near future. The replies from younger correspondents reinforce the opinions of health educators that an integrated curriculum for schools should include the subject of contraception.

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REFERENCE

Birth Control Campaign (1972). A Birth Control Plan for Britain. London.

QUALITY IN GENERAL PRACTICE

Sir,

The paranoid squeal when someone stands on a doctor's corns is deafening and unbecoming.

Maybe Mr Honigsbaum (July *Journal*) did make an overstatement but his article should serve to remind us that some of us are not very good: some of us who think we are good could be a great deal better, and that none of us are good all the time.

We have made a lot of progress since many of Mr Honigsbaum's references were originally penned but we have no room for complacency; no time to rest on laurels.

The paper was depressing and unfair but it nevertheless needed to be said.

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QUALITY IN GENERAL PRACTICE

Sir,

I write about the article by Mr Honigsbaum in the July *Journal*. Like many other people his article seems to me unbalanced, out-of-date, and amateurish; not really worthy to be regarded as serious criticism.

He makes very simple deductions from his statistics and is clearly able to relate in his own mind, for instance, the rise in the number of tests performed each year in laboratories as a sign of increasing excellence amongst certain doctors, and, by the same reasoning I suppose, the opposite in his mind would indicate a lower quality of care.

We have recently started doing our own haemoglobins and E.S.R.s in the surgery and there would be no doubt that this very common test, which could have previously shown on statistical figures given by the hospital laboratory, would indicate that we were practising a lower standard of medicine.

Many of his arguments seem to me to be very naive. He mentions a grey-wedge photometer as being an essential part of a general practitioner's equipment, which is so often lacking. By July of this year the grey-wedge photometer was out-of-date and anybody wishing to do their own haemoglobins would normally be advised to get a more modern haemoglobinometer. Criticism is very necessary for us, but it is of little value when made at Honigsbaum's level.

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REFERENCE

Honigsbaum, F. (1972). *Journal of the Royal College of General Practitioners*, **22**, 429–451.

DIETICIANS IN GENERAL PRACTICE

Sir,

I am studying, with the financial support of the Department of Health and Social Security, and the full approval of the British Dietetic Association, the use of dieticians on the community.

In order io obtain information concerning the current experience in general practice, I should be grateful if any reader who is a general practitioner and who employs a dietician in his practice would contact me at the Health Services Research Unit, Cornwallis Building, University of Kent and Canterbury.

K. SHERIDAN DAWES
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Canterbury,
Kent.

Sir,

Dr M. J. Whitfield (October *Journal*) reports his findings in a study of the relationship between the year of patients' registration and morbidity in his practice. A number of conclusions are made in this publication which cannot be allowed to pass without further comment.

(1) The paper is presented in a haphazard manner with methodology, results, and part of the discussion all coming under the heading 'Method'.

(2) There is no indication of which system is used for disease classification, i.e., was it the International or the College of General Practitioner's Classification of Disease?

(3) Two groups of males and females matched by date of birth are compared to ascertain differences in consultation rates by year of registration. This cannot be a valid comparison as the groups are not matched by social class which is known to have a significant effect on consultation patterns.

(4) It is stated that "12 of the female patients who registered in 1970 consulted during the first week of registration; only two of the males who registered in 1970 consulted in the first week. This indicates the tendency of patients to register only when they are ill". There is no evidence presented to support this conclusion.

(5) The results in Table IV are not tabulated and no totals are given. If one calculates the

total consultations in Table IV they are not comparable with the total consultations in Table II, i.e.—

	Males		*Females*	
	1955–59	*1970*	*1955–59*	*1970*
Table II				
Consultations	101	125	132	225
Table IV				
Consultations (by diagnostic category)	113	129	152	240

We assume that the reason for these apparent discrepancies is due to patients in Table IV presenting with more than one diagnosis. However, there is no explanation of this in the text.

(6) From Table IV it is claimed that newly registered female patients compared with patients registered for over ten years show a marked difference in consultation patterns for mental disorders and genito-urinary disorders. There is no attempt to apply statistical techniques to determine if the difference is significant and if so the reasons for this difference. There in in fact a significant difference (using χ^2) between the two groups as far as mental disorders are concerned ($p<001$). The numbers for genito-urinary disorders are really too small to apply statistical methods.

(7) Table IV outlines the disease categories of 100 patients who consulted during the study year. It is hard to believe that only five consultations out of a total of 624 could be classified under "Ill Defined Conditions". If this is in fact true what is the reason for this?

(8) It is stated that practices were selected at random in Bristol to get information about percentages of the total lists who register during a year. There is no description as to how these practices were randomly selected.

The author concludes that patients who have recently registered cause him more work. Do they cause *significantly* more work? The statement that patients tend to register when they are ill may be true but it is not supported by the presentation of facts in this paper.

The author goes on to argue that certain practices with a large yearly intake of new patients, and thus a higher workload, should have a weighted capitation fee for patients during their first year of registration. This is totally unacceptable, as similar arguments could be made in favour of other 'high user' categories, i.e., children under five, female patients over 15, patients with serious illness requiring frequent surveillance, etc. Similarly, a practitioner may practice in the vicinity of a university or college of further education and have a high 'floating' population of young people on his list. This will expand his list size but will probably not increase his work significantly.

Finally, the references used are extremely limited and we would draw the author's attention to the work of Shepherd *et al.* (1969), who studied in depth the effects of mobility and change of environment on the mental health of patients.

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REFERENCES

Shepherd, M., Cooper, B., Brown, A. C. & Kalton, G. W. (1969). *Psychiatric Illness in General Practice*. Oxford: Oxford Medical Publications.

Whitfield, M. J. (1972). *Journal of the Royal College of General Practitioners*, **22**, 675–8.