Reading journals (which ones? You would not learn much if you only read the RCGP *Journal!*) for 140 hours per year or attending selected Section 63 courses will not necessarily 'plug the gaps' for those that do so: but what about those who do not? At present a new principal, complete with MRCGP, can sit back and do nothing until he reaches age 70 years. Did not my generation all swear we would keep ourselves up-to-date with our MB ChBs? Who knows where the medical gaps actually are in our knowledge unless we are probed? The fact is there is no incentive to do anything.

Training committees are probably moving in the right direction in requiring trainers to have membership of the RCGP and also expecting *all* members of the practice to teach and have a well-run practice. This I believe is right as no trainer, no matter how good, can 'go it alone': the trainee could well pick up bad habits if this were not so.

But even if all the members of a teaching practice were to be MRCGPs this in itself would be insufficient — for reasons stated. However, suppose the MRCGP was *only for 15 years* (to be retaken at ages 45 and 60 years) and that membership was linked to seniority awards? Many general practitioners already do resit the exam regularly.

Speaking as only an Associate of the College I would be the first to agree that the exam is far from perfect(!) However, what would the effects of *some* suitable exam be? Surely the answer is that we would *have* to ensure we kept up on all-round competence, not just attending courses on our favourite subjects or reading interesting articles; and if we did not we would lose the right to display the magic letters, lose out financially and perhaps feel less inclined to 'hang on' when we reach our sixties (or alternatively demonstrate to the brash youngsters they are not the only ones who know anything about medicine!).

A. E. FINNIGAN

Summertown Health Centre
160 Banbury Road
Oxford OX2 7BS

Sir,

I have just had a note about a course for established general practitioners who wish to join our College. 'This may be particularly difficult for the established GP' it says!

If we are making it particularly difficult for an established GP to join our College then there is something the matter with our College.

P. N. JARVIS

'Whaddon House'
221 Whaddon Way
Bletchley
Milton Keynes MK3 7EA

## Social class and health status

Sir,

The recent report *Social class and health status*[1] and the editorial regarding it (May *Journal,* p.241) appear to have more in common with polemics than objective appraisals of the subject. The report starts by drawing a somewhat dubious distinction between difference and inequality stating that inequality is a 'weasel word' and best replaced in this context by the word 'different'. Does the author really believe that inequality is an inappropriate concept when describing variations in such events as perinatal death? Surely the anodyne term 'difference' is only more appropriate if there is no agreement that one situation is preferable to another. The study concludes by stating dogmatically that there is clear evidence that general practitioners compensate for any inadequate use or misuse of health services by social class 5, and that equal opportunities for health are already largely realized.

On what evidence are these reassuring statements made? The data presented show that patients of lower social class consult more frequently, particularly for chronic conditions. No justification is given for the assumption that consultations involving these chronic conditions are doctor- rather than patient-initiated. It is also shown that variation between doctors is one of the most important factors in consultation and referral rates. Neither of these pieces of evidence is new, and neither justify the conclusion drawn. No attempt is made to utilize a use : need ratio as previously developed.[2] This is calculated by dividing use (number of consultations) by a measure of need (days off work). A study that considered general practitioner usage using this ratio showed that the advantages for lower social class suggested by consideration of consultation rates alone were eliminated or reversed when such ratios were compared.[3]

It is surely equally naive to assume that by simply counting consultations one can make any statements about the quality of care offered to each group. No mention is made of studies which have shown that consultations with patients from lower social classes are shorter, and that within this time the consultation is used less effectively with a higher administrative (for example, sickness certification) and lower clinical content.[4,5] It has also been shown that middle-class patients are more likely to have general practitioners with a high level of characteristics (for example, no use of deputizing, well-baby clinic, list size below 3,000) generally approved by the College.[6] The Black Report[7] suggests that middle-class patients appear to receive a better service when they present themselves than do their working-class counterparts. No evidence is cited in Dr Crombie's report to refute this suggestion.

The report becomes even more polemical when discussing prevention and social class. In denying any responsibility for low use of preventive services by social class 5, the explanation given is that 'under-usage by patients and

not service inadequacy' is responsible, and that 'the more efficient medical care becomes, the more complex it becomes'. The conclusion drawn is that underusage is therefore inevitable, because social class 5 patients have difficulty coping with complexity. It is a strange defence of our current system to suggest that increased efficiency of the service inevitably leads to decreased usage by social class 5.

Crombie uses the technique of attributing beliefs to people which they do not in fact believe, and then demolishing them. The Swedes, for example, do not themselves in general claim to be an equal classless society. On the contrary, the Swedish National Central Bureau of Statistics published in 1981, at the request of the then Government (an anti-socialist coalition), the *Social report of inequality in Sweden,*[8] which uses data from several national sources to chronicle the extent of inequalities in the country, a cause of surprise to foreigners.

Another report by Landell,[9] a psychiatrist working in the community, mainly with primary health care teams, relates the differences between different municipalities within Stockholm County in such measurements as sickness absence, and demonstrates that these are clearly related to class and socioeconomic status.

A recently published review of pregnancy outcome and social indicators in Sweden[10] demonstrates a clear difference between different social groups in such matters as birthweight and the incidence of pre-term births. Of critical importance, however, is that this paper also demonstrates no such relationship with perinatal mortality. In other words, good services can overcome the situation — there is nothing inevitable about inequality in perinatal mortality. Nor is this situation solely a feature of a wealthy country such as Sweden. The Sighthill project, which has brought community antenatal care to a very socially deprived district of Edinburgh, has apparently succeeded in reducing the perinatal mortality rate of Sighthill to below the city average (Boddy K, personal communication).

Thus, we suggest, inequalities in health do exist, but are not in all cases inevitable. To us differences in society will continue to exist and are a good thing — it would not be a good idea for both Liverpool and Everton to play in red.

However, an inequality is different. We do not think it is using 'weasel words', or suggesting a weasel philosophy, to say that it is a bad thing that the mother from an unskilled working-class family should have twice the chance of her baby dying in the perinatal period than that of a mother in a professional family,[11] particularly when, as has been described, something can be done about it, including by the primary health care teams.

The College has missed a valuable opportunity to tackle this important subject in a scientific and thorough way. Occasional papers should surely be seen as attempts to analyse the strengths and weaknesses of general practice, rather than documents which present data in a contentious way in order to persuade ourselves that all is well in the state of general pratice.

ANDREW WILSON
*Lecturer in General Practice*
RICHARD MADELEY
*Senior Lecturer in Community Health*
University of Nottingham
Queen's Medical Centre
Clifton Boulevard
Nottingham NG7 2UH

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Sir,

Drs Wilson and Madeley have written that Crombie's Occasional Paper[1] and my editorial in the May *Journal*[2] 'appear to have more in common with polemics than objective appraisals on the subject'.

The starting point for Dr Crombie's McConaghey Memorial Lecture was the Black Report,[3] in particular its claim that 'people in social class 5 have poorer health than those in social class 1, yet they make less use of health services including primary care and get a poorer service when they do use them'.

This quotation was included in the editorial and one of the conclusions of Dr Crombie is that as far as use by social class is concerned, those in category 5 actually see general practitioners more often than patients in social class 1, at least among the population he studied.