College has an organizational role. It is from these groups that standards will emerge, not overnight, but gradually. The list mentioned in this paper, though quite obvious in retrospect, emerged as a realizable objective from a consideration of practice performance in preventive care.[5]

Quite apart from establishing standards, there is an additional value in the discussion of measured performance. At an individual level an important part of progress is the identification and discarding of redundant and inappropriate procedures or treatments. Learning is so often associated with the acquisition of new gems of information that it is easy to miss the importance of discarding the waste. Eccentric behaviour is quickly identified where we measure performance and compare it with our colleagues'.

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Table 1. Comparison and correlation of individual practice activity rates—Second National Morbidity Study; year 1 and year 2.

	Number of Practices	Year 1 70–71 Mean	SD	Year 2 71–72 Mean	SD	*r*
Consultations per patient at risk	23	3.30	.80	3.46	.75	.93
Specialist referral per 1,000 patients at risk	22	119	56	119	47	.88
Patients investigated per 1,000 patients at risk	21	153	88	149	94	.89
Home visits per 1,000 patients at risk	25	562	305	522	320	.97
Home visits per 1,000 consultations	25	158	65	150	69	.95

Quality of Care in General Practice

Sir,

A warm welcome for Dr Irvine's paper (August *Journal,* p. 521) and for the Council debate. There could however have been more effort devoted to finding the cause of the trouble; why do too many general practitioners have low standards?

From 1920 to 1948 I was in general practice in Wandsworth and Battersea ('Up the Junction') where the quality of care was not always of the highest. There were several reasons for this. A doctor entering general practice had:

—no test to pass. Anyone (with some cash) could take on a large practice the day after he qualified. Hence new entrants always included the dregs.
—no proper training. He had been prepared for hospital work but knew nothing of general practice.
—no time. In the poorer districts low payments for panel patients and even lower fees for their dependants meant few doctors, large lists and long hours.
—a solution provided by the patients. They wanted symptomatic relief—above all a bottle of medicine (tablets alone they would have scorned). So 'Here's the prescription. Next please.'

How far have things changed today? There is now one hurdle before entry—vocational training for three years; and unless this sinks below the level of other entry tests the first danger is overcome.

Other perils are lessened but not eliminated. There is some training in general practice; but is one year enough to counteract the influence of the seven or eight spent in undergraduate and postgraduate hospital training, with its implication that only consultant practice is really worthwhile? Above all, can training ever be satisfactory while the great majority of teachers—and the leading medical journals—persist in trying to find a material cause for everything, and (unscientifically) disregard the influence of the mind?

As for time, there is more but not enough. There cannot be without more general practitioners—and we shall not get them unless we can overcome the resistance of the consultant establishment and the civil servants at the DHSS, who have jointly secured the preponderance of the acute hospital services.

Some patients are not now satisfied with a physical examination and a prescription—but are they more than an intelligent and well-publicized minority? The great majority appears still to demand only immediate relief for its present condition. In any case is it not better for doctors to lead patients than patients doctors?

Council has adopted two aims. Both are entirely reasonable, but both are marred by one word. 'Should' implies a claim to superiority in knowledge, intelligence and morality which does much to explain the antagonism which our College excites amongst certain members of the profession.

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Sir,

I am surprised that Council's debate on Dr Donald Irvine's briefing paper (August *Journal,* p. 521) survived beyond Dr John Fry's searching question 'What is quality and how do we measure it?' and Dr Paul Freeling's answer 'We can't'. But it did; and now Council has decided to send the paper, in its present form, to the faculties for further consideration.

In my view the basic flaw in the paper is that, unwittingly, Dr Irvine has used the words 'quality' and 'standard' throughout as if they were synonyms. Quality implies a grade of goodness. Like excellence, beauty, health or pain, quality is a perception that cannot be corporately defined and measured. Standard, on the other hand, is a level of adequacy. Standards can be set and can therefore be measured. Surely this is what Dr Irvine meant. If his paper were retitled 'Standards of care in general practice: our outstanding problem', and the word 'standard' substituted for 'quality' throughout the text, then it would prevent faculties from becoming embroiled in yet further futile discussions about what is good quality in medical care.