not on the telephone) in preference to calling at their homes. With the use of shorthand-typists and dictaphones much information can be relayed rapidly to patients—cutting down not only visits but also surgery consultations.

Increasing awareness of three or four practices in the North-east of England where nurses are employed to do many of the repeat visits has made me more and more concerned whether the visit I was making really required a doctor. In December 1967 the decision to employ a nurse part-time visiting chronic patients and making some follow-up visits was taken by the partners. The effects of this step will become apparent during 1968. However, before transferring work to a nurse it was obviously vital to evaluate the work itself lest she perpetuate a work pattern for which there was no true clinical indication. It is more than probable that if a nurse had been employed in 1960 the reduction in total visiting in the last eight years might not have been achieved.

**Result of Fewer Visits**

This paper deals with visiting in itself. The total work-load in the practice has probably increased in the eight years, but the shift has been away from the home and into the surgery. In that patients can be attended more quickly (and probably more thoroughly) within the surgery premises, the work-load has been carried out more effectively and the number of hours worked has fallen. Similarly, the practice list has been able to grow without an increase in the number of doctors.

Here is evidence that the highly organized family doctor of the future, working with a full team of ancillary and para-medical helpers, could possibly look after far more patients than the 3,000 which is current practice in many urban and suburban areas. Alternatively, should list sizes stabilize at the present level then family doctors will have time available to increase the depth, quality, and range of care of their patients and possibly accompany some of them into hospital to continue to attend them. It might perhaps even be in the interest of the national economy that the Ministry of Health recommend patients to look on the visiting doctor as a person rarely needed in the normal course of events.

**Further Steps to Reduce Visiting**

What more can be done by the profession to reduce visiting further? Firstly, hospital doctors must realize that the well-organized family doctor does not expect to visit his patients routinely at home. Particularly if discharge from hospital patients should be instructed to attend the surgery at the appropriate time after a few days' convalescence in their homes. Secondly, works medical officers and ambulance men must look on the family doctor's surgery as the site of their workers' medical care—and not, except in cases of serious illness, their bedrooms. After prearrangement on the telephone, transfer by the works ambulance or car to the doctor's surgery, en route for the patient's home, would be a commendable innovation. Thirdly, urban and suburban practitioners might well get together and rationalize the geography of their practices in order to minimize the travelling distances of each doctor. Fourthly, visiting nurses (be they mentally reoriented attached local authority nurses or nurses employed direct by the practice) should be working for every family doctor. Fifthly, and the only factor not utilized in producing my falling rate, the possibility of transporting housebound and chronic patients to the surgery by suitable transport could well be more actively explored.

**Conclusion**

There is no doubt that seeing a patient in his own home often provides vital and valuable diagnostic information about him and his illnesses. For this reason alone visiting must always play some part in comprehensive family care. Nevertheless such visiting can be overdone; for great reductions in visiting were achieved between 1960 and 1967.

I acknowledge the help of Miss Susan Hayton, A.A.M.S., in compiling the figure used in this paper.

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**NEW APPLIANCES**

**Abdominal Robot Retractor**

Mr. D. Lang Stevenson, surgeon, Whipps Cross Hospital, London E.11, writes: A robot retractor has been designed which offers considerable advantages to the surgeon in a wide range of abdominal operations. What is achieved is sustained retraction in any desired position, thus dispensing with the constant need for rest and readjustment inherent in hand retraction, not to mention the arduous task often imposed on an assistant. Moreover, the apparatus provides the valuable additional services of upward traction.

The basic assembly consists of a horizontal bar attached to two uprights which fit into the rail fixtures on any standard operation table. On the bar are three friction disc devices for grasping the retractor arm. Movement in two planes is thereby permitted as well as lengthening and shortening of the arm. All parts can be autoclaved. The photograph shows the apparatus assembled.

Two large curved retractor blades are used for the abdominal wall. This pattern is particularly effective for retracting in the midline towards the xiphoid or pubis. Upward as well as lateral retraction greatly improves exposure. For deep retraction a special ball-and-socket jointed holder provides attachment for blades of different size and pattern, which can be held in any desired position. A special inverted-U-shaped blade accommodates the gall bladder, the porta hepatitis, and the oesophageal hiatus. A portacaval anastomosis can be done virtually single-handed through an eleventh ribs incision without opening the chest. An assistant is thereby relieved of an unenviable, but often required to require almost as much post-operative resuscitation as the patient.

The makers of the retractor are Abbey Surgical Instruments Ltd., 69 Wimpole Street, London W.1, who will be pleased to make any retractor blade to specification.