attendance, and also agree substantially on our morbidity findings.

The two studies were conducted in dissimilar practices and Westhead's attendance rate is lower, even at current (1984) levels than my own. This provides an opportunity to assess the validity of the conclusion that a high 'N' score indicates the presence of a factor associated with a high attendance rate. Although no formal statistical comparison between the two practices is possible here, it is clear from the difference between the high scoring groups in Westhead's practice and the low scoring groups in my practice — 9.00 and 9.78 in the former and 23.6 and 24.7 in the latter — that it would be consistent with the observations to argue that my practice has higher work rates because of a larger proportion of people with a high 'N' score. In this respect the two practices have different proportions of people who have this type of vulnerable personality.

Westhead defined his frequent attenders as the top 10% of his practice and found that they were responsible for 30% of the total practice work. I calculated the equivalent figures from my sample and concluded that 15.7% of the practice population was responsible for 40% of the practice work. These proportions are similar.

The two studies provide a logical explanation for the anomalous finding that the number of consultations made by a practitioner is not related in a linear way to list size[10] and that reducing list sizes would not necessarily result in a reduction in workload which was directly proportional to the change in list size.[11] The minimum requirement would be that all practices should have equal proportions of frequent attenders.

The phrase, 'frequent attender', is simply a convenient label to categorize people according to the demands they make on their practitioners. The 'N' dimension of personality is only one factor which can put an individual into this group. Westhead's and my studies together confirm that there is no reason to assume that the proportion of vulnerable personalities is the same in every practice. This conclusion is supported by Shepherd's earlier finding[12] that minor mental illness was distributed unevenly among the London practices in his survey, and that this inequality was not an artefact produced by the different diagnostic habits of his contributing doctors.

These variables in patient characteristics may not be easily quantifiable but this is no reason to ignore them. Further work on this subject is required as a matter of urgency because a thorough understanding of the factors involved in producing demand/need for medical attention is an essential prerequisite to a successful search for high quality general practice.

ALBERT JACOB

10 William Street
Dundee DD1 2NL

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Family planning: general practice and clinic services

Sir,

I would like to reply to the three points made by Dr Watson (August *Journal,* p.396) about my article on family planning services (April *Journal,* pp. 199-200).

She is indeed fortunate to work in the Lothian area of Scotland which is well-known for its high standard of family planning service provision and excellent coordination of the hospital, clinic and general practitioner services. South of the border, only one-fifth of district health authorities had proposals to coordinate clinic and general practitioner services after the 1982 NHS reorganization.[1]

While Dr Watson is correct in thinking that the concept of the specialty of medical gynaecology has not so far been accepted by the Royal College of Obstetricians and Gynaecologists, the final word has not yet been said on this subject. I believe that an RCOG Working Party on Women in Gynaecology is shortly to present a report to the RCOG Council. Also a 1982 RCOG Working Party report on Further Specialization within Obstetrics and Gynaecology recommended specialized training and consultancies in the field of fertility and infertility. I understand that a new book specifically on medical gynaecology is shortly to be published.

I stated quite clearly that it is not necessary for all clinic doctors to work full time. The very part-time doctors I referred to comprise about one-half of the 3500 or so post-holders in the United Kingdom, who work for four family planning sessions or less a month.[2] Approximately 2% of all clinic doctors hold no recognized family planning qualification.[2] Such doctors in my view are unlikely either to attain or maintain the knowledge and skills commensurate with staffing a secondary centre to which difficult problems can be referred by general practitioners who hold the Joint Committee on Contraception certificate.

Dr Watson implies that female doctors are more likely to be able to empathize with patients than male doctors. This is surely a highly subjective judgement. While as many as half of clinic attenders express a preference for a woman doctor, there are other qualities of a clinic which rank higher in the eyes of the consumers.[3,4] Isobel Allen has shown that the friendliness of the staff and the expertise offered in the choice of methods and treatment are the main reasons for satisfaction with clinic services.[5]

SAM ROWLANDS

35-37 The Baulk
Biggleswade
Bedfordshire SG18 0PX

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Prevalence of disability in an Oxfordshire practice

Sir,

I read Dr Tulloch's paper on the prevalence of disability observed in a practice (August *Journal,* pp. 368-370) with interest, yet I was disappointed by his failure to fulfil his stated study objectives. This