

areas of Britain fell by about 60 per cent between 1961 and 1971, and that sulphur dioxide concentrations fell by 30 per cent. The decrease is expected to continue. London and Sheffield have achieved a faster rate of reduction than average.

CORRECTION

Dr B. C. S. Slater has been appointed a regional adviser in general practice for the North-west Metropolitan area and not the North-east Metropolitan area as was incorrectly stated in the July *Journal*.

Correspondence

COT DEATHS

Sir,

The sudden unexpected death of a healthy infant is surely one of the greatest tragedies which can befall a family. Even those closest to or best placed to support the parents often feel helpless in the face of such finality. "How does it happen?" "What did we do wrong?" "Why can't it be prevented?" So many questions flood the mind.

Enclosed with this issue of the *Journal* is a leaflet which for some years has been given to parents whose baby has suffered a 'cot death'. Many have found it brings considerable comfort to them.

In the leaflet are explanations formerly advanced to explain these deaths, e.g. 'overlying' or smothering by bedclothes, which are now known to be specious. The Registrar General has recently accepted 'sudden unexpected death' or 'sudden death in infancy syndrome' as a registrable cause of death. This condition is defined as the sudden unexpected death of any infant or young child, which is unexpected by history and in which a thorough post-mortem examination fails to demonstrate an adequate cause for death.

The Foundation for the Study of Infant Deaths, of whose Council and Scientific Committee I am a member, was formed and registered as a charity in 1971. Its objectives are to raise funds to promote research into sudden unexpected deaths, to give information and reassurance to bereaved parents and to communicate and exchange knowledge in the United Kingdom and other countries.

Further copies of the leaflet may be obtained from the Foundation at 23 St. Peter's Square, London W6 9NW (Telephone 01-748 7768). An authoritative report, edited by the late Professor F. E. Camps and Professor R. G. Carpenter, on cot deaths has just been added to our college library.

The Foundation is already supporting research on a substantial scale. The Welfare Committee (which includes medical members) answers many personal enquiries and is, for example, co-operating in projects to devise a more sympathetic procedure for interviewing bereaved parents on behalf of the coroner.

My purpose in writing is to draw your readers' attention to the problem, to elicit their interest in the scientific and welfare work of the Foundation, and to invite them to seek its help if ever the

occasion should arise. Enquiries, suggestions or proposals for research are welcome.

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(See *Editorial, book review and insertion*)

QUALITY IN GENERAL PRACTICE

Sir,

A kick in the pants is one kind of stimulus. It may be therefore that Frank Honigsbaum's article (*July Journal*) will serve a useful purpose for many of his criticisms have some validity.

The value of his commentary is however reduced by inaccuracies and ill-supported statements. Some of these have clearly arisen from an assumption that published evidence is synonymous with established fact. Thus some of the articles quoted are based, inevitably, on limited surveys and in situations which are the subject of constant change.

Does it follow, for example, that an increase in the number of general-practitioner principals would necessarily lead to a higher quality of care? It might require a lowering of entry standards to our medical schools, and maybe a smaller number of highly trained leaders of larger teams with a wider range of supporting services is a better answer.

What evidence is there that the range of services that a general practitioner provides is in any way and necessarily connected with his 'quality' of care? Is it indeed any more desirable for him to remove sebaceous cysts than gall-bladders?—or to own and use his own microscope when a fully efficient pathological service is on his doorstep? (Incidentally how many consultant surgeons and physicians regularly use their own microscopes?) Of course, the isolated general practitioner may have to do all these things, but in our view width and depth of care are not necessarily related—and they appeal to different personalities.

Honigsbaum has a good point when he suggests that the principle underlying the 'hospital plan' is divisive. On the other hand his suggestion for an industrial medical service "to give men easier access to medical care" would only be creating yet another such division!

Again the notion that "cost calculations weigh

heavily against" the cottage hospital is currently being hotly disputed—and nothing is said about the Oxfordshire concept of the 'community' hospital which holds such promise in this regard.

We also think that Honigsbaum has failed to appreciate the difference between voluntary or do-it-yourself and obligatory vocational training for general practice. We do not share his pessimism because the average age at which doctors become principals in general practice is over 29 years. Clearly therefore the problem is not as great as he suggests and consists rather of ensuring that the training is made relevant rather than longer, and obligatory rather than voluntary.

On screening it is questionable whether quality in general practice can be criticised because of, for example, the continued existence of unrecognised diabetes. Cervical cytology has been held up by lack of technicians initially on the hospital side. Similarly the deficiencies in diagnostic investigations arose in the first place because general practitioners were for so long denied access to them. This was a failure in the hospital services which it will take time to correct fully.

It is no doubt true that some general practitioners write bad notes and bad letters, and both are indefensible. However even bad notes kept continuously from birth to death are better than the complete absence of continuity seen in many other systems. It must also be remembered that general practice records are usually compared directly with those kept in hospitals. Such a comparison is unfair first because the general practitioner has often to write an immediate letter in anything but ideal conditions (e.g. at the patient's bedside), secondly because this is often supported by a telephone conversation which *should* be recorded in the hospital notes, and thirdly because hospital records are written up at leisure by the junior hospital staff (which has no equivalent in general practice) and at least in part as a training exercise.

Finally, if the above is not sufficient, to suggest that general practitioners hold on to maternity cases outside their competence for financial reasons is in our view needlessly provocative.

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REFERENCES

Honigsbaum, F. (1972). *Journal of the Royal College of General Practitioners*, **22**, 429–451.
Journal of the Royal College of General Practitioners (1972). Editorial, **22**, 425–6.

Sir,

In a recent editorial you invited comment on the paper by Mr Frank Honigsbaum. Readers were told that Mr Honigsbaum's purpose was to assess quality of care in general practice through a review of the literature. Such an undertaking

suggests scholarship. In fact the work, if intended as a piece of serious research, reveals significant deficiencies which can be categorized under four heads, examples of which are given below.

1. *Biased selection of evidence*

In general, Mr Honigsbaum has chosen to construct his case on old and often obsolete data. This may lead the reader to conclude that evidence inconvenient to the writer's case has been ignored. Thus, for example, in criticising equipment used in general practice, Mr Honigsbaum cites Cartwright's studies which have been superseded entirely by later work relating to the whole of general practice by the B.M.A. Planning Unit (1971) and material indicating that general practice cannot be treated as a homogeneous entity (*Teaching Practices*, 1972).

More serious, perhaps, are his omissions in the field of education; recent developments in the undergraduate demonstration of general practice and vocational training, of tremendous significance, are not even mentioned (college bibliography on education). Little wonder that he can conclude that vocational training . . . "has been coldly received by the profession and is unlikely to be implemented" especially at a time when the profession has just agreed to universal vocational training for general practice based on three-year programmes.

2. *Use of statements unsupported by any evidence*

The writer furnishes no documentation to support these sample statements drawn from the text.

- a) *On undetected illness*. . . "if anything, there is probably less undetected illness in the United States than in Britain except for those below the poverty line" ('poverty line' undefined).
- b) *On outpatient departments*. "General practitioners prefer, instead, to hand over responsibility entirely to consultants. . ."
- c) *On midwives*. "They probably inspire more careful work in antenatal care but may increase general-practitioner recklessness in booking".

3. *Broad statements extrapolated from limited evidence*

The following are examples of broad statements phrased in the context of today's general practice, and based on limited, dated and often partial evidence.

- a) *On chemists*. "Is this why chemists are so popular in Britain? They provide more medical care than practitioners. . ." (evidence: one study in Bermondsey, 1964: the term 'medical care' is undefined in the text).
- b) *On maternity*. The general statements indicating 'general-practitioner negligence' in maternity are based on two studies carried out and published between 1962 and 1964.
- c) *On records*. In support of the title 'Poor records', Mr Honigsbaum offers two references: the first is an opinion expressed by Dr David Kerr in 1957; the second relates to