efforts. This thought has brought about changes in our understanding of what really happens in general practice consultations. We are beginning to see more clearly that the few cures we have to offer impress most of our patients less than the extent to which we understand and care about them. And we have developed a conviction that our main role is to uphold the interests of the whole individual, while specialists concern themselves severally with parts of their bodies. We have therefore learned to see how our roles are qualitatively separate from, yet complemented by, those of our specialist colleagues.

We therefore are certainly changing, qualitatively, in our attitudes. Mr Honigsbaum, on the other hand, advocates the same measures of "quality" now as we accepted 20 years ago, learned from, and are transcending.

Is the pot calling the kettle black?

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REFERENCE

Honigsbaum, F. (1972). *Journal of the Royal College of General Practitioners*, **22**, 429–51.

Sir,

I was interested to read Frank Honigsbaum's article together with your editorial comments (July *Journal*).

There is no doubt that his criticisms of general practice in the N.H.S. are based on a great deal of research into the literature and that many of them are perfectly valid. However, unlike Dr J. S. Collings he has no personal knowledge of the problems of general practice. We are, most of us, well aware of our many shortcomings but to maintain that there has been no improvement since the Collings report is palpable nonsense.

Mr Honigsbaum's criticisms are so numerous that it would be impossible to deal with each one in detail in the short space of a letter so I will confine myself to a few.

Apparently the great British public is so easily satisfied that it does not realise how bad a service it is getting from its general practitioners. I find it very difficult to believe that patients in the United Kingdom are any less sophisticated than in other countries. Nevertheless a scheme to provide private general-practitioner service through the British United Provident Association has failed through lack of support.

Mr Honigsbaum places great faith in the medical check-ups and screening services and accuses British general practitioners for failing to provide them. He goes on to say that in the United States people visit their doctors more frequently than in the United Kingdom and that routine medicals are much more popular, especially among middle aged men. It therefore seems strange that male mortality statistics in the United States are even worse than in the United Kingdom, according to Table I in his article.

He also points out that male life-expectancy at one year is greater in Greece and Spain than in the United Kingdom and uses this fact as an index of the overall performance of our medical service. Does this mean that these two countries have health services superior not only to ours but also to Belgium, West Germany, Australia, U.S.A., Finland and France?

This biased use of statistics casts a doubt on the impartiality of the remainder of his article. I expect that his quotation from the literature have been carefully selected and often shorn of their context in order to further his argument.

Your editorial mentions that if part or all of his criticisms are justified then publication may in itself prove beneficial to general practice. This may be true, but I cannot help feeling that the quotations from the article in the lay press, particularly the statement that British doctors hate their patients, do the many conscientious hardworking doctors in this country a great disservice.

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Sir,

Like a claxon horn in a string orchestra, Mr Honigsbaum (July *Journal*) cannot be ignored. His paper is an event that should not have occurred, but having done so must be dealt with in a way that strengthens good primary care.

His paper is not about quality in general practice, but about badness. The fact that quality must be measured, that it consists of a number of more or less independently variable quantities in a continuum from execrable to excellent, each of them unevenly distributed in social and geographical space and in time—all this has escaped him, or at least he tells us nothing about it, though all of us would be most interested in the answers. Apparently his collection of bad things about British general practice impresses him so unfavourably that his simple verdicts are sufficient, without measuring what is good, or seeking to locate what is bad—"failures in screening . . . failure in geriatrics . . . negligence in midwifery . . . negligence in prescribing . . . negligence in hygiene . . . inadequate time for consultations . . . poor records . . .", and so on; success, apparently, in nothing.

With all the confidence of a young man whose experience of health services is virtually confined to what other people have written about them, he proceeds to international comparisons illustrating the inferiority of British primary care in every respect, and to historical comparisons showing that we are not only bad but worse now than in the

1950s—on the sole evidence of a declining proportion of general practitioners to population and a rising mean age of practitioners. The College of Practitioners, its *Journal* by whose courtesy his paper appears, the postgraduate medical centres, the whole body of primary care research ("the negligible amount of research published by general practitioners"—filling 180 foolscap pages in the last bibliography prepared by the college librarian), the extension of group practice, the use of ancillary and attached staffs, the university departments of general practice, the considerable beginnings of vocational training, and all of these created largely or wholly by working general practitioners—all are either ignored or dismissed as without proven effect on quality. Public opinion, so generally favourable to British general practice, and so hostile to its equivalents in the United States, is likewise dismissed.

In these terms there is no case to answer; the serious criticisms of primary care made in many of the papers quoted by Honigsbaum were constructive and valuable in their own right, qualities entirely lost by selective accumulation in an anthology of failure and negligence. The most obvious conclusion must be that review papers should conform to the normal standards of scientific journals, by evaluating all the evidence relevant to the author's hypothesis, not just the bits and pieces that can be made to appear to support it. It might also be a good rule that authors seeking to review such a wide area should have some substantial personal experience of it, or have carried out original field studies before settling down in their libraries.

It is to be hoped that some qualified person will now write a serious paper on quality in general practice. Irvine and Jefferys[1], whose very important paper Honigsbaum does not quote, have summed up the evidence on changes in quality since Cartwright and Marshall[2] and Cartwright[3] did their studies in the early 1960s; they show improvement, accelerating since the package deal, but are clearly worried at the relatively small proportion of practices showing a real shift to patient-orientated teamwork.

There is so far no evidence that the concentration of poor clinical standards in industrial areas which was truthfully described by Collings,[5] has changed; there certainly has been an improvement in absolute terms, but relative to standards in 'desirable' areas where most doctors want to live and work, there is no evidence of improvement, or of any serious planning to obtain it.[4]

In the present atmosphere of infatuation with managerial solutions, typified by the recent White Paper on National Health Service reorganisation, and with inevitable pressures to conform with West European primary care services heavily biased toward the conservation of private practice, a return to a dual clinical standard conforming to social inequalities is a real danger. The very complex task of developing appropriate scales for measuring the main components of quality, and of setting up valid population samples for continuous or semicontinuous monitoring of quality, cannot be left to managers who for their own personal care can bypass the normal channels of use of the NHS, have a merely academic interest in equality of care, and no conception of fraternity. It is a job that should be undertaken by those of us whose careers have been mainly devoted to rectifying the horrifing truth described by Collings.

Mr Honigsbaum is no Collings.

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1 Irvine, D. & Jefferys, Margot (1971). *British Medical Journal*, **4**, 535.
2 Cartwright, Ann & Marshall, R. (1965). *Medical Care*, **3**, 69.
3 Cartwright, Ann. (1967). *Patients and their doctors*. London: Routledge & Kegan Paul.
4 Hart, J. T. (1971). *Lancet*, **1**, 405.
5 Collings, J. S. (1950). *Lancet*, **1**, 555–85.

Sir,

The paper by Frank Honigsbaum (July *Journal*) on the quality in general practice in the United Kingdom was most stimulating and its provocative contents, as suggested in the editorial of the same issue, need to be closely examined and answered by admission or denial as the charges are laid at the very foundation of general practice.

Before commenting on the article it must be frankly admitted that within the confines of general practice there exists a very wide range of quality of service and witness to this fact is the very existence of the Royal College of General Practitioners which, in common with the other Royal Colleges, aims to maintain standards.

The various activities of the College in connection with the education of doctors to participate in a more profound way in the field of primary medical care are aiming directly at this problem of complacency with attending low standards.

Honigsbaum's paper appears to be a summary with personal conclusions of statistical material concerning health in Britain compared with the world in general and the U.S.A. in particular. The figures relating to life expectancy may have little to do with the quality of primary medical care but may well reflect the rise in the death rate from such conditions as coronary thrombosis and bronchitis which is known to affect males more than females. Over the past 100 years the average maximum expectation of life for males in the United Kingdom has only increased by approximately four years. This superficially reflects poorly on British medicine as a whole, until a more detailed analysis reflects a lowering of early death but an increase of those in the 40–60 age group. Medicine has