devised neutral terms for their training grades, such as registrar. It will be a challenge for the profession to change a term of such longstanding use, but perhaps it is time to think of a more accurate description.

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List sizes

Sir,

One of our recent research studies involved practice list sizes over one year. Inspection of the list sizes for each of the four quarters revealed grater variation than expected and it may be helpful for other readers to record our experience.

In 1990–91, data had been obtained on practices in 20 family health services authorities, a total of 2700 practices. List sizes varied between 0 and over 27000. A total of 262 practices (9.7%) had a zero list size in at least one quarter, and clearly had to be excluded from most of the analyses. The mean list size over the four quarters for the remaining 2438 practices ranged from one to 27622. There were 68 practices with mean list sizes of under 1000 patients, of which 11 had fewer than 100 patients. Quarterly list sizes for the smallest and most variable of these practices are given in Table 4. To exclude atypical practices, an arbitrary minimum of 1000 patients was adopted, leaving 2370 practices (87.8% of the original 2700 practices).

We then investigated stability of list size over the four quarters. The maximum change (maximum minus minimum list size) was expressed as a percentage of the mean list size over the year. For practices with mean list sizes greater than 1000 this change ranged from 0 to 126%. A total of 1816 practices showed a change of up to 4%, 346 practices showed a 5–9% change, 122 practices showed a 10–19% change, 69 showed a 20–49% change, 15 showed a 50–99% change, and two practices showed a change of 100% or greater. Thus most practices remained fairly constant with changes of less than 20%. The practice with the largest change had quarterly list sizes of 653, 664, 2689 and 2785. For any analysis depending on measures per 1000 patients it is necessary to have stable populations. Exclusion of practices with changes of 20% or greater left 2284 practices (84.6% of the original 2700). The corresponding number for exclusion of practices with changes of greater than 10% was 2162 practices (80.1%).

Table 4. Quarterly list sizes for six practices with small list sizes or high variability.

Quarter	List sizes					
1	1	3	3	21	3	116
2	1	3	7	69	93	376
3	1	3	1	92	95	464
4	1	1	1	65	105	492

The presence of 10% of the practices with a zero list size in at least one quarter was surprising and an important consideration in our analysis. These zero list sizes were thought to be indicative of major reorganization. Small list sizes also occur when a few patients register with a practice in a neighbouring family health services authority (Wain K, Leeds Family Health Services Authority, personal communication). The explanations for zero list sizes and for small and highly variable list sizes are not entirely clear and readers may like to comment. It may be important in other research studies to be aware of our finding that when standardizing by list size, only 80–85% of registered practices were suitable for inclusion in the analysis.

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Refugees' health needs

Sir,

We wish to report the results of a pilot study seeking information on refugees' contacts with general practitioners in London in order to assess what special needs general practitioners perceive these patients as having, and the services available to meet these needs.

A random sample of 50 general practitioners were contacted from the London boroughs of North East Thames Regional Health Authority and a short semistructured interview was carried out over the telephone.

Thirty two general practitioners had seen refugees over the previous year (range 1–60 patients per doctor). Significantly more inner compared with outer London general practitioners had seen refugee patients (85% of 20 versus 50% of 30; $\chi^2 = 4.95$, 1 degree of freedom, $P<0.05$). No general practitioners knew the size of the refugee groups in their locality or the ethnic breakdown of their patients.

The problems general practitioners identified were diverse. Language difficulties were identified by 17 doctors. Nine general practitioners mentioned refugees' adjustment problems, while five described their own anxiety in trying to cope with the special needs of these patients who seemed to take up a disproportionate amount of time. Lack of information about previous treatment and uncertainty over continuity of care in the future added to the doctors' difficulties (mentioned by three doctors). Refugees' physical problems were identified by nine doctors and included injuries, chronic infections such as tuberculosis and the human immunodeficiency virus (HIV), and more general problems such as malnutrition and poor hygiene. Psychological problems, cited by six doctors, included patients being unhappy or extremely anxious. Six general practitioners were aware of histories of torture. Eight reported having seen patients with housing or financial difficulties.

Eighteen general practitioners had access to special services for refugees. For example, five described help with translation, and access to housing or a community centre through social services, while one each referred patients to a hospital based nurse liaison worker, a counselling service for ethnic minorities and a refugee officer who could be contacted through the family health services authority. Thirteen general practitioners made use of non-statutory services, including six who had referred patients to the Medical Foundation for the Care of Victims of Torture.

General practitioners described a number of difficulties using the services available. Local authority provision was sometimes seen as too bureaucratic or paternalistic (mentioned by two doctors), while some patients seemed embarrassed with voluntary workers whom they might know acting as translators in the surgery (two doctors). With all types of service there were difficulties in making contact in a reliable way.

Twenty four general practitioners saw a need for an increase in targeted services. Seventeen wanted more readily available interpreters or language training, particularly for the women refugees, and 12 wanted a service offering information and advice to refugee patients on how to find work and accommodation and in dealing

with financial problems. Ten identified a need for help in enabling refugees to adjust better to living in this country, for example, on ways of overcoming their feelings of isolation.

In general, although some general practitioners had developed links with voluntary services, overall there appeared to a lack of targeted statutory services. This may in part be a result of limited access to information about services. Further evaluation of the provision of services would help to resolve this point.

With increasing numbers of refugees, a coordinated approach to providing a service for members of refugee populations will be essential.[1] The best method of service delivery remains open to discussion. Greater dissemination of skills, rather than simple reliance on expert centres, may be important in providing comprehensive care for these patients.[2]

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Health care for homeless people

Sir,

The homeless population is not a single homogeneous social group, rather it may have subdivisions of people with varying health problems and needs. One such subdivision is the temporary homeless population living in bed and breakfast accommodation prior to permanent rehousing. This group appear to be high users of services provided by the secondary care sector. The bed and breakfast homeless population accounted for 8% of all emergency admissions to an inner London teaching hospital[1] and an estimated 7500 unplanned acute hospital admissions annually in London.[2] These high levels of utilization have raised concerns about access to primary care available for the temporary homeless population. Using data from the North West Thames Regional Health Authority health and lifestyle survey[3] an analysis was undertaken of the use of general practitioner services by those living in bed and breakfast accommodation and compared with that of residents in the area as a whole (not all respondents answered every question).

Of the sample, 54.1% had been in their hotel for less than three months and 23.3% had been there for over six months. Overall, 92.9% of the 319 subjects were registered with a general practitioner; 44.6% had been registered for less than one year and 18.2% lived more than five miles away from the surgery.

One quarter of the 319 subjects (26.7%) had consulted their general practitioner within the 14 days before interview; this consultation rate was approximately double that reported by the resident population (that is, excluding the homeless) (13.0% of 528 subjects). Virtually all the homeless people in bed and breakfast accommodation (85.2%) had consulted their general practitioner within the last year. Six per cent had seen a nurse in the previous 14 days and 4.2% had seen a health visitor (for the regional population the rates were 3.1% and 1.2%, respectively). Of the 319 homeless subjects 42 (13.2%) had visited a casualty department in the previous three months. Of these, only one was not registered with a general practitioner and 38 had consulted a general practitioner during the same period that they had attended a casualty department.

In London, there are concentrations of homeless people living in hostels and temporary bed and breakfast hotels. It is widely assumed that homeless people use secondary care services (especially casualty departments) because they are not registered with a general practitioner. For the homeless population in bed and breakfast accommodation in this survey, rates of general practitioner registration were high (93%). Several factors may account for this. First, the official homeless population are more settled than the more transient, roofless population. Secondly, within north west Thames region there are several innovative schemes which aim specifically to provide primary care to homeless people in hotels, for example, the Bayswater families doctors practice. This practice probably accounts for the observation that almost half of the sample had been registered with their general practitioner for less than one year.

Access to primary care is not simply a matter of registration with the general practitioner. Another factor is proximity of the practice. Homeless people from all over London may be placed in bed and breakfast hotels within north west Thames region. This may account for the finding that a high percentage of homeless people were registered with a general practitioner who was not local. This may also reflect the reluctance of many homeless people to change their general practitioner when they are placed in temporary accommodation: changing general practitioner may be a tacit admission that their stay is not going to be temporary. One study found that the mean length of stay in bed and breakfast accommodation was 13 months.[4]

Over a quarter of the sample of homeless people had consulted the general practitioner within the last 14 days. Of those who had visited a casualty department, almost all had consulted with their general practitioner over the same period. This would suggest that casualty departments are not simply being used by homeless people as a substitute for primary care.

Rates of long-term health problems and mental health problems among those in bed and breakfast accommodation are at least twice those for regional residents.[3] Given the high rate of mental and physical morbidity it may be that homeless people are under-users of services rather than over-users.

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Citizens' advice bureaux

Sir,

With recent changes to community care, and general practitioners' relatively poor knowledge of social security benefits, it has been suggested that providing citizens' advice in general practice would satisfy many unmet needs.[1] A recent study in Birmingham concluded that citizens' advice bureau sessions in general practice were an effective way of providing advice on life problems and securing proper payment of benefits, particularly to patients with health problems.[2]

Sandwell Family Health Services Authority and our local citizens' advice bureau have operated a pilot scheme of