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	—	—

Table 2. Rates of highest-rate partners compared with lowest-rate partners.

	Practice rate	Rate of two lowest-rate partners (A)	Decrease on practice rate (%)	Rate of two highest-rate partners (B)	Difference between A and B (%)
Episode rate per person on list	2.0	1.7	*15*	2.1	*19*
Consultation rate per person on list	3.2	2.9	*9.3*	3.5	*17*
Patient/consulting rate per person on list	0.67	0.63	*6*	0.71	*11*
Episode rate per person under four years old	2.9	2.5	*3*	3.4	*23*

When change does occur, if it is indeed desirable, I believe doctors may have to give up some of their archaic 'priestly mantle', which presumes a right and even an ability to be seen to cure.

I believe patients may have to change and come to accept the limitations of medicine and to accept greater autonomy and independence.

Finally, I would like to know if any of your readers have any data which show how the certificate strike some years ago, which according to the DHSS produced the lowest seasonal certified sickness rate for many years, affected their consultation rates.

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References

Royal College of General Practitioners (1973). *Present State and Future Needs of General Practice. Reports from General Practice No. 16.* London: *Journal of the Royal College of General Practitioners.*

Office of Population Censuses and Surveys, Royal College of General Practitioners and the Department of Health and Social Security (1974). *Morbidity Statistics from General Practice. Second National Study 1970-71.* London: HMSO.

PRACTICE ORGANIZATION

Sir,

The practice organization committee of the North of England Faculty has conducted a five-year study of work-handling in eight practices. Great variation was found in the size of practice staff, the degree of delegation to nurses, health visitors and midwives, the demands made by patients and the doctors' responses to them. One practice differed widely from the rest in its use of hospital services. The only change in organization over the five-year period was an increase in the issue of repeat prescriptions.

The range of organization observed was so wide that no ideal standard could be described, and it was concluded that practice organization is not suitable material for comparative auditing. Practice organization represents an equilibrium: a balance between the social attitudes of patients to medicine and what might be termed 'style' on the part of the doctor. Although many factors must influence both sides of this equilibrium, it appears to be stable.

I. C. FULLER
Sedgefield
Stockton-on-Tees.

EARLY DIAGNOSIS OF PREGNANCY

Sir,

May I be permitted two clinical comments on the paper on the early diagnosis of pregnancy (June *Journal*, p. 335)?

The breast changes of pregnancy are not described in the paper, and the only reference is to "tender, tingling breasts" which is in the nature of a symptom. The physical signs might well have been described as prominent veins, enlargement and pigmentation of the areolae and nipples with the appearance of Montgomery's tubercles. These changes do not regress, of course, and are therefore of less value to multiparae. However, one now sees the breast changes of pregnancy in nulliparous girls who have been taking the oral contraceptive pill, so that it is no longer a reliable physical sign of pregnancy.

Secondly, there is no mention that systolic murmurs are common in pregnancy and are a useful confirmatory sign. This is mentioned in Greenhill's book on obstetrics and other authors state that a systolic murmur can be heard in over 90 per cent of pregnant women (Bleich, 1970; Cutforth and MacDonald, 1971). In my own practice I am able to detect a systolic murmur in over 50 per cent of my antenatal patients. I have found this physical sign useful in dealing with missed abortion, when the murmur has disappeared a day or two before the 'Pregnosticon' test has gone negative. This physical sign deserves to be more widely known.

ANDREW MILLAR
Hethersett
Benson
Oxford.

References

Bleitch, A. (1970). *Journal Medical Association Georgia,* **59**, 34-35.

Cutforth, R. & MacDonald, C. B. (1966). *American Heart Journal,* **71**, 741-747.

Greenhill, J. P. (1965). *Obstetrics.* 13th edition. New York: Appleton-Century-Croft.

DR D. SCOTT NAPIER

Sir,

May I point out that the first provost of the East Anglia Faculty was not Dr Scott Napier, as stated in Dr Woolstone's obituary (June *Journal*, p. 382), but was the late James Dundas Simpson, a member of the Foundation Council? In commemoration of this an annual address is delivered by a member of the Faculty.

It was in the home of Scott Napier in Norwich that the meeting of foundation members was held to inaugurate the Faculty, and he became its first representative on Council.

GORDON L. MC CULLOCH
Moorfoot
Bathpool
Launceston.

SINGLE-HANDED GENERAL PRACTICE

Sir,

I should like to confirm that single-