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.

Quite simply, faculties should be asked to suggest what *the minimum acceptable standards* of practice should be, bearing in mind the uneven spread of resources, manpower, demand and expectations that is so vividly described in the Black Report.[1] When this baseline has been established—and why should it not include new roles in the community for our specialist and nursing colleagues?—it would become both a target to aim for and something tangible to measure. Building, painstakingly, on such a foundation towards successively higher standards may take longer, but it is more likely to be successful than starting from anywhere else.

Whether the collective list of personal 'weaknesses', which Council members will provide for us next summer, will get us going remains to be seen. I have my doubts—especially if those that they choose turn out to be of the same relative insignificance as the two cited by Dr Irvine. My guess is that, sheltered by anonymity, the faculties could produce something more useful.

As for quality, its essential inconstancy will continue to make it elusive. It is also likely that it will remain hidden from us all in the clouds of our own personal and professional uncertainty about what is best for our patients. We must never stop thinking about quality but I am certain it would help greatly if we stopped trying to tell each other what it is.

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Reference

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MEDICAL NEWS

Smoking related disease: symposium report

British family doctors could in one year persuade more than half a million patients to give up smoking.

This statement made by Dr G. H. Fowler expressed succinctly the overriding theme of a symposium held on 20 June at the College under the title: 'Smoking Related Disease: Intervention Better Than Cure?'.

Dr John Horder, chairman of the symposium and immediate past-President of the College, pointed out that the general practitioner, in giving advice on smoking cessation, has a major opportunity to reduce the widespread nature of a number of serious disorders. This view was echoed by several speakers at the symposium, sponsored by Lundbeck in association with the College, which covered smoking related diseases, education and smoking cessation.

The effects of smoking were put into horrifying perspective by Dr Fowler when he commented that out of 1,000 young men who smoke cigarettes regularly, on average, one will be murdered, six will die on the roads and 250 will be killed before their time by tobacco.

The presentations examined the issue from a variety of angles:

- —producing detoxified cigarettes and the problems with this if nicotine addiction is the reason for smoking.
- —mounting successful mass campaigns to motivate people to try to give up.
- —helping individual smokers to understand the needs met by each cigarette and so to develop a personal plan for stopping.
- —extending the skills of nurses so that they can contribute more help.

The symposium is part of a wider programme to encourage a positive attitude to intervention in smoking cessation amongst general practitioners. The College meeting preceded a series of workshops that are to be held around the UK. The first of these was held on 30 June at the Queen Elizabeth Postgraduate Medical Centre in Birmingham when 40 general practitioners took part in a special project to encourage them to see themselves in the role of smoking cessation counsellors. General practitioners from Dundee, Glasgow, Newcastle, Leeds, Manchester, Liverpool, Cardiff and Southampton will be able to take part in further groups in the series which is planned to start in the Autumn.

For more information on the smoking cessation workshop programme, contact Kate Winskill, Burson-Marsteller, 25 North Row, London W1.

Guide to Benefits for Handicapped Children and their Families

A revised edition of this book has been produced by the Disability Alliance Education and Research Association. It provides a clear introduction to the benefits available to handicapped children and their families and can be obtained from the Disability Alliance ERA at 25 Denmark Street, London WC2H 8NJ. (Tel: 01 240 0806). The booklet costs £1.20.

A Patient's Guide to the National Health Service

This book has been published by the Consumers' Association and Hodder & Stoughton in collaboration with the Patients' Association. It is a guide to the NHS and explains all aspects of how to get inpatient or outpatient treatment and what to do if things go wrong. It covers such topics as how to choose your general practitioner, dentist and optician; maternity and child health services and all aspects of going into hospital. The roles of different health workers are described as are the mental health services. There is a chapter on services for the elderly.

The book is based on the wide range of queries and problems that people put to the Patients' Association. It is available from bookshops or The Subscription Department, Consumers' Association, Castlemead, Gascoyne Way, Hertford SG14 1LH—price £3.95.

Problems Afoot

Problems Afoot: Need and Efficiency in Footcare is a leaflet published by the Disabled Living Foundation. It shows how the footcare service of the NHS can be improved and made available to more people. It can be obtained from the Disabled Living Foundation (Sales) Ltd, Book House, 45 East Hill, Wandsworth, London SW18 2QZ, at £5.60 per copy (including postage and packing).

Well Being

The special *Well Being* programme 'Heart Attack' will go out on Channel 4 on Friday 11 November at 22.30. Its theme is prevention.

The first of a series of 10 new *Well Being* programmes will be shown in February 1984.

So much interest was generated by the programme on diabetes that a videotape of it is being produced for sale.