FREQUENT USERS

Sir,

I read the letter from Lord Taylor on this topic with considerable interest (November *Journal,* p. 698), but I must, with regret, take issue with him.

I did in fact follow up McGregor's pioneering work, but my technique differed from McGregor's because I used a sample population in preference to the whole practice. I argued that it would be cheaper and easier to use such a sample, and that, provided any bias in its construction was known, this could be allowed for in extrapolating the results obtained. I selected a sample of 500 people from the surgery attenders and followed each for a year, recording every contact in detail. In addition, each individual completed an intelligence and personality test. The system was called an 'artificial practice' because the population was not a random sample of the practice population and because psychometric testing is not part of normal general practice. Both factors might have introduced some unrecognized bias.

I calculated from the observations that in my practice 15·7 per cent of the real practice population would be responsible for 43 per cent of the total work, a result which is similar to McGregor's findings.

At that time, I worked with Mr James Pearson of the Department of Community and Occupational Medicine in the University of Dundee, and in response to my request that he should help me find an underlying pattern in the morbidity of the 'artificial practice', he demonstrated that the episode pattern was close to a negative bionomial distribution, a result which lends support to the 'proneness' hypothesis. We were able to go further because the proneness seemed to suggest system vulnerability, i.e. respiratory proneness, skin proneness, alimentary proneness and so on. It should be noted that recurrent illness was excluded from this part of the study in order to avoid a false result. We also demonstrated that when people had multiple episode patterns, one of the episodes was likely to be a serious condition and not necessarily related to the system involved in the recurrent part of the pattern.

A special study was made of those whom Taylor would call "multiple ailment heavy burden" patients, although I coined a different descriptive name for them. As a group their intelligence performance was poor and they had high neuroticism and introversion scores. This group also contained a larger number of young women and old men than one might expect to find by chance.

The study suggested a number of possible developments but I was sidetracked into a different area of research and will not have the opportunity to return to my original interests for another two years. However, it is clear that there is a need for much more study into the factors which generate need and demand for medical attention, and Taylor's plea for further research in this area should not go unanswered.

ALBERT JACOB

Duncraig
10 William Street
Dundee DD1 2NL.

References

Jacob, A. (1966). An 'artificial practice' as a tool for research into general practice. *Journal of the College of General Practitioners,* **11**, 41-48.

Jacob, A. & Pearson, J. (1967). Morbidity in an 'artificial practice'. *Journal of the Royal College of General Practitioners,* **13**, 303-312.

Jacob, A. (1968). Age, sex and patient category in an 'artificial practice'. *Journal of the Royal College of General Practitioners,* **15**, 203-207.

Jacob, A. (1968). The intelligence of the population of the 'artificial practice'. *Journal of the Royal College of General Practitioners,* **16**, 462-467.

Jacob, A. (1969). The personality of patients in the 'artificial practice'. *Journal of the Royal College of General Practitioners,* **17**, 299-303.

Lord Taylor was asked to comment on Dr Jacob's letter. He writes:

"I am sorry I missed Dr Jacob's papers on 'Multiple ailment heavy burden' patients. I was at that time moving to Canada and learning a new job. I must congratulate him on his good work. His finding of 'system vulnerability' is most interesting. I can confirm that, amid the multiple ailments, a serious condition often appears. Unless one is constantly alert, this can easily be missed in the welter of minor complaints.

My experience is that these patients are by no means necessarily unintelligent or introverted. I would expect to find a high neuroticism score, as Dr Jacob finds. But it is the combination of physical and psychiatric weakness which is so striking. Two further points: they seem to fatigue easily; this often, though not always, sets a limit to their achievement. They are also fairly often skilled at adapting themselves to the slings and arrows of outrageous fortune, which is just as well in view of what they have to put up with."

CATCHMENT AREAS

Sir,

I was interested to see your leader and geographical article (November *Journal*). I think the majority of patients who remain with doctors after they have moved do so through fear. They are afraid to change to a doctor that they don't know and have no confidence in should they have to see him in an emergency. I do not know whether this could be called "voting with their feet".

If we allow the organization of the NHS to be based on "better the devil you know" then it is indeed a bleak future. I am sure it is in patients' interests for us to try and educate people to use their local facilities unless they have good reasons not to.

CHRISTOPHER SLADEN

The Surgery
Llangennech
Llanelli.

KEEPING COPIES

Sir,

An aid to self-preservation as a National Service Medical Officer was to keep copies of all letters—from requests for more vaccine to copies of letters acknowledging receipt of receipts. The ploy could go on until one was posted elsewhere.

This habit has persisted in general practice. Letters received about patients are filed in their records chronologically, and if a letter contains no important information the top right hand corner is clipped off so that it is discarded when its immediate usefulness is past. When any letter is written about a patient the back of the most recent unclipped letter is used by the typist to make a carbon copy for future reference.

This proves that a letter has been typed on a certain date, and it can also give certainty that all relevant information has been passed on to a consultant—for example drug sensitivities or changes in medication. Equally, copies of letters written by another general practitioner often give a much more revealing picture of the patient's background than can ever be given by a consultant on the basis of a single interview.

Not least, keeping copies can be a valuable method of auditing a general practitioner's work, even if only a "do I pass on all the helpful information?"