

the opportunity of seeing the conditions under which their patients work.

All the above obviously requires a great deal of time—a commodity hard to find. My partners and I regard 60 surgery consultations and ten domiciliary visits a day each as the usual load. Much of this is due to increased interest shown by patients in what they consider to be abnormalities, probably as a result of careless propaganda by well-meaning physicians, those who try to 'educate' the public. It would be better if these people devoted their efforts to encouraging the public and industrialists to improve conditions of work and living and so remove the causes of much morbidity.

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Sir,

Quality control is a concept of industry not directly applicable to the professions. But your editorial policy of accepting articles like those from Mr Honigsbaum and me is dangerous. Mr Honigsbaum looks at general practice as a layman not in active practice in our profession. I look at those aspects of active practice not directly related to medicine and in particular that aspect which is concerned with the 'quality' of personal knowledge of the list, in the demographical sense.

The danger is that your policy provides a vast loophole for all sorts of non-medical articles to be accepted in preference to those directly to do with general medicine in the context of the natural environment of family life.

Having learnt to walk, the College is now beginning to march on its strong legs of education and research, and with its proven, academic status and democratic structure it can sustain a journal for its large membership, both as a vehicle for house news and notices and for articles by its members for its members and others; but with the wealth of medical newspapers and magazines now distributed freely to all doctors there is no fear that the non-member's point of view is hidden under a bushel.

Articles like Honigsbaum's and mine are only justified in your columns if they genuinely break new ground in the study of the quality of care, so that the policy of getting to know the patient as a person can be seen as an essential prerequisite for the highest quality and greatest 'cost-effectiveness' attainable. If such a policy is adopted by the College as a body, it then leads on to all sorts of strictly medical and organisational aspects of general practice, not the least of which would be a code of practice laid down by the College as a guideline for judging the reputability of a practice as a business.

Any new entrant to partnership expects to be able to look at the books before committing himself. The books should be kept, so that the

demographical features of the practice population are available for comparison, quite apart from the financial ones. But perhaps you consider that to be more a matter for departments of social medicine and therefore outside the scope of the *Journal*!

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Sir,

I was interested to read the article *Quality in general practice* but surely the greatest cause in deterioration has been the development of large partnerships—the 'multiple stores' of general practice. I found that being a member of a five or six man partnership looking after 14,000 patients, there was no defined patient-responsibility. Too much time was spent 'tiding over' a patient until they could be seen by their 'own' doctor, whose earliest appointment was a week ahead—often for the patient to be told that neither the treatment nor the diagnosis was appropriate.

For two thirds of the year a partner was away, so that one was faced with the overwhelming payload of 2,800 or so patients and approximately another varying 700 patients as each partner was away in turn. Thus one was involved in the problems of 5,600 patients which is nearly three times the workload recommended by the College.

After heated arguments in which each partner (and his wife) were claiming that they were working too hard—and rightly so, we agreed to withdraw into smaller units. We formed a true group practice of a three-handed and two single-handed practices. Thus I am able to pace out my own appointment system, look after and get to know my own exactly-defined group of patients, institute any screening measures, research projects, and organisational changes that I feel should be done for the improvement of the medical care of my patients.

During the first six months of 1972, my consultations dropped from 5,320 to 3,950 (for 2,750 patients) a drop of 25 per cent. As my consulting times were the same, or probably even longer, I now have more time to deal with each problem as it arrives, and *time* is the one commodity that is needed to improve standards in medical care—and which cannot be bought.

Our group practice is now working most amicably. The three-handed partnership has more flexibility for their holiday and study leave; my single-handed colleague tells me that he is happier in general practice now than during the past 15 years; the 'dragons' meet with 'Pyreneed' breath; my personal secretary has a public relations job far more varied and interesting than her previous 'pounding the typewriter' existence; and I have two tails to wag. I know and control the extent of my clinical responsibility. I know my own deficiencies in clinical skills.

A consultation with a colleague is now meaning-