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 continuity of care was first systematically examined in this country by myself in 1975,[1] given sound academic credence by Dr Denis Pereira Gray in 1979[2] and was recently reviewed by Dr George Freeman[3] 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 spoilt 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.

8. Repeat prescriptions can be the responsibility of the doctor initiating them.[1]

Neither a personal nor a combined list system is synonymous with quality of care. The operation of a combined list is adaptable, and personal care can be offered if and when required by the doctor or patient. Flexibility and cooperation form an essential part of the organization of general practice.

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Reference

1. Pickworth KH, Melrose DM. Repeat prescriptions: safety and control. *Update* 1972; April: 961.

Sir,

It is a pity that Dr Tant in his editorial on personal lists mentions only the advantages of the system. As this is a controversial issue it might have been better if he had stated the pros and cons, weighed them up and come to a conclusion. To redress the balance I here record some of the disadvantages of strict personal lists.

First, for the doctor the disadvantages are:

1. He has less awareness of his partners' ways of working and has less opportunity of learning from them.
2. He loses the stimulus and enjoyment of discussing patients; discussing cases is not quite the same thing.
3. There is likely to be less consensus over management and treatment.
4. Personal lists may lead to an unfair balance of work, both in general and on a particular day when the 'busy' partner may have to lower his standards.
5. The organization of surgeries will at times be very difficult for receptionists.
6. Partners will work different hours and be less likely to meet for discussion.
7. It is uneconomic for two partners to drive long distances to the same area.
8. It is difficult for training practices to provide a realistic list for the trainee.

Secondly, from the patient's point of view the disadvantages are:

1. He has no opportunity to sample the doctors and choose the one that suits him.
2. He has little chance of seeing a different doctor if he wishes.
3. He may have to wait longer for an appointment and longer at the surgery and may feel disgruntled at other patients apparently jumping the queue.
4. In an emergency he would prefer to meet a doctor who is not a complete stranger.

To my mind the answer is a compromise. This can either be called a personal list with wide powers of discretion or a combined list with patients encouraged to see a particular doctor. The logical conclusion of Dr Tant's approach is a group of individual doctors working in the same building for convenience. This, I submit, is not a partnership.

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Sharing problem cards with patients

Sir,

I would like to support Peter Tomson's article 'Sharing problem cards with patients' (November *Journal,* pp. 534-535). In our practice we are about to computerize our records and when we have medical summaries available on computer we hope to have two summary printouts, one for the patient and one for the practice records.

I agree with Peter Tomson's list of four possible advantages of sharing problem cards with patients and I would add three more:

1. If a patient moves away and needs to register with another general practitioner he/she can present the problem card to the new doctor. In my experience it takes between three and six months for patient records to be transferred from one general practitioner to another through the family practitioner committees so that caring for a patient with a complex or chronic illness becomes particularly difficult during this period. This is particularly relevant in an inner-city practice like ours with an annual turnover rate of 28%.
2. The patient can carry his/her problem card when travelling on holiday or attending hospital.
3. Fully patient-held records will probably become standard practice in the more distant future. The patient-held problem card seems an ideal intermediate stage.

Patient-held problem cards are to be welcomed.

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Printed record sheets in general practice

Sir,

The opinion has been expressed that good records are an essential part of general practice.[1,2]

In an attempt to improve our records we have introduced printed record sheets for certain consultations. Our practice is based in a new housing estate where 22% of the population is under five years of age. Our most common presenting complaint is the febrile child and we have therefore introduced a paediatric febrile illness chart as shown in Figure 1.

We mainly use the chart for children under two years of age but sometimes for children over this age at the discretion of the doctor. We have now been using this

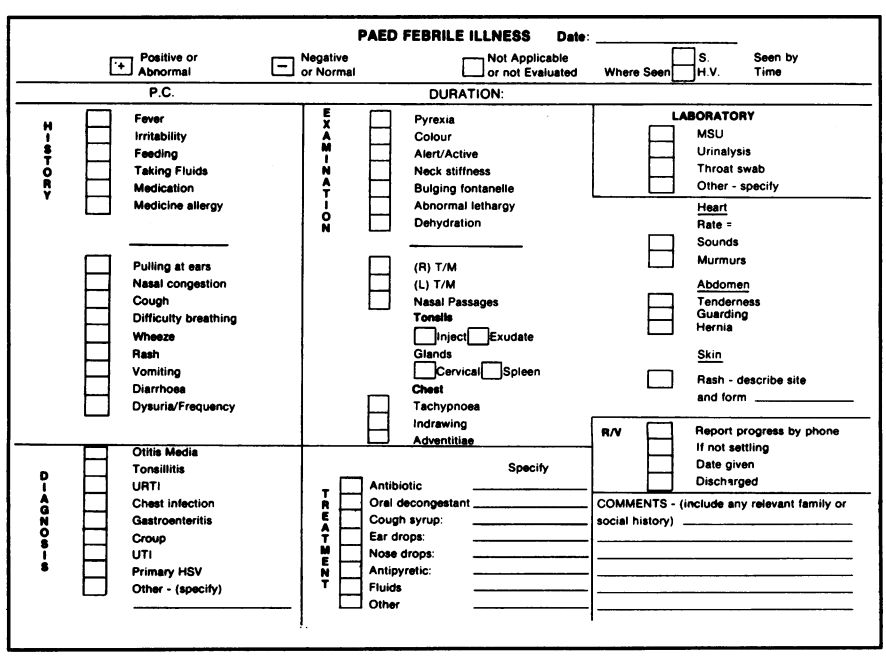

Figure 1. *The front of the paediatric febrile illness chart. The reverse side has space for details of follow-up.*