coming gallantly to my support. And it is good to know also that the ladies are achieving their increased span by the ministrations of ageing and inefficient doctors who seldom wash their hands. The mind boggles at the ultimate prospects of longevity which will be open to them when all their doctors are young and washed and deodorized and with-it.

How glad I am too that Mr Honigsbaum has let me off the hook with all this postgraduate study lark. For quite a long paragraph he had me worried that I wasn't doing nearly enough—being a bit aged, although I do wash from time to time—but bless him, in the last sentence I am told it's all no good anyway, so I continue to wallow in my native indolence in that manner to which I have become accustomed.

Pleased I was, too, after that long stern criticism of me for not doing enough in the way of cervical cytology, to find that once again the amiable Mr Honigsbaum was going to save my face with his welcome little postscript that the whole exercise was a waste of time. I could quote other examples that have given me rare pleasure, but I know Sir, that your space is limited, and have no doubt that many others will be clamouring to express their appreciation.

JOHN MILES

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Sir,

*Quality of general practice* is a provocative review of general practice in Britain today. A few of the author's observations are very much to the point, but others are grossly distorted and inaccurate.

Mr Honigsbaum suggests that patient satisfaction with a system is a very poor guide to the efficiency of the service. This is true. He goes on to point out that the personality barrier created by the capitation fee can be a stronger deterrent to care than the financial barrier in the United States, and that whereas in America the doctor is hated by his patients, here in Britain the doctor hates his patients. This is true in certain quarters, and the idea is well stated. These are the pearls of wisdom in a load of old hack. Most honest doctors will agree that the National Health Service as a whole is not perfect, but the patient-care today is far better than it was at the time of the Colling's report.

"The older the doctor, the poorer the care tends to be." How does Mr Honigsbaum know that? Does this apply to all doctors or just to the general practitioner? Are other professions afflicted in the same way?

We are accused of not screening our patients adequately. Here he is strangely illogical as he himself agrees that such surveys can be worthless. He wrote that doubts have arisen about the efficacy of even effective detection programmes. I agree with this observation. This village has been screened three times for diabetes; and the conclusion has been drawn that such major efforts obey the law of diminishing returns. A great deal of time and energy can go into the location of a few overweight diabetics, most of whom will refuse to keep to a diet.

He goes on to say that on the basis of general-practitioner records there has been a negligible amount of research published. This is just not true, and on page 463 of the *Journal* in which his paper is printed he will find a list of 32 general-practitioner papers recently published in other journals, many of which are in fact founded on good records. The college oral-contraceptive study is based on the everyday records of well over 1,000 general practitioners. I don't take any American journals, but do the general practitioners in the States do more and better research than we do in Britain?

He suggests many senile dements go undetected. To screen for an incurable illness seems a futile occupation—it would be better to check haemoglobin levels and look for senile depressions. These conditions may well yield to treatment.

The five-minute appointment in the context of British general practice is a very practical arrangement. There are short cases such as the issue of certificates which only take up a fraction of that time. We all know that there are cases which need much more time, and in a well-run practice the patients get all the time and attention they need. Of course there are black sheep in every fold, and the unscrupulous general practitioner can earn a fat salary by practising bad medicine. To be without a washbasin in a consulting room is inexcusable today.

Mr Honigsbaum may distrust a writer, he is entitled to do so, but what right has he to advise the readers of his paper to treat the work of Professor Margot Jefferys with caution? She is an eminent authority in her field, and her readers can surely decide for themselves the merits or demerits of her work.

This paper is the work of an armchair critic. He has read widely but he has never got down to the practical work of visiting and assessing practices and practice methods in person.

I cannot help feeling that if Tom Eagleton of the United States of America had had a good general practitioner he might have been spared the stigma of a psychiatric clinic, and still be in the running for the Vice-presidency.

C. A. H. WATTS

The Limes,
Ibstock,
Leicestershire.

Sir,

Like a fish I am unable to resist rising to Mr Honigsbaum's bait which is clearly intended to be provocative. In his study on the *Quality of General Practice*, much of his evidence is irrelevant, out-dated or meaningless. To criticise various items in his paper will help to point this out.

Longevity is no guide to the quality of general-practice care. Few general practitioners would claim to prolong the lives of many of their patients significantly. Far more significant are social factors such as overcrowding, legacies of the industrial revolution, with climatic, geographic and public health factors all being of greater importance than family medicine.

To measure the quality of practice by an unfavourable comparison with the greater hours worked by American doctors is not valid as increasing tiredness brought on by increasing hours is likely to produce a corresponding decrease in performance.

Failures in screening can be excused by lack of evidence that efforts in this direction are productive. As Mr Honigsbaum says there is no evidence that cervical cytology reduces morbidity of cancer of the cervix, and there is to my knowledge no evidence that diagnosis of maturity-onset diabetes prolongs life. General practitioners should be given the credit for appreciating this. The existence of a clinical condition does not necessarily mean the patient will benefit from treatment.

Negligence in midwifery may well exist, but it is noteworthy that one of Mr Honigsbaum's sources is ten-years old. Since then, many general practitioners have acquired haemoglobinometers. The relatively low demand on pathology and x-ray facilities is not necessarily to the patient's detriment as many hospital patients suffer from unnecessary venepunctures and x-rays, the former painful, the latter causing unnecessary dosage in radiation.

Records are improving particularly in group practices and one may comment that research for its own sake is valueless and irrelevant to the quality of the work.

Among the clinical failures it is surely not necessarily a failure not to refer management of an epileptic as this can usually be done perfectly well by a general practitioner. The fact that 62 per cent of outpatient attendances are for only one consultation, for a second opinion, can surely equally well be taken to mean that the quality of practice is high, and that further attendances are unnecessary.

Under his paragraph concerning negligence in hygiene and poor qualities of surgery premises, the failure to use the General Practice Finance Corporation is no measure of a failure to improve surgery facilities. The majority of surgeries improved since 1963 have been by private finance, which is cheaper.

I regret the length of this letter and would agree that criticisms of our work can only be beneficial but the evidence for the criticism should be very much stronger than that provided, if it is to be of any real value.

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Sir,

Mr Honigsbaum's paper is provocative. A detailed reply would need to be as lengthy, but some answer is called for. It seems to be a comprehensive survey, with 137 references, no less; but seven are to Forsyth and Logan's *Gateway or Dividing Line?*, and five to the Royal College of General Practitioners (1970) *Report from General Practice* No. 13., 'Present state and future needs of general practice'. Thus a cursory glance reveals inflation; closer inspection may reduce the list further. It is not his facts with which I quarrel, but his interpretations.

Throughout his paper there is emphasis on inadequate time spent with patients. "The ultimate measure must be 'quality' which has not yet been related to 'time'."[2] Yet he equates inadequate time spent with patients, with poor quality of care. To quote 'average' consultation times without giving the range, is meaningless. A large proportion of patients need neither 'time' nor extensive examinations for their repeat certificates or prescriptions. Eight could easily be accommodated in a 'five minute consultation', giving an average 'time' of 37 seconds!

The evidence for a low standard of care is confusing. In one paragraph, "... the general practitioner sees at least 70 per cent of his patients each year and 95 per cent once every five years". Later, "... the average patient sees his general practitioner fewer times per year in Britain than in America". His section on clinical failures is similarly woolly. He quotes the number of deaths from toxaemia of pregnancy in 1967; but deaths from "abortion without sepsis", and "other deaths from delivery", exceeded the 1963 level in 1967.[3]

If 25 per cent of general practitioners generate 75 per cent of referrals to hospital diagnostic facilities, it is worth recalling that 75 per cent of the general-practitioner's workload is generated by 25 per cent of his patients. One test for every five to six patients excludes those referred for outpatient consultation.

One could go on dissecting the paper and reinterpreting the facts. I support Honigsbaum's thesis that quality monitoring is necessary and likely to raise standards. I think he is correct that the quality in Britain is not high enough. If bad medicine is costly, good medicine is not cheap. His paper presents a biased view, and makes one ask "How much is he denigrating the National Health Service in the interest of the American anti-socialised-medicine lobby."

H. CAIRNS

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REFERENCES

1 Forsyth, G. & Logan, R. (1968). *Gateway or Dividing Line*? London: O.U.P.
2 Royal College of General Practitioners (1970). Present State and Future Needs, second edition. *Report from General Practice No.* 13.