent, the Research Advisor. Miss H. Openshaw at the Hope Hospital, Salford, typed the draft and manuscript most expertly. Thanks are also due to our spouses for their advice and patience while this paper was being prepared.

LETTERS TO THE EDITOR

HOW MANY PATIENTS?

Sir,

None of your correspondents have described the threatening feeling in a practice when data collection reveals enormous variations in the patterns of work.

In our six-man practice we have nearly full lists, an active child health programme, attached nurses and health visitors, good local outpatient diagnostic facilities, and short hospital waiting lists. We were shocked when we finally received the results of the first year of the 1970/1 National Morbidity Survey (Table 1). One partner has one of the highest episode rates for the 0 to 4-year age group in the whole National Morbidity Survey. He thought this was because "he follows up his patients more frequently". Data do not support this. In fact his patients consult for more illness and the rate per episode is not significantly different from the other partners'. In addition, Dr E. has the highest rates recorded in the practice for all parameters measured.

On the other hand Dr B. has the lowest rates in the practice with uniformly lower rates than the whole practice.

What is the difference? Each considers himself to be practising "good medicine", but good for whom?

If we were to consider our practice with the two partners with the lowest and highest rates working together as a two-man practice, we would obtain the figures in Table 2.

This reveals a difference of about 20 per cent in workload. The hard-working high-rate partners flattering themselves on how hard they worked would merely be seen by their low-rate colleagues as doctors "at the beck and call of their patients".

The two partners with the lowest rates would see 20 per cent fewer patients and perhaps might be giving more time to each but would be wondering what the fuss about full lists was all about. They would support Fry (RCGP, 1973).

As it is, with all the partners working as a group, the low-rate doctors subsidise in terms of time the habits of the high-rate doctors.

Table 1. Episode rates of Ashford practice compared with National Morbidity Survey (OPCS, RCGP and DHSS, 1974).

	Dr A	Dr B	Dr C	Dr D	Dr E	Dr F	All practices	Ashford practice	5th percentile	90th percentile
Episode rate per person on list	1.7	1.7	1.9	2.1	2.2	2.0	1.8	1.9	1.2	2.3
Consultation rate per person on list	3.1	2.7	3.3	3.2	3.5	3.4	3.0	3.2	2.0	4.5
Patient consulting rate per person on list	0.6	0.6	0.7	0.7	0.7	0.7	0.7	0.7	0.6	0.7
Episode rate per person under four years old on list	2.7	2.5	2.5	2.8	3.9	2.8	2.8	2.9	—	—