London: *Journal of the Royal College of General Practitioners.*

3 Department of Health and Social Security (1970). *Domiciliary Midwifery and Maternity Bed Needs.* p. 77. London: H.M.S.O.

Sir,

An 'outside' view of general practice could indeed be a stimulus for critical reappraisal of their role and performance by general practitioners. What a pity it is that the quality of the article chosen for that purpose is itself questionable. Personal opinions are quoted as if they convey demonstrable fact; particular studies are assumed to have general significance; and several sections contain classical examples of the *non sequitur*! To avoid writing a complete article in reply, only two points will be made here.

"Efficient use of the resources available" must preclude *routine comprehensive* health screening altogether, and lead to critical assessment of the efficiency and productivity of individual domiciliary consultation. Moreover, the attainment of more efficient 'outpatient' care lies not in 'posting' the consultant to the health centre, but in questionning the need for follow-up by a registrar rather than by the general practitioner.

The use of technical resources, the facilities available for both patient and doctor in the doctor's premises, and the technical competence of the doctor himself can only be improved by critical appraisal, leading to implementation of appropriate remedial measures. Such appraisal and control will never be possible when independent contractors of equal status behave with the licence possible outside a formal career structure.

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London, W14 0PA.

Sir,

I became a founder associate of the College because I was appalled at the state of general practice at that time, and believed that there was a need for an academic body devoted to improving the standards of our discipline. In my paper, of which you quote snippets, I pointed out that two factors led to a change; the publication of the charter and the influence of the College. The order was deliberate; without the political will and power of others to force change, the idealism of the College would have been ignored. I believe that this is true today.

The charter was published in 1965 and several years elapsed before the improvement in the service became apparent. Yet over half the references in Mr Honigsbaum's article in the July 1972 issue of the *Journal* refer to works published before 1968!

Whilst accepting that editorial discretion is desirable, and necessary, the appearance of Mr Honigsbaum's article in our *Journal* gives it the cachet of credibility. It was extensively quoted in the press, as if it referred to general practice as it is now; 'facts' from it were used to discredit present-day general practitioners. The sensationalist press does not bother to check back to original sources, and disclaimers are of no value.

The inclusion of quotations from an article of mine immediately after Mr Honigsbaum's article may give the impression that I share his views. Perhaps you would be so kind as to quote the last paragraph of my paper "Given sufficient goodwill, foresight and imagination and a willingness on the part of the community to accept the financial implications of progress, the future possibilities for the family practitioner services, and especially the general medical services, are exciting and almost unlimited."

JOHN MARKS

REFERENCE

Marks, J. H. (1972). *Journal of the Royal College of General Practitioners*, **22**, 451. (*from Proceedings of the Royal Society for the Promotion of Health*, April).

Sir,

I read Frank Honigsbaum's essay on *Quality in general practice* with interest. He reaches the kernel of the matter when he discusses the relationship between hospital consultants and general practitioners.

In this area—Liverpool region—there is total exclusion of general practitioners from hospital work. Furthermore, the domiciliary consultation is a farce. Consultants are not willing to arrange to meet the general practitioner at the patient's home and some do not bother to inform him of their findings and opinion, unless he importunes them. Thus what could be a valuable experience degenerates into a mere commercial transaction. In obstetrics the consultants endeavour to exclude the general practitioner from practice.

I agree that only those who have taken special training should practise obstetrics, but there is no encouragement to do this when one is actively excluded from the practice of the art, which should be done in a consultant supervised unit.

With regard to training for general practice, I suggest that a six-month appointment in each of the following departments should be mandatory—general medicine, surgery, obstetrics and gynaecology, ear, nose and throat and eye, paediatrics, and casualty.

When in practice a general practitioner should have the opportunity, and be encouraged to take it, of attending his patients in hospital, with a consultant, and of attending operations on his patients, and attending the necropsy of those who die. Only thus can one co-ordinate clinical findings with pathological conditions.

In the field of preventive medicine a much greater knowledge of factory processes and working conditions is necessary; few practitioners have