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LEADING ARTICLES

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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

List size and quality of practice

SIR,—In discussions about optimum list size in general practice attempts at assessing clinical quality have, inevitably, to use factors that are measurable, such as extent of record keeping, time spent with patients, and consultation rates (Dr Martin Lawrence, 12 July, p 135).

It is harder to take account of a more nebulous, but fundamental, aspect: the need for the list to be big enough to supply an adequate mass of clinical material of wide range. If the mass is not large enough to keep the GP's diagnostic skills constantly engaged and stimulated his clinical acumen and intuition are bound to get rusty. For this reason there is a strong, though unfashionable, case for encouraging the GP to take on the maximum number of patients he can cope with. This applies especially where there is, effectively, competition between local hospitals and GPs for the "clinical material" available.

With its direct bearing on medical employment and unemployment in the NHS, list size is, of course, a medicopolitical and economic hot potato. But it would be unfortunate for the patients and demoralising for those doctors who have jobs if a smaller maximum list, while leading to an overt fall in unemployment, brought with it a hidden rise in clinical underemployment of a degree that reduced quality.

It is probably a fallacy that the longer a doctor spends with the patient the better must be the quality of the clinical transaction. It may simply be that the doctor with even a medium size list is at his wits' end to know how otherwise to fill up his day, unless he also does a job outside his practice.

It may be that the problem of medical unemployment will have to be solved by work sharing, but we should not disguise from ourselves that that is what is happening, or try to ignore its effects on clinical competence.

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Steroids, the eye, and general practitioners

SIR,—The debate on steroids and the eye has become predictably adversarial (31 May, p 1448, 28 June, p 1737). By its very nature consultant experience is distilled from the (apparently very few) general practice cases that go wrong. Too much consultant admonishing means that GPs who prescribe steroids will do so without declaring this in their referrals. In this practice we recently had an audit of our use of steroids in the eye and found it difficult to find cases, though we do prescribe such steroids.

We would like to compliment Mr Patrick Trevor-Roper (p 1738) on his pragmatic approach and amplify some of the indications he has listed. The following guidelines for steroid use in general practice have emerged as a result of discussion between the GPs in this practice and a consultant ophthalmologist.

(1) Never give steroids for an undiagnosed red eye.

(2) Never prescribe if visual acuity is impaired.

(3) Refer if condition is getting worse rather than better after 24 hours; review patient next day after starting steroids.

(4) Avoid steroids on a repeat prescription without expert opinion: patient may be a "steroid reactor."

(5) Avoid if there is a history of dendritic ulcer.

(6) Be more wary if problem is unilateral.

(7) Check cornea first with fluorescein.

We hope that the many GPs who prescribe steroids will find these guidelines helpful.

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Nursing dependency in registered nursing homes and long term geriatric wards

SIR,—We were interested in the contrasting levels of dependency found by Dr Anne E Capewell and colleagues between patients in nursing homes and those in geriatric wards in Edinburgh (28 June, p 1719). We recently surveyed the total provision for continuing care in one district of Cornwall, including public, private, and voluntary sectors, and confirm many of their findings.

The Edinburgh team allude to a smaller contribution by NHS hospitals to total long term bed provision in Britain than may have been hitherto assumed, and this was confirmed in our survey, which showed more than three beds in private nursing homes to each continuing care bed in hospital (151 *v* 44) and more less dependent patients in nursing homes than in hospital wards. However, given the greater numbers of nursing