research from records. The extensive bibliography on medical records in general practice is ignored. He does however concede, despite his dogmatic heading, that "we know little about the condition of records in general practice today".

4. *Incorrect data*

The following is an example of an incorrect statement. "Over 70 per cent of practices in England and Wales now receive grants to *cover secretarial expenses* . . ." Readers may agree that more than 70 per cent of practices take part in the ancillary staff reimbursement scheme; but they will not concur with the statement that such grants 'cover secretarial expenses' when they find themselves contributing 30 per cent of the total cost.

In citing these examples (no doubt readers have found many more) I have ignored questions of opinion and judgment such as the validity of some parameters chosen as reflecting 'quality of care' or the impact of the 'Charter' on general practice. These matters could form the basis of yet another discussion.

What is surely more important, and sad in a way, is that the *Journal*, presumably with the intention of stimulating a debate on quality in general practice, has chosen to launch its campaign from such a shaky foundation. Some of the writer's conclusions merit closer examination; unfortunately, his careless and insensitive handling of the evidence is likely to ensure that the professions' defence mechanisms are invoked to the full whilst real issues of importance to patients remain obscured a while longer.

DONALD IRVINE

The Lintonville Medical Group,
Old Lane,
Ashington,
Northumberland, NE63 9UT.

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Sir,

As is stated in one of the editorials of the July *Journal*—articles published may form a focus for debate. Mr Honigsbaum's paper on *Quality in General Practice* stimulated a rush of press enquiries. Correspondents before going to press particularly wished to know if the College would refute the allegations and were advised that the honorary editor had the absolute right to decide whether articles were published or not, that it was clearly stated in the *Journal* that the views expressed in articles should not be taken to represent college policy and that any debate should take place in the correspondence columns of the *Journal* where it rightly belonged. Most correspondents took heed of this.

Your decision to publish this article was a right and courageous one. Comment and criticism of the article itself are, however, required.

As is usually true of articles that are merely surveys of papers published by others, there is an element of truth in some of the conclusions. All of us must realise without placing ourselves in either category that there are good and bad general practitioners just as there are good and bad consultants, good and bad solicitors, good and bad politicians and, indeed, good and bad critics.

In this article, however, some of the conclusions are wrong. It is stated, for example, that in this country cervical cytology is restricted to those women over 35 once every five years, whilst the facts prove that this is not so. It is only the payment for this service that is restricted. Some other conclusions are misleading and some are contradictory. In the space of a letter one can only limit comments to some of these.

In the section on comparative performance, Mr Honigsbaum draws up his national league table on the difference between life expectancy at one year in males and females instead of on the life expectancy itself. He does this apparently because of the well-documented fact that women between the ages of 15 and 45 attend their doctors more often than men and insinuates that the difference in life expectancy could be due to the fact that men in this age group neglect their health while in the prime of life. This is a devious argument without an element of proof. It could be just as likely, if not more so, that the explanation of the more frequent attendances of women of this age is that they take the opportunity of having a consultation whilst taking their children to see the doctor anyway. In this age-group women do consult for more minor illnesses than men do. As far as I am aware there is no evidence that these women consult more frequently with serious or potentially serious illnesses.

Much of the section on quality within the health services is irrelevant in so far as conclusions could be opposite to those stated. For example, the 'reasoned guess' that the fall in general practitioner to patient ratio suggests that each practitioner has less time available per patient than in the 1950s and that this affects quality, does not take into account any of the increased efficiency in general practice brought about by better practice organisation, appointment systems, the health team concept, etc.

The main evidence considered to point to a low standard of care in general practice seems to lie in the failure of screening and early diagnosis. The low rates of screening for cervical cancer compared to those in America are cited and yet the final paragraph states that there is as yet no evidence that this type of screening is effective either in stopping the spread of cervical cancer or the mortality from it. The same can be said of screening for diabetes in which the College, through Dr D. L. Crombie and his colleagues, did some of the pioneering work. Is there any evidence

that the diabetic discovered presymptomatically and given treatment survives longer or escapes the sequelae than do other diabetics who present with symptoms?

The statement that there is probably less undetected illness in the United States than in Britain *except in those below the poverty line* is equally probably one of the most damning indictments of American medicine so far printed.

Many further criticisms of the conclusions drawn in this paper could be given but it is probably more constructive just to say that if the paper does give rise to debate and clearly points out that further research need be done, then the College, which has through its members the interest and the know-how to conduct that research, is prepared to undertake it. That is one of the reasons for the recent launching of the Appeal for the sum of £2 million.

B. C. S. SLATER
Press Officer
Royal College of General Practitioners
14 Princes Gate,
Hyde Park,
London, SW7 1PU.

Sir,

I have read the recent paper by Mr Honigsbaum. I have re-read it carefully several times, pencil in hand making marginal notes indicating obsolete reports, inaccurate facts, quotations—out-of-context, and biased selection and judgements; and I have produced a list as long as that of the author's bibliographical references at the end of his paper.

As a summary of the shortcomings of general practice under the Health Service, the paper may once have been accurate, but it is now out of date. As a commentary on standards of general-practitioners, it is not only erroneous, but in places offensive. As a scientific article it is so biased in its selection of data, so false in its reasoning, and it has prejudged its conclusions so much that it is difficult to see how it could be considered worthy of a place in a scientific journal.

I submit, Sir, that the publication of such an article, *without comment at the time*, and giving it pride of place in the text, was a serious error of judgement. It has now been said, later, and in other places, that the publication was only to promote discussion, and that the College was anxious to refute the kind of criticism which the paper contained. But the details of Mr Honigsbaum's article appeared to the public through the mass media immediately after publication. Indeed, I read a summary in the local press (which actually described the article as being the views of general-practitioners themselves!) before I had received the *Journal*. In this type of journalism the advantage is always with the one who publishes first; denials, retractions and apologies coming at a later date rarely have the same prominence or effect as the original statement.

I fear that the College, in an attempt in a misguided way to counter poor criticism of all general practitioners, may have created even more difficulties and adverse comment than were previously extant.

G. H. PAGDIN
Greenside,
Hackenthorpe,
Sheffield, S12 4LQ.

Sir,

Congratulations upon your courage in printing the *Quality in general practice* article in the July *Journal*. Although there are a few minor points upon which I would differ, most of the article rings true and in my opinion Mr Honigsbaum deserves our thanks for forcibly bringing these facts to our notice.

It has always been an enigma to me why our leaders and negotiators did not insist upon better terms at the time of the charter. The present situation in general practice is certainly a great improvement upon pre-charter days but there is still much to be done and no room for complacency. Until general practitioners are properly housed; reasonably equipped; have adequate time, say 15 minutes per patient; access to general beds in district or community hospitals and regular consultant contact, then they will still appear to be inferior doctors to their hospital and foreign colleagues. To those who would say that a high technical competence is less important than an attitude of 'caring' for the community, it is an established fact that those doctors who have a technical and clinical approach to general practice also tend to score highly in their social and psychological approach.

There is little financial incentive to quality of care in general practice such as use of ECG and other equipment; treatment of minor casualty and minor surgical procedures. Doctors who do this work as a routine are penalised financially and are left only with the satisfaction of doing the job.

The general medical services have had a small share of the cake from the inception of the National Health Service. (This is no less a scandal than the improper distribution of monies within the hospital service with the starvation of capital to the long-stay 'caring' units such as geriatrics, subnormality and psychiatry.) The growth of the hospital staff and services in the last 25 years compared with the almost complete stasis of general-practitioner manpower has brought a touch of the farce to the NHS. What a waste of scarce resources, manpower and money. If only the reverse manpower trend and injection of monies into the community services had occurred, we could now have an average list size of say 1,500 per principal and all the time needed to apply the skills and knowledge taught at medical school not to mention a reduced loss from emigration. Outpatient departments could be slashed from the present size with the general practitioners doing much of the work on their own premises.