How can good general practitioner care be achieved?

Sir,—Professor D C Morrell and Dr M O Roland have produced good reasons to suggest that good quality practice requires a reduction in average list size to no more than 1750 (17 January, p 161). They further suggest that in deprived inner city areas a list size of 1500 may be too many, and effective list size should probably be smaller.

If they are right, and I believe they are, there are serious implications for GP training because under the current regulations a trainer in an urban area should normally have not fewer than 2000 patients on his or her list (red book section 38.5/f). In practice this means to mean an average list size of 2000 for the practice as a whole, and I understand that in some training practices the average may be nearer 3000, nearly twice as many as that of patients that Professor Morrell and Dr Roland feel can be given good quality care. As trainees are supposed to be supernumary and as training practices should be able to function normally when the trainee is absent, there seems to be a paradox: training practices are particularly in inner cities, cannot give good quality care or show it to trainees, and good quality practices with small lists cannot take on trainees.

The profession has for some time accepted that average lists must come down to around 1700. The time has come to review the acceptable number of patients for a training practice. This must include a maximum number as well as a minimum, as it is clearly wrong for trainers to be encouraged to have higher than ideal lists.

PETER GODFREY
Bristol

Sir,—As Professor D C Morrell and Dr M O Roland point out, there is an emerging consensus from general practice that an average consultation length of 10 minutes or more is needed and some evidence that longer consultations are associated with beneficial outcomes. There are difficulties, however, in using this evidence to make recommendations about list size. Two recent studies have shown only weak associations between average consultation length and list size; it seems that the list size is associated more with consultation rate than consultation length. The problem with such observational studies is that we do not know which of these variables is dependent on the other. Doctors with low consultation rates (determined by demographic and possibly practice factors) might have chosen to use the extra time to increase their list size. Alternatively, practices with large lists might force a low consultation rate on their patients by lack of availability.

A recent study of training practices found that scores for preventive activity were higher in practices with lower list sizes. Importantly, practices with formal screening programmes rather than a policy of case finding in the consultation achieved the best results. Specific clinics rather than extended consultations might be a better use of any time made available by lower list size.

Andrew Wilson
Department of General Practice,
Queen's Medical Centre,
Nottingham NG7 2UH


Why women are not receiving anti-Rh prophylaxis

Sir,—Dr Ruth M Hussey (10 January, p 119) claims that the number of Rh negative mothers who developed Rh antibodies because they received an injection of anti-D immunoglobulin in the Liverpool region was less than that reported from the Yorkshire region; particularly when the failure of administration was after an abortion. However, more recent data (table) reveal less of a discrepancy. Failures of administration in 1985 were only 13% of the new cases compared with Liverpool’s 7%. It must also be noted that in 28% of Dr Hussey’s series the cause of the sensitisation was unknown. Thus the Liverpool results are similar to those of Yorkshire. This is reinforced by almost identical incidences of antibodies developing in primigravidas (14% in Liverpool and 18% in Yorkshire) and in failure of protection (44% and 56% respectively).

Unfortunately, this reduction in the number of mothers who failed to receive an injection was not reflected in the total number of new cases (49 in 1980 and 39 in 1985). This has led to a proportional increase in the number of mothers who developed antibodies in a subsequent pregnancy despite receiving an injection of anti-D immunoglobulin after the previous pregnancy (failures of protection).

I believe that this continuing incidence of failure of protection is due not to the injection of insufficient anti-D immunoglobulin but to intra-pregnancy sensitisation. In our recently published study, quoted in your report, of 166 new cases developed anti-D between 30 and 40 weeks’ gestation (40%), and these women cannot be protected by any dose of anti-D immunoglobulin given after delivery. Antenatal prophylaxis is the only procedure available at present to protect these mothers.

L A DERRICK TOVEY
Regional Transfusion Centre,
Leeds LS15 7TW


Rh haemolytic disease of the newborn caused by anti-D antibodies in Yorkshire region 1980-5. Values in parentheses are percentages of new cases

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<tbody>
<tr>
<td>Total No of mothers</td>
<td>133</td>
<td>115</td>
<td>96</td>
<td>96</td>
<td>101</td>
<td>91</td>
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<tr>
<td>&quot;Old&quot; cases</td>
<td>49</td>
<td>73</td>
<td>35</td>
<td>62</td>
<td>54</td>
<td>52</td>
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<tr>
<td>&quot;New&quot; cases</td>
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<td>42</td>
<td>61</td>
<td>34</td>
<td>47</td>
<td>39</td>
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<td>Failure of administration after:</td>
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<tr>
<td>Full term delivery</td>
<td>17 (35)</td>
<td>6 (14)</td>
<td>12 (29)</td>
<td>9 (27)</td>
<td>8 (19)</td>
<td>8 (13)</td>
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<tr>
<td>Abortion</td>
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<td>3</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td></td>
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<tr>
<td>Failure of protection</td>
<td>18 (37)</td>
<td>21 (50)</td>
<td>20 (49)</td>
<td>15 (44)</td>
<td>25 (53)</td>
<td>22 (56)</td>
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<tr>
<td>Primigravidae</td>
<td>4*</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>9</td>
<td>7 (18)</td>
</tr>
<tr>
<td>Previous pregnancy not eligible for anti-D prophylaxis</td>
<td>10</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5 (13)</td>
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*Yorkshire antenatal trial.