Medical Care Research Unit
University of Newcastle upon Tyne
21 Claremont Place
Newcastle upon Tyne NE2 4AA.

Reference

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FIT-INS

Sir,
I was interested to read the article on 'fit-ins' by Dr Jenny Field (March *Journal,* p.173) as she highlighted a problem that was becoming apparent in our practice: some patients were being thought of as nuisances, which was engendering a sense of irritation in the minds of both doctors and receptionists; this, in turn, was being reflected in their treatment of these and other patients. In fact, we were worried that the whole attitude of the practice was becoming coloured by the aggravation that these patients seem to cause. So we set out to attempt to solve the problem.

Six of us work from a privately owned group surgery in Highcliffe, two of whom work on a part-time basis. We have a smaller than average list of 9,150 but a very mugh higher than average age: 38 per cent for all patients over 75 (24 per cent for the 65 to 75 age group and 14 per cent for the over-75s).

One of my partners suggested a scheme which has been working admirably now for nine months—long enough to have proved itself. Each surgery can be booked in advance for the first half of the surgery session, with seven and a half minutes allowed per patient; the other half of the surgery time is kept for bookings on the day in question, that is during the morning for the morning surgeries, and late morning and afternoon for the afternoon sessions. We have also staggered the consulting times: 08.45 hours to 10.30 hours and 11.15 hours to 12.15 hours; and then 14.00 or 14.30 hours to 15.30 or 16.00 hours. There are no surgeries after that time, although bookings can sometimes be made at a later time if necessary.

We always have at least two doctors consulting at the same time—sometimes three. Thus we have given equal importance to new bookings on the day, and those which are booked ahead, so the fit-in has disappeared to everyone's relief and to the benefit of doctors, patients, and receptionists alike.

When we instigated this scheme we feared that people might soon catch on to the fact that they could be seen the same day and ignore the advance bookings, but this has not been the case. Life has been very much easier for the reception staff and the doctors have found themselves under much less strain, which is reflected throughout the surgery, and I am quite sure it has led to better medicine and happier doctors.

M. J. FALKNER-LEE
280 Lymington Road
Highcliffe
Dorset BH23 5ET.

TYPES OF PRACTICE

Sir,
Practices are often categorized in such terms as 'urban', 'rural' or semi-rural'. It is an unsatisfactory classification, partly because it is subjective, but more importantly because it fails to distinguish between very different types of practice. A more objective classification would be one based on the size of population unit in which the practice is situated. There are five easily recognizable population units which might be defined in terms of population somewhat as follows:

1. Megalopolis (London): Several million
2. Large cities (about 20 exist in the UK): 250,000-1 million
3. Small cities and towns: 20,000-250,000
4. Market towns: 1,000-20,000
5. Villages: Under 1,000

In the United Kingdom the truly rural practice without a village centre is rare and even village practices are uncommon. What is usually called a rural practice is in fact a market town practice with its surrounding catchment area. Most of the population is looked after by practitioners based on one of the first four population aggregates noted above. Each level of population size is characterized by an appropriate level of complexity of medical organization.

London stands alone in its size, its complexity, its facilities, and its problems. It is distinguished by its abundance of teaching hospitals, medical schools, general hospitals, and special hospitals of all kinds. It has a large concentration of specialists, and general practices of various kinds relating to the subdivisions of this very large city. It has deputizing services, and single-handed practice is not uncommon. In its role as the metropolis, London bears witness to the cephalization of society and within its boundaries are to be found the headquarters of many national medical organizations such as the Department of Health and Social Security, the Royal Colleges, the General Medical Council, the British Medical Association and the Public Health Laboratory Service.

The large cities repeat many of the features of London, but in a much simplified form. Not all have teaching hospitals.

The smaller cities and towns occasionally have teaching hospitals, but most do not. Hospitals are few and not specialized. General practice is typically in partnerships and each practice often covers a large part of the town and sometimes the fringe villages as well.

Each market town usually supports a group of three to six general practitioners working from a central surgery. Single-handed practitioners are rare. This type of practice looks after the market town with its satellite villages and isolated habitations. Its catchment area is that of the market town and usually extends to the borders of the catchment area of the next market town. Some support a cottage hospital looked after by general practitioners but rely on the larger hospitals of the neighbouring towns and cities for the treatment of complex conditions.

The populations given for the various categories are approximate and somewhat fluid and special considerations might apply in conurbations such as the West Midlands and Greater Manchester. Nevertheless, this classification of types of practice in relation to population aggregates is useful not only as a method of characterizing general practices, but because it has a more general application in classifying other professional services.

N. B. EASTWOOD
71 Victoria Road
Oulton Broad
Lowestoft NR33 9LW.

THE JOURNAL

Sir,
In the *February* issue of the *Journal* (p.90) there appears an article entitled "Hernia repair and time off work in Oxford". It covers five and a half sides. Two and a half consist of tables: detailed, obsessive, and utterly unmemorable. The entire useful material in the article is contained in the first quarter column, the summary. The information presented there is of interest, although perhaps chiefly to those at the Department of Health and Social Security.

In the whole issue there are only nine articles. This particular offering could well have been presented as a letter or simply as a summary, leaving space for two or even three extra short articles.

We are exhorted to write good English. Please also let every column inch count.

N. T. A. Oswald
125 Newmarket Road
Cambridge CB5 8HB.

Sir,
I think the *Journal* was right to publish the interesting article by Dr K. Williams (January *Journal,* p.33), based on a study of 500 women years, particularly as this must roughly correspond to the number of women 'on the Pill' in many practices. In my opinion, there was a great enough number of patients with chest pain in the study for the conclusion to be valid.

I agreed that it does not rule out a relationship between any single cause of chest pain (e.g. pulmonary embolism) and oral contraceptives, but it does show that, in the average practice, chest pain is as frequent in non-users as in users.

I believe that the Editor of the *Journal* is right to encourage student studies of this calibre by publishing them when possible, and would expect all thinking doctors to read this article, taking into account the status and experience of the author and not allowing the mere fact of publication to prevent them from reading it as critically as Dr Sackin (May *Journal,* p306) obviously has.

R. Hillman

WHAT KIND OF COLLEGE?

Sir,
I quite agree with Dr M. R. Thompson (February *Journal,* p.118) when he states that he would give humility a high place on the list of qualities required of a good general practitioner.

As a non-member of the College, but as a reader of your *Journal* by courtesy of my partners, I cannot reconcile the concept of humility with either the exclusive nature of the College, or the pomp and ceremony of College robes, maces, and official junketing.

If humility is judged to be a worthy attribute of the family doctor, then it should be similarly judged in relation to the College which seeks to represent him.

I believe that it is the apparent absence of this quality on the part of the College which lies at the root of its inability to attract the interest and support of more than a minority of established general practitioners in this country.

N. W. S. Hester
The Surgery
Shaw Lane
Albrighton
Nr Wolverhampton WV7 3DT.

WOMEN GENERAL PRACTITIONERS

Sir,
I am sure that the findings of Drs Ann McPherson and Jackie Small (February *Journal,* p.108) about women general practitioners in Oxfordshire could be duplicated elsewhere, and I agree that the under-representation of women as principals in general practice arises from attitudes to women doctors rather than lack of training or ability.

In this area, however, there seems to be no lack of openings for part-time work, and I have had many offers of this since finishing vocational training here. However, I have chosen to work full time. This has really brought me up against the sexists attitudes of some of the medical profession, exemplified by an all-male training practice (with College members) blatantly specifying in a private handout that they were seeking "a young male replacement" and summed up by a comment by a general practitioner colleague: "I wouldn't take on a woman unless she brought her ovaries in a jar."

Admitting women to medical school and to vocational training schemes purely on the basis of merit is hollow egalitarianism if, when it comes to the crunch, that is, taking on women as partners in general practice or employing them in senior hospital grades, prejudice reveals itself as strong as ever.

Gail Young
129 Salters Road
Gosforth
Newcastle.

REPEAT PRESCRIPTION SYSTEMS

Sir,
The Practice Organization Committee of the College has been considering the problem of repeat prescription systems. We are trying to draw together relevant information about repeat prescribing and efficient systems of keeping this activity under control. Eventually we hope to produce a document on repeat prescribing, which would be available to anyone interested.

I should be very glad to hear from any practice which has a repeat prescribing system which they feel functions efficiently and which may have features that they consider of particular value.

K. J. Bolden
Chairman
Practice Organization Committee
Royal College of General Practitioners
14 Princes Gate
London SW7 1PU.

WASTED CERVICAL SMEARS

Sir,
It would be unfair to describe Mr Burslem's piece on wasted cervical smears (March *Journal,* p.189) as a wasted letter, because it is often helpful to be reminded of what one knows already. However, I suspect (though I have no supporting data) that there is a far greater source of wasted smears which he failed to mention. These result, not from faulty technique, but from the thoughtless following of routine: "A routine cervical smear was taken." This sentence occurs so frequently in letters from gynaecology, antenatal, and family planning clinics that it could well be incorporated into a rubber stamp. As general practitioners we ought to mention the date of the last smear test in our referral letters or, even better, enclose a duplicate copy if one is to hand. The same applies to the results of screening for syphilis and rubella antibodies.

Maybe such wasteful duplication will only start to decrease when patients carry summaries of their medical records, perhaps on the lines of the French *Carnets de santé.*

V. P. Smith
The Old Grammar School
St Ives
Cambridgeshire.