

Sir,

I was interested to read the paper on well woman care (October *Journal*, pp. 490-491) from workers in a depressed inner-city district. The questions asked and the answers given are not unique to cities. Family planning service provision by the district health authority and the degree of overlap with the service provided by general practitioners has been debated just as vehemently in Maidstone, a county town, and its surrounding rural district. A similar questionnaire completed by family planning clinic patients produced similar answers to those obtained by Jessopp and colleagues as well as some trenchant criticism of general practitioner services.

However, it is important not to overlook that both here and in Hackney only family planning clinic patients were interviewed, and anecdotal evidence suggests that were we to try a much more representative survey we would get similar criticisms of family planning clinics. A substantial proportion of women vote with their feet; in this district in 1983 64% of women were attending general practitioners for their contraception. We do not know why, and perhaps we ought to find out.

At present we are interested in developing ideas similar to those suggested by Jessop and colleagues — collaborating with interested general practitioners in helping to set up surgery-based family planning services, with the offer of support (mostly nurses and doctors). The district health authority might pay for the staff until such time as the clinic becomes self-supporting.

Jessop and colleagues make a rather mysterious remark about male general practitioners who may have an ambiguous relationship with the woman (client). This comment is supported by a reference which does nothing to clear up this mystery.¹

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Reference

1. Robertson MC. Use of clinic family planning services. *Br J Family Planning* 1981; 6: 118-119.

Personal lists

Sir,

It was a pleasure to read Dr Darryl Tant's leading article on personal lists (November *Journal*, pp.507-508), in which he so comprehensively and lucidly reviewed the advantages of this important aspect of practice organization. Personal con-

tinuity of care was first systematically examined in this country by myself in 1975,¹ given sound academic credence by Dr Denis Pereira Gray in 1979² and was recently reviewed by Dr George Freeman³ in what is now the fullest source of literature on the subject.

While there are great advantages to patients, doctors and other health care team members in operating a personal list system, we must not lose sight of the fact that the majority of general practitioners, perhaps three-quarters, do not use one. The collusion of anonymity perpetrated by most group practices is a strong force for denial and improvement in personal care and the resulting enhancement of the quality of that care will be delayed if this issue is not squarely faced. I gain the impression that personal lists are slowly being adopted but there is still a need for further research to examine this.

The weakness in Dr Tant's excellent editorial is that no attempt has been made to forestall the sceptics' objections. This could have been done by quoting evidence in support of the arguments presented using, for example, some of the 58 references listed by Freeman.³

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References

1. Aylett MJ. Seeing the same doctor. *J R Coll Gen Pract* 1976; 26: 47-52.
2. Gray DJP. The key to personal care. *J R Coll Gen Pract* 1979; 29: 666-678.
3. Freeman G. Continuity of care in general practice: a review and critique. *Fam Pract* 1984; 1: 245-252.

Sir,

Dr Darryl Tant's editorial on personal lists sums up the advantages of this system most eloquently. He should not be worried that this system might fall down if partners are 'involved regularly in other medical duties'. On the contrary, the system works very well. Our own partnership of six operates on such a system, sharing some 24 clinical assistant or hospital practitioner sessions.

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Sir,

We must write approving the excellent editorial by Dr Daryl Tant (November *Journal*, pp. 507-508). How strange that no mention of personal lists appears in the College's policy statement *Quality in general practice*. The policy statement

talks at length of collecting data, primary health care teams, accountability and resources, but hardly mentions the patient and access to a personal physician without delay.

We are in total agreement with Dr Tant, a personal list does provide the best basis for high quality family medicine. The personal, medical and family history are already known so more time is allowed for the patient without recourse to notes for details. It is true that on some days one partner seems to have all the work and the others comparatively little, but it is easier, more pleasant and more rewarding with personal lists and the workload seems to even out in the end. The first priority should be seeing patients and seeing them without delay. We have average list sizes and our patients can always see their own doctor on the day the request is made.

Quality in general practice is spoiled by this major, glaring omission which should extol the virtues of the individual list.

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Sir,

Dr Tant (November *Journal*, pp.507-508) makes a very good case for personal lists. However, there are also advantages in the operation of a combined list in group practice, which in the interests of balance, should be described:

1. Doctors are less isolated.
2. Outside commitments are easily assimilated into the practice organization.
3. Appointment systems are easy to run. A patient wishing to see a particular doctor may be given a time convenient to that doctor; patients wishing to attend at a particular time, can have an appointment with any available doctor in the partnership. Waiting times for appointments are reduced and emergencies and acute illnesses cause less disruption.
4. A patient may choose his doctor from among the partners every time he makes an appointment.
5. Rota systems and holidays are easy to arrange.
6. Competition between doctors is limited to professional competition and there is no financial competition.
7. Personal care is available if required, and partners can commit themselves to the aim that wherever possible, any one episode of illness may be dealt with by one doctor.