LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Workload in general practice

Sir,

Drs Fry and Dillane presented statistical data for a 36-year period (September *Journal*, p.403) and discussed the trend in their practice which showed a reduction in home visits (91%) and surgery consultations (43%). These figures led them to question whether list sizes should be encouraged to decline or whether the numbers of general practitioners could be reduced.

When debating the optimum list size it is important to compare data from different practices. Table 1 compares the 1985 figures for our Edinburgh dockside practice with those of Fry and Dillane (personal communication). Our practice has a smaller list size and a larger number of doctors but has a home visiting rate which is nearly eight times greater and a greater consultation rate. While I am unable to comment on the trend over the years in our practice, I think the figures for 1985 are important as they demonstrate the considerable differences between practices.

Professor Jarman's editorial in the same issue (September *Journal*, p.395) focused on the inner cities and the problems which NHS services in the community must tackle. He pointed out that there has to be objective evidence in order to make allowances for the difficulties experienced working in these areas. Our practice data perhaps illustrate how the different work profiles of an inner city practice and a suburban practice mean each requires different resources.

When discussing the issue of list size per doctor it is necessary to consider other factors in addition to consultation and home visiting rates such as the social class composition of the practice, the geographical area and educational commitments. Drs Fry and Dillane rightly pointed out that their data only measured the quantity of work and not the quality.

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Table 1. Comparative practice data for 1985.

	Edinburgh dockside practice	South-East London suburb
List size	5806	8650
Turnover	*23%*	*6%*
Doctors	4 plus trainee	2.5
Staff	2 full time, 3 part-time	2 full-time
Population social class	4 and 5	2, 3 and 4
Consultation rate	3.76	2.14
Home visiting rate	0.61	0.08

Sir,

We were interested to read the article by Drs Fry and Dillane (September *Journal*, p.403). We agree that information on differing consultation patterns is scarce and much of it out of date. We have been collecting similar statistics since 1979 and would like to add our figures to the debate.

We are a four doctor practice with a regular training commitment practising on the edge of Hull. Many of our patients live in a large local authority housing estate and many of them are unemployed. Our practice numbers over the past five years have been relatively stable at approximately 8200 (Table 2). The mean total consultation rate has increased by 22% since 1979 with a 35% increase in visits, our mean consultation rate over this period is 3.3 which is considerably higher than that reported by Drs Fry and Dillane.

Table 2. Mean number of consultations per patient per year over the period 1979–85.

	List size	Surgery consultations	Visits	Total consultations
1979	8117	2.5	0.34	2.90
1980	8168	2.7	0.37	3.10
1981	8000	2.7	0.38	3.05
1982	8072	3.2	0.37	3.55
1983	8152	3.1	0.40	3.50
1984	8225	3.1	0.42	3.60
1985	8212	3.1	0.46	3.55

Our impression is that our workload is continuing to increase. As we search for our patients' problems using screening programmes we generate work, both in the screening and in the treatment of the diseases found. This partly explains our increasing consultation rate.

The increase in the visiting rate is much more a reflection of patient demand. The increase is not due to lack of appointments as patients can always be seen on the day of their choice. If this rate continues to rise then eventually visits will begin to make inroads into the time available for consultations. This will have implications on planning for the future.

Changes in the pattern of care of the elderly and mentally ill have also increased our requests for visits. Factors peculiar to our practice may be the level of unemployment and the social disadvantage of many of our patients.

We would argue that to improve the quality of care to our patients we must resist pressure to increase our list size.

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Sensory Chvostek symptoms, apparently owing to dietary fibre

Sir,

A man aged 68 years in good general health complained initially of an unpleasant feeling of warmth in his feet brought on by pressure on the legs, for example when they were crossed. After about two months this was replaced by tingling now attributable to pressure on the thighs caused by sitting, particularly in the evening when even slippers could not be tolerated because contact with them was uncomfortable. After another month or so, tingling with an occasional stab of burning pain affected the ulnar two fingers of each hand when the forearms were rested on a table or desk.