changed the pattern of mortality and morbidity statistics and new problems are continuously being produced.

Reference to the comparison between British general practitioners and their American counterparts needs to be correctly evaluated. Primary medical care in the U.S.A. is well below standards in this country. More American doctors specialise and the general practitioner, as seen in that country, is getting a rarer species much to the detriment of the patients in America who not infrequently cannot afford to go to their doctor or, as is now occurring, cannot find one in their locality if it happens to be in a poor-class area.

The fact that American doctors spend more time with their patients each week may only indicate the fact that if a patient is paying his doctor he may expect more of a doctor's time. Statistics can be misleading for if the figures quoted by Honigsbaum for the average consultation rate for patient *per annum* in Britain is four as compared with America at 4·5 and bearing in mind that American doctors work 50–60 hours per week compared with a British doctor's total of 39–43 hours and with the periodic medical examinations and their multiphasic screening examinations, why, it may be asked, is the life expectancy for the American male 1·3 years less than his counterpart in England and Wales and 0·5 years less with respect to American women.

The age of the British practitioner, according to Honigsbaum, is a notable feature responsible for the poor quality of medical practice in this country; seven out of every ten doctors are now 40 years or over. A case could easily be made out for active principals being nearer the 40 mark in the future after the initial training in general practice has been increased and time allowed for a doctor to settle into the environment of the practice in which he has become established; surely experience, which is only acquired at the expense of youth, must count for something.

Although much of the immense data collected by Honigsbaum does not prove where specific weaknesses are to be found, he does justify satisfactorily many faults with general practice. Negligence in prescribing, poor practice accommodation and staffing, low personal standards, inadequate records, low standards of referral letters and insufficient use of laboratory facilities in an intelligent way are frequently encountered. These are signs of poor quality of practice, the root cause of which may well be low standards of personal achievement and professional interest on behalf of many doctors, which obscures the efforts of many whose standards are higher and whose abilities benefit not only the patients directly under their care but serve British medicine as a whole.

The College is gradually making its mark in primary medical care in this country and eventually it will turn more of the profession towards the way indicated by such individuals as its first President and thereby create the true nature of medical practice *cum scientia caritas*.

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REFERENCE

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## DIAGNOSTIC CERTAINTY

Sir,

Dr C. K. Drinkwater[1] in his letter (August *Journal*) identifies an important problem which arises in comparing the research findings of different workers.

In our study of symptoms[2] we attempted to define levels of diagnostic certainty so that we could subsequently compare the performance of the doctors taking part in the study. Symptomatic was defined as the mere repetition of the patient's presenting symptom, provisional indicated that the doctor proposed to take further diagnostic action, but this included a positive decision 'to wait and see'.

A presumptive diagnosis indicated that the doctor was prepared to and indeed in our training programme challenged to defend his diagnosis to his colleagues. This probably acted as a disincentive to the doctors to record a presumptive level of certainty unless they were very confident. In contrast many research projects encourage the doctor to record a precise diagnosis in order to simplify the classification of diseases.

It may be that the differing objectives of the two studies which Dr Drinkwater has considered account for the apparent anomaly which he has detected.

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REFERENCES

1 Drinkwater, C. K. (1972). *Journal of the Royal College of General Practitioners* **22**, 539.
2 Morrell, D. C. (1972). *Journal of the Royal College of General Practitioners* **22**, 297–309.

## PREPARATION FOR GENERAL PRACTICE

Sir,

The Royal College of General Practitioners recommends that vocational training courses approved for the MRCGP examination should include at least 18 months' experience in hospital appointments, in subjects 'relevant to general practice'.

This recommendation seems to us to blur two entirely distinct issues. The first issue concerns the training appropriate to doctors entering general practice; the second is about the training appropriate to becoming a member of the College by