In training practices there is an extra dimension to consider. Shared list systems allow trainees to be integrated and enable them to build up their own following of patients without difficulty. In a personal list system it is less clear which patients should see the trainee and indeed those who are asked to consult him may feel betrayed by their personal doctor.

Which is the best arrangement? Every practice is unique and will adapt to local conditions and requirements. On the whole, the discussion so far has been between doctors only, each claiming that the favoured solution is ultimately in the interests of the patients.[3,6,7] But what of the doctor with a personal list who is unaware that his patient has no confidence in him? In practices with shared lists, how can patients who dislike being constantly asked to see different doctors always see the same doctor? The few published surveys of patients opinions[8-10] suggest that the majority of people do not give high priority to always seeing the same doctor and a recent editorial in *Update* makes the case for shared lists.[11] Clearly the debate continues.

SAMUEL PRIESTMAN
General Practitioner, Bath

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Practice annual reports

PRACTICE annual reports are being produced by an increasing number of practices since McGuiness posed the question 'Why not a practice annual report?' in 1980.[1] He described his practice's first two reports for the years 1977/78 and 1978/79 and the Weaver Vale practice will this year complete its ninth report. Many other practices, including my own, have introduced reports during the 1980s, but none can rival the Ballymoney health centre where 1987 will see the publication of its eighteenth annual report.

Many practices have become used to generating practice activity data and taking part in internal audit. Regular annual collation of data provides a means of observing change in the practice. The national morbidity surveys have provided valuable data which individual practices can use to compare with their own. The decreasing isolation of general practitioners through the development of group practice and the introduction of vocational training with its associated trainers' meetings has provided a stimulus to gather practice data which provides objective comparison of activities and workload. General practitioners have long been involved in the provision of maternity and contraceptive services and are increasingly involved in the detection of hypertension and cervical carcinoma. They are involved in immunization, developmental surveillance and the supervision of chronic disease such as diabetes and asthma. It now seems relevant to report these activities regularly in the format of an annual report. There is obvious benefit in being able to compare one year's clinical activity with another and then to plan the next year's activities accordingly.

Study of the workload of the individual partners, the degree of personal care where personal lists are used, in association with data from the appointments book can pin-point the need for change in medical staffing or in methods of practice. Such matters are well highlighted in annual reports.

The financial aspects of the annual report show whether the business side of the practice is in a healthy state. The annual accounts of the practice are much more meaningful when viewed in the context of a full practice annual report with its workload and activity data.

Most other branches of the medical profession are used to gathering data on their activities and often utilizing it to their advantage. Consultants can demonstrate their recruitment needs by the length of their waiting lists and claims for additional resources in hospital are usually well backed up by statistical information. General practitioners who have served in the past on area and district management teams have often found their position weakened by the lack of available data of the type provided in an annual report.

Practices which would like to produce an annual report will find Pereira Gray's framework[2] a useful starting point (see p.161 of the *Journal*). In addition, the Royal College of General Practitioners collects examples of annual reports and is willing to provide help and information.

Consideration needs to be given as to how widely annual reports should be circulated. The General Medical Council has recently given support to the wider distribution of practice brochures, but there remains uncertainty about access to annual reports. My own reports have been made available to the practice staff, to the regional advisor in general practice and to the secretary of the local College faculty. They have also been seen on an exchange basis by a few local practices. They have not been released to the patients or to any other outside body lest a breach of regulations on advertising occurs.

Family practitioner committees and community health councils would be interested in the contents of annual reports and eager to make comparisons with other practices. How they would use the data would depend on how individual committees see their role. The information could prove helpful to doctors, for example by exerting pressure on health authorities to provide more nurses and health visitors where a need was shown. On the other hand some committees could see their role as judgmental and punitive and the conclusions drawn may not always be valid.

General practitioners may be uneasy about revealing so much detail of their practice activity, understandably so with regard to the financial aspects of the practice. But general practice should have nothing to fear from providing a fuller account of what it does. Practice annual reports can provide this information and practices should be encouraged to produce them.

A.S. URQUHART
General Practitioner, Northumberland

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