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.

JOSEPH L. KEARNS
Medical Adviser
J. Lyons Group of Companies
Cadby Hall,
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

the opportunity of seeing the conditions under which their patients work.

All the above obviously requires a great deal of time—a commodity hard to find. My partners and I regard 60 surgery consultations and ten domiciliary visits a day each as the usual load. Much of this is due to increased interest shown by patients in what they consider to be abnormalities, probably as a result of careless propaganda by well-meaning physicians, those who try to 'educate' the public. It would be better if these people devoted their efforts to encouraging the public and industrialists to improve conditions of work and living and so remove the causes of much morbidity.

T. A. TAYLOR

112 Manchester Road,
Warrington,
Lancashire.

Sir,

Quality control is a concept of industry not directly applicable to the professions. But your editorial policy of accepting articles like those from Mr Honigsbaum and me is dangerous. Mr Honigsbaum looks at general practice as a layman not in active practice in our profession. I look at those aspects of active practice not directly related to medicine and in particular that aspect which is concerned with the 'quality' of personal knowledge of the list, in the demographical sense.

The danger is that your policy provides a vast loophole for all sorts of non-medical articles to be accepted in preference to those directly to do with general medicine in the context of the natural environment of family life.

Having learnt to walk, the College is now beginning to march on its strong legs of education and research, and with its proven, academic status and democratic structure it can sustain a journal for its large membership, both as a vehicle for house news and notices and for articles by its members for its members and others; but with the wealth of medical newspapers and magazines now distributed freely to all doctors there is no fear that the non-member's point of view is hidden under a bushel.

Articles like Honigsbaum's and mine are only justified in your columns if they genuinely break new ground in the study of the quality of care, so that the policy of getting to know the patient as a person can be seen as an essential prerequisite for the highest quality and greatest 'cost-effectiveness' attainable. If such a policy is adopted by the College as a body, it then leads on to all sorts of strictly medical and organisational aspects of general practice, not the least of which would be a code of practice laid down by the College as a guideline for judging the reputability of a practice as a business.

Any new entrant to partnership expects to be able to look at the books before committing himself. The books should be kept, so that the demographical features of the practice population are available for comparison, quite apart from the financial ones. But perhaps you consider that to be more a matter for departments of social medicine and therefore outside the scope of the *Journal*!

MICHAEL J. JAMESON

21 Upper Lattimore Road,
St. Albans,
Hertfordshire.

Sir,

I was interested to read the article *Quality in general practice* but surely the greatest cause in deterioration has been the development of large partnerships—the 'multiple stores' of general practice. I found that being a member of a five or six man partnership looking after 14,000 patients, there was no defined patient-responsibility. Too much time was spent 'tiding over' a patient until they could be seen by their 'own' doctor, whose earliest appointment was a week ahead—often for the patient to be told that neither the treatment nor the diagnosis was appropriate.

For two thirds of the year a partner was away, so that one was faced with the overwhelming payload of 2,800 or so patients and approximately another varying 700 patients as each partner was away in turn. Thus one was involved in the problems of 5,600 patients which is nearly three times the workload recommended by the College.

After heated arguments in which each partner (and his wife) were claiming that they were working too hard—and rightly so, we agreed to withdraw into smaller units. We formed a true group practice of a three-handed and two single-handed practices. Thus I am able to pace out my own appointment system, look after and get to know my own exactly-defined group of patients, institute any screening measures, research projects, and organisational changes that I feel should be done for the improvement of the medical care of my patients.

During the first six months of 1972, my consultations dropped from 5,320 to 3,950 (for 2,750 patients) a drop of 25 per cent. As my consulting times were the same, or probably even longer, I now have more time to deal with each problem as it arrives, and *time* is the one commodity that is needed to improve standards in medical care—and which cannot be bought.

Our group practice is now working most amicably. The three-handed partnership has more flexibility for their holiday and study leave; my single-handed colleague tells me that he is happier in general practice now than during the past 15 years; the 'dragons' meet with 'Pyreneed' breath; my personal secretary has a public relations job far more varied and interesting than her previous 'pounding the typewriter' existence; and I have two tails to wag. I know and control the extent of my clinical responsibility. I know my own deficiencies in clinical skills.

A consultation with a colleague is now meaning-