less favourable elsewhere. These variations may further polarize the quality of medical care, creating a high-quality urban general practice (with diplomas, colleges and what have you) but an increasingly deprived rural sector.

In short, I seriously question that British general practitioners have a great deal to offer in improving health care in the developing world, and that any forays into this area should be, at least, circumspect.

M. R. OWEN
Deputy Director of Medical Services
c/o Ministry of Health
Mbabane
Swaziland.

Sir,

We accept Dr Owen's concern for the appropriateness and relevance of any help provided by English general practitioners to the development of primary care in developing countries. Indeed one of our chief concerns in writing the article was to alert people to this important issue.

We were at pains to tell the doctors of Sri Lanka that we could not provide them with a blueprint for an ideal general practitioner based on a European model. However, we did feel (and have not changed our view) that the educational model appropriate to postgraduate training in the UK is equally relevant in Sri Lanka. We believe that a general practitioner, whether in Nottingham, Manchester or Colombo, should be encouraged to question his or her clinical practice as well as teaching methods using the following progression: "What are you doing now?" "What needs to be done?" "How can you do this?" "How can you be certain that you have done it?"

The perceived needs of our hosts were that the knowledge, skills and attitudes pertaining to primary care, whatever the model on which its provision was based, should be taken seriously by medical schools which, like many others, seemed to value only the skills pertaining to secondary care. Our hosts' concern was that the powers that be should understand that there were skills peculiar to the provision of primary care which had not been taught to the network of junior doctors deployed in government health clinics throughout the small towns and rural areas. What we were asked to do, and we think succeeded in doing, was to convince the powers that be that there should be appropriate postgraduate training for the doctors they were deploying in primary care. The knowledge, skills and attitudes needed were to be sorted out by the people on the ground. Indeed our whole Workshop was hung on the idea of developing needs-related objectives for that training and the use of learning methods such as project work that would ensure relevance.

Of course, all the charms of Sri Lanka could not blind us to the fact, of which we had been in no doubt in any case, that the provision of adequate primary care for the whole population of the island would require delegation and sharing of skills and that there would be many aspects of primary care of far higher priority than the skills of western medicine. The interesting point was that the invitation came from a group of Sri Lankan primary care doctors whose assessment of the needs of the population in general showed that there were things that could be learned from British general practice, in particular its educational skills, and that they could share these skills across a wide spectrum of primary care providers.

While we share Dr Owen's concern that medical care in developing countries be no further incapacitated by the unquestioning absorption of western ways and western values, we plead not guilty!

DAVID METCALFE
Professor of General Practice
Department of General Practice
University of Manchester
Darbishire House
Upper Brook Street
Manchester M13 0FW.

M. A. VARNAM
Little Wick
42 Nottingham Road
Ilkeston
Derbyshire DF7 5PR.

Referral rates (percentages in brackets).

Specialty	Dr A	Dr B	Dr C	Dr D	Trainee	Total
General medicine	1 *(5)*	11 *(52)*	5 *(24)*	4 *(19)*	0	21
Other medical	3 *(10)*	11 *(35)*	9 *(29)*	6 *(19)*	2 *(6)*	31
General surgery	7 *(17)*	9 *(21)*	15 *(36)*	9 *(21)*	2 *(5)*	42
Orthopaedics	4 *(13)*	8 *(25)*	16 *(50)*	2 *(6)*	2 *(6)*	32
Gynaecology	4 *(16)*	6 *(24)*	10 *(40)*	3 *(12)*	2 *(8)*	25
Other surgical	7 *(32)*	8 *(36)*	5 *(23)*	2 *(9)*	0	22
Total medical	4 *(8)*	22 *(42)*	14 *(27)*	10 *(19)*	2 *(4)*	52
Total surgical	22 *(18)*	31 *(26)*	46 *(38)*	16 *(13)*	6 *(5)*	121
Total referrals	26 *(15)*	53 *(31)*	60 *(35)*	26 *(15)*	8*(5)*	173

Outpatient Referrals

Sir,

During October and November of last year I recorded the outpatient referrals of the four-man practice in which I was trainee. It was known that the partners had widely differing referral rates, in spite of having equal and separate lists (2,400 patients each). I decided to study their referrals in more detail to see where these differences lay. Referrals to casualty and venereal disease clinics were excluded. Obstetric referrals were also excluded because they were invariably referred for consultant care by all the partners.

The findings are shown in the above Table. Doctors B and C referred more than twice as many patients as A and D. Doctor B accounted for 52 per cent of the general medical referrals and 42 per cent of all medical referrals. Doctor C accounted for 50 per cent of all orthopaedic referrals and 40 per cent of gynaecological referrals.

In an audit of his own outpatient referrals, Brown (1979), whose referral rate was just over half Fry's national average of 425 per doctor per year, found that fewer than half of his medical, orthopaedic and gynaecological referrals were definitely worthwhile (32, 40 and 44 per cent respectively). Bearing this in mind, it is tempting to conclude that Doctors B and C may have been referring some patients unnecessarily to these specialists. However, it should be noted that their rererral rates are below the national average. This suggests that in many practices with above average referral rates, unnecessary referrals may be the rule rather than the exception.

T. J. CANTOR
34 Preston Lane
Faversham
Kent.

Reference

Brown, J. M. (1979). Why not audit hospital referrals? *Journal of the Royal College of General Practitioners*, **29**, 743.