

Royal Army Medical Corps¹ in February 1982 in time for at least one regimental medical officer to pass it to his commanding officer who studied it carefully before embarking for the Falkland Islands. It was clear from talking to regimental medical officers afterwards that they understood the problem.²

Price's article (quoted by Jones and Lovell) appeared in June 1984.² (Incidentally, Price wrote 'No Royal Army Medical Corps psychiatrists were invited to the Falklands'. In fact two full teams were standing by.) In a letter to the *Journal of the RAMC*³ Lt Col Brown reported in 1984 that in the course of a survey on noise induced hearing loss he had interviewed 184 Welsh Guardsmen who had been on board LSL *Sir Galahad* during the bombing of 8 June 1982. He enquired about jitteriness, inability to concentrate lasting more than 24 hours, and noticeable sleep disturbance. Sixteen uninjured men experienced such symptoms.

Army doctors were reminded of delayed post-traumatic stress disorder by two further publications by the same *Journal* on Australian Vietnam veterans⁴ and on Israeli veterans.⁵ Clearly there is abundant awareness.

Turning to treatment in the military setting, far from being discouraged, grief was expressed openly in the South Atlantic, and there are several reports of groups of men weeping freely, thus assisting the normal resolution of grief. The three cases quoted by the author 'found it impossible to report emotional distress to a service doctor' (but one of them also 'would not attend a civilian clinic'). Could this be not just a barrier to relief of their distress but also a manifestation of it, namely their estrangement, detachment and active avoidance of situations that arouse painful memories: classical features of post-traumatic stress disorder? Certainly other servicemen have not been inhibited by such difficulties. This was demonstrated most recently in the course of following up all servicemen (and dependents for whom the Army is responsible) who were caught up in the Zeebrugge disaster to ensure that help was available to them. One or two had already been referred to the psychiatric service. Another robust young man had reported to his regimental medical officer with acute symptoms. With the help of his doctor, who saw him daily, and his regiment, he recovered in a week.

P. ABRAHAM

Ministry of Defence
First Avenue House
High Holborn
London WC1V 6HE

References

1. Abraham P. Training for battleshock. *J R Army Med Corps* 1982; **128**: 18-27.
2. Price HH. The Falklands: rate of British psychiatric combat casualties compared to recent American wars. *J R Army Med Corps* 1984; **130**: 109-113.
3. Brown JR. The Falklands campaign — battleshock casualties. *J R Army Med Corps* 1984; **130**: 202.
4. Boman B. Post traumatic stress disorder (traumatic war neurosis) and concurrent psychiatric illness among Australian Vietnam veterans: a controlled study. *J R Army Med Corps* 1985; **131**: 128-131.
5. Bleich A, Garb R, Kottler M. Combat stress disorder and the military physician: an approach to a category of post traumatic stress disorder. *J R Army Med Corps* 1986; **132**: 54-57.

Patterns of work in general practice

Sir,

The paper by Armstrong and Griffin (*June Journal*, p.264) is a welcome addition to the considerable body of evidence on consultation workload and patterns of care. It is a pity, however, that the authors did not discuss their material in the context of other studies or discuss the implications of their findings.

General practitioners in Bromley certainly seem to have a higher consultation rate than their colleagues in Manchester.¹ The Manchester figure of 3.0 compares with 3.2 reported by the 1971-72 national morbidity study and 3.4 by the 1981-82 survey.^{2,3} Although Armstrong and Griffin do not provide an overall consultation rate, it would seem to be close to the national morbidity survey figure for 1981-82. These apparently small differences in consultation rates are important. A difference of 0.4 is equivalent to 800 consultations per year for 2000 patients. Patterns of care also differed so that the Bromley general practitioners recorded a prescribing rate of 61% and a rate of requests for pathology tests of 5.2%, compared with 72% and 4.5% respectively for Manchester general practitioners.¹ Although the Bromley results were extrapolated from one week in March, our own analyses of seasonal variation suggest that this would not have much effect on the number of consultations recorded.⁴ Variations between general practitioners practising in different areas are of concern because of the implications for quality of care, workload and costs. Acheson has highlighted this with respect to referrals to hospital.⁵

The Bromley data show relatively little association between doctor characteristics and patterns of care, but the authors do not elaborate on the significance of these findings. The same is true with respect to their exploration of the relationship between different aspects of care. No ex-

planation is offered as to why there should be a relationship between prescribing and home visits or requests for X-rays. There seems to be a danger in general practice research of measuring that which is most easily measurable without considering what it might in reality represent.

The authors' comparisons of their findings with our data show that, despite the overall higher consultation workload borne by Bromley general practitioners, the relationship with list size almost exactly parallels the findings of the Manchester study. The similarity is quite remarkable. We drew the conclusion that, on the basis of consultation rates and consultation time, there were grounds for reducing average lists below 2500, but that reducing lists below the present 2100 would not give patients more consultation time. Although Armstrong and Griffin do not have the same data, the similarity in the relationship between list size and consultation rates seems to support our view. Indeed general practitioners in their study with lists between 2001 and 2250 had a markedly higher consultation rate than those with lists between 1751 and 2000. If cross-sectional data of this sort provide at least some indication of the likely effect of changes in list size, the evidence suggests that a reduction in the present average list would result simply in a reduction in the consultation workload rather than an increase in the number of consultations available for each patient or the amount of consultation time.

DAVID WILKIN

Centre for Primary Care Research
Department of General Practice
University of Manchester
Rusholme Health Centre
Walmer Street
Manchester M14 5NP

References

1. Wilkin D, Ho S. *General practice variability and its correlates*. Research report, Centre for Primary Care Research, Department of General Practice, University of Manchester, 1985.
2. Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security. *Morbidity statistics from general practice 1971-72. Studies on medical and population subjects no. 36*. London: HMSO, 1979.
3. Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security. *Morbidity statistics from general practice 1981-82*. London: HMSO, 1986.
4. Hallam L, Metcalfe D. Seasonal variations in the process of care in urban general practice. *Epidemiol Community Health* 1985; **39**: 90-93.
5. Acheson D. Variations in hospital referrals. In: Telling-Smith G (ed). *Health, education and general practice*. London: Office of Health Economics, 1985.