Correspondence

THE GENERAL PRACTITIONER AND THE ABORTION ACT

Sir,

Allow me to contribute two comments to the excellent article *The general practitioner and the Abortion Act* in the August *Journal*.

First, would it not be helpful to many family doctors in doubt about pregnancy to seek the opinion of a consultant about their patient? This at least would obviate the concern of some doctors in getting pregnancy tests performed.

Secondly, it is considered essential upon referral of a patient for consultation that the opinion of the family doctor as to the need or otherwise of a therapeutic abortion should be clearly stated.

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REFERENCE

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INDUCTION OF LABOUR

Sir,

Rupture of the forewaters is a simple procedure that can be carried out in the home, or general practitioner unit, in patients who are selected for delivery outside the specialist hospital. The indications for ARM are usually the prevention of postmaturity in the infant and the avoidance of pre-eclamptic toxaemia in the mother when she is at term and 'ripe'. The method becomes hazardous when labour does not start within 24 hours. Transfer to hospital becomes necessary and attempts to induce labour with oxytocic drugs follow with all their inherent dangers.

Salzmann (1971) described the tapping of maternal oxytocin, by manual suckling, in the maintenance of labour and the active management of the third stage. He expressed doubt whether suckling could be used for starting labour; "it was observed that suckling was usually ineffective if cervical dilatation was absent." Stretching of the cervix and sweeping of the membranes frequently precede the actual rupture of the membranes; thus conditions can be set for an immediate response to suckling after ARM.

By using the suckling method described by Salzmann immediately after cervical stretching and forewater rupture, contractions of the uterus were induced at five-minute intervals, either with the first period of stimulation, or after a maximum of six (30 minutes total delay). Thereafter, contractions followed regularly and stimulation was stopped after five or six consecutive contractions.

The method cut the mean induction-delivery time from 22·6 to 11·2 hours, almost entirely by removing the delay between ARM and the establishment of labour.

Further study is needed using much larger numbers. This was a relatively small personal series in which the two groups could not be matched for parity; (there were more primigravidae in the suckled group). But there is an indication that the method can shorten the induction-delivery interval and increase the certainty that labour will supervene without drugs. The safety of induction by general-practitioner obstetricians could be greatly enhanced thereby.

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1 Salzmann, K. D. (1971). *Journal of the Royal College of General Practitioners*, **21**, 282.
2 Salzmann, K. D. (1971). *Journal of the Royal College of General Practitioners*, **21**, 670–8.

QUALITY IN GENERAL PRACTICE

Sir,

Mr Honigsbaum's article (July *Journal*) will have provoked very strong, very mixed feelings among its readers. I am sure that his confident pronouncements, made it seems entirely on the basis of library scholarship, will have struck many as impudent; nevertheless the same readers may join me in being impressed that he managed at all to surmount the task of reviewing a literature of such extensive scope. Most will have found themselves agreeing with at least some of his conclusions: in my view the points made about records, about hospitals, and about consultants in health centres are cogently argued. Others of his conclusions, argued from very lean and peripheral evidence, are impressive only in their naivety: the suggestion that better life expectancy in women may be related to their more frequent consultation of their general practitioners is the first and best example. He has even got at least one fact wrong, in referring to the reimbursement system for salaries of ancillary staff.

Intrepid scholar though he may be, he has failed to tackle the one issue which flaws his paper totally. "Quality in medical care is hard to measure" he says, ". . . and cannot be quantified". Can it even be defined? He fails to do so: instead he gives an extensive account of quantity, and applies his own assumptions as to how much constitutes good. The assumptions are characteristically North American, and he makes no secret at any point of his intense loyalty to the values of his consultant countrymen: there are as a result sections in his text where no claim to scholarly objectivity could possibly be entertained.

The trend since 1950 has in fact been quite other than that which he seeks. Many practitioners in this country have given extensive thought to the meaning of the fact that many of the quantitative indices of general practice "performance" are highly refractory to change, given even their best

efforts. This thought has brought about changes in our understanding of what really happens in general practice consultations. We are beginning to see more clearly that the few cures we have to offer impress most of our patients less than the extent to which we understand and care about them. And we have developed a conviction that our main role is to uphold the interests of the whole individual, while specialists concern themselves severally with parts of their bodies. We have therefore learned to see how our roles are qualitatively separate from, yet complemented by, those of our specialist colleagues.

We therefore are certainly changing, qualitatively, in our attitudes. Mr Honigsbaum, on the other hand, advocates the same measures of "quality" now as we accepted 20 years ago, learned from, and are transcending.

Is the pot calling the kettle black?

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REFERENCE

Honigsbaum, F. (1972). *Journal of the Royal College of General Practitioners*, **22**, 429–51.

Sir,

I was interested to read Frank Honigsbaum's article together with your editorial comments (July *Journal*).

There is no doubt that his criticisms of general practice in the N.H.S. are based on a great deal of research into the literature and that many of them are perfectly valid. However, unlike Dr J. S. Collings he has no personal knowledge of the problems of general practice. We are, most of us, well aware of our many shortcomings but to maintain that there has been no improvement since the Collings report is palpable nonsense.

Mr Honigsbaum's criticisms are so numerous that it would be impossible to deal with each one in detail in the short space of a letter so I will confine myself to a few.

Apparently the great British public is so easily satisfied that it does not realise how bad a service it is getting from its general practitioners. I find it very difficult to believe that patients in the United Kingdom are any less sophisticated than in other countries. Nevertheless a scheme to provide private general-practitioner service through the British United Provident Association has failed through lack of support.

Mr Honigsbaum places great faith in the medical check-ups and screening services and accuses British general practitioners for failing to provide them. He goes on to say that in the United States people visit their doctors more frequently than in the United Kingdom and that routine medicals are much more popular, especially among middle aged men. It therefore seems strange that male mortality statistics in the United States are even worse than in the United Kingdom, according to Table I in his article.

He also points out that male life-expectancy at one year is greater in Greece and Spain than in the United Kingdom and uses this fact as an index of the overall performance of our medical service. Does this mean that these two countries have health services superior not only to ours but also to Belgium, West Germany, Australia, U.S.A., Finland and France?

This biased use of statistics casts a doubt on the impartiality of the remainder of his article. I expect that his quotation from the literature have been carefully selected and often shorn of their context in order to further his argument.

Your editorial mentions that if part or all of his criticisms are justified then publication may in itself prove beneficial to general practice. This may be true, but I cannot help feeling that the quotations from the article in the lay press, particularly the statement that British doctors hate their patients, do the many conscientious hardworking doctors in this country a great disservice.

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Sir,

Like a claxon horn in a string orchestra, Mr Honigsbaum (July *Journal*) cannot be ignored. His paper is an event that should not have occurred, but having done so must be dealt with in a way that strengthens good primary care.

His paper is not about quality in general practice, but about badness. The fact that quality must be measured, that it consists of a number of more or less independently variable quantities in a continuum from execrable to excellent, each of them unevenly distributed in social and geographical space and in time—all this has escaped him, or at least he tells us nothing about it, though all of us would be most interested in the answers. Apparently his collection of bad things about British general practice impresses him so unfavourably that his simple verdicts are sufficient, without measuring what is good, or seeking to locate what is bad—"failures in screening . . . failure in geriatrics . . . negligence in midwifery . . . negligence in prescribing . . . negligence in hygiene . . . inadequate time for consultations . . . poor records . . .", and so on; success, apparently, in nothing.

With all the confidence of a young man whose experience of health services is virtually confined to what other people have written about them, he proceeds to international comparisons illustrating the inferiority of British primary care in every respect, and to historical comparisons showing that we are not only bad but worse now than in the