final six months, divided by the hospital posts. Newcastle was first in developing stricter methods for the selection of general practitioner trainers, which included considering their personal qualities, their practices (premises, records, staff, equipment, and organization), and the qualities of their partners. The selection procedure included a visit to the practice.

The initiatives for these schemes were different in each case: at Belfast it was by the Department of Postgraduate Medical Education for Northern Ireland; at Ipswich by the Postgraduate Medical Centre (making a conscious experiment to base the scheme on a district general hospital for the first time); at Newcastle by a Subcommittee of the Regional Postgraduate Organization; and at Manchester by the University Department of General Practice.

The Manchester scheme was intentionally subdivided, for research purposes, one part having a theoretical course at the start, one an extended course over one year, and the third no course at all.

All four of these early schemes submitted themselves to a large assessment study by the Department of General Practice at the University of Manchester, which aimed "to evaluate one course against another by measuring the changes effected in those taking part in terms of knowledge, skills, and attitudes, and some methods of thought and factors of intellect". The results of this study were published in 1976[42,43]. This important effort in evaluation was the initiative of Professor P. S. Byrne, who also played an important part as Chairman of the Education Committee (RCGP) from 1966 to 1970 and in producing (1966) the first course for general practitioner teachers aimed at increasing their teaching skills.

This most unfortunate mistake is very much regretted.

LETTERS TO THE EDITOR

CORONARY PREVENTION

Sir,

The coronary screening programme described by Dr J. Stuart Brown (December *Journal,* p.735) appears well planned and efficiently performed but it leaves some questions unanswered. If 22 per cent of ECGs are abnormal, is this a sensible screening test from the patient's point of view? It may be a useful baseline for the doctor but what does one say to the patient? Similarly, do the complex lipid tests performed on 20 per cent of patients really have a useful function? It is a little alarming that only 48 per cent of patients were "told that all tests were 100 per cent normal". Were the other 52 per cent reassured or frightened? The several patients who asked when they could have their next screening test may have done so through anxiety rather than enthusiasm. In other words, it seems to me that the *accent* of this programme does not seem quite right, being to "prevent coronaries' rather than lead to advice on good health in general. In our practice, we carry out a 'forty plus' examination almost identical to Dr Stuart Brown's except that we do not perform routine ECGs and do not take slight biochemical abnormalities very seriously. The accent is on reassurance and redirection. It may be that the risks of creating alarm and a demand for repeated screening should be taken more seriously than Dr Stuart Brown implies.

C. P. ELLIOTT-BINNS
31 Church Street
Cogenhoe
Northampton.

Sir,

I was interested to read Dr J. Stuart Brown's article on coronary screening (December *Journal,* p.735) and congratulate him on a well thought out and executed investigation. I do, however, think that something ought to be said about his reference to ECGs. He refers to 15 patients with "ECG abnormalities, the majority being T-wave changes or the presence of ventricular extrasystoles". He then goes on to say that "most of the T-wave changes were considered to be within the normal range" and "more recently the general trend is to attribute ever diminishing significance to premature beats". If one accepts these comments, I imagine very few, if any, of the 15 in fact had ECG abnormalities.

The classical ECG changes of ST depression and T-wave changes can be produced by a large variety of other conditions and are not pathognomonic of ischaemia. Ectopic beats (even ventricular ones), as Dr Stuart Brown points out, are of very doubtful significance.

I am sure this is important to say, because there are many people walking about who are anxious about their hearts simply because doctors have told them that they have "minor ECG changes", whereas in fact these "abnormalities" are perfectly acceptable within the normal range.

WILLIAM BENSON
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SELECTING TRAINERS

Sir,

Dr John Oakley's letter (February *Journal,* p. 117) complaining about the Oxford Region's criteria for the selection of trainers and training practices raises some important issues. He calls the requirement for new trainers to have passed the MRCGP examination presumptuous, unfair, and an insult to colleagues in general practice. Strong words indeed.

The Oxford Regional Committee's General Practice Sub-Committee is concerned that trainers should be clinically competent. It was because a number of our *trainees* felt that some trainers were not competent enough to teach clinical medicine in general practice that those from one of our vocational training schemes asked the Sub-Committee to introduce passing the MRCGP examination as a requirement for new trainers in April 1977. The members of the Sub-Committee agreed unanimously to do so. Existing trainers are not affected, although a number of them have sat the examination because they wished to do so.

The suggestions for assessing clinical competence published by the Joint Committee for Postgraduate Training in General Practice that Dr Oakley mentions are for guidance only. Passing the MRCGP examination is just one of the suggestions: in the Oxford Region we use all six. Anyone with experience in assessing and appointing trainers—and the members of our regional appointments committee and visiting assessors panel have a very great deal of experience—knows that judging a doctor's clinical ability is very difficult.

Local knowledge may be inaccurate, references are often inadequate, and attendance at courses does not tell selectors anything about ability. You cannot tell a man he is turned down because you have heard on the grapevine that he is not clinically sound: he would appeal against the decision, and rightly so. For this reason we supplement examining the clinical records with the only objective yardstick for measuring clinical ability in general practice that is available—the MRCGP examination. All examinations have their limitations, and of course the MRCGP is not perfect, but if Dr Oakley has a better objective method of assessing clinical competence in general practice we will be glad to hear from him.

We have never claimed that passing the examination makes someone a better trainer: it is merely a basic step. Of course we take into account all the other points Dr Oakley lists and we are in full agreement with him that character, experience, personality, and so on are of great importance. Nor are we concerned in the slightest whether trainers belong to the College, or pay their subscriptions, and we have no intention of asking them.

Teaching general practice is largely to do with clinical medicine. It is a great pity that in the necessary development of training a number of doctors seem threatened by any attempt to have their performance measured. Dr Oakley talks about an insult to colleagues in general practice. We suggest the insult is to our colleagues the trainees, in that we are not prepared to set our sights high enough. In the final analysis, as Dr Oakley says, each region or area must make its own decisions. Prospective trainees can choose whether to apply to the Oxford region or to Kent.

PHILIP HANDFIELD JONES
Chairman
General Practice Sub-Committee

JOHN HASLER
Regional Organizer for General Practice Training
Old Radcliffe Observatory
The Medical School
43 Woodstock Road
Oxford.

SUITABLE CASE FOR THE JOURNAL?

Sir,
A book review containing in its very first sentence the words "claws", "tyranny", "brutally", "ruthless" (and these epithets were not even to do with the book itself) certainly makes the reader sit up—perhaps it was intended to do so—but reads oddly in a journal of a learned profession, flanked as it was by *The New Sex Therapy* and *Manual of Medical Therapeutics* (December *Journal,* p.761).

One can commiserate with your reviewer's sense of hopeless impotence in the face of the big battalions, but there must be more appropriate places for him to parade his compassion. Having read the review I am little wiser about the quality of the book; on the other hand I feel I know a lot about his moral indignation. His language would not have disgraced one of our more outspoken political broadsheets. Are we now to expect reviews couched in similarly intemperate terms apostrophising Fascist hyenas and the running dogs of British imperialism?

Under your enlightened editorship an impressively wide range of topics have been aired in the *Journal's* columns, for we are a liberal as well as a learned profession; and you give your reviewers a great deal of latitude, as I have reason to know. But in this case, Sir, one can only wonder whether you took leave of your editorial senses. If ever there was a case for asserting the editorial mailed fist under the velvet glove, this was it.

J. S. NORELL
Dean of Studies
Royal College of General Practitioners
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The above letter refers to Dr J. Miles' review of The Light in the West *and was shown to Dr Miles, who replies as follows:*

Sir,
If the Soviet Union's invasion of Hungary in 1956 was not tyrannical, brutal, and ruthless, then these words have lost all meaning. The claws were out all right: ask any Hungarian who survived this painful period—if you can find one at liberty to speak. And as a matter of cold fact, my first paragraph—to which such fierce exception was taken—was a digest *from the book.*

I was aware when I wrote this that the views therein might make me unpopular in certain quarters, and this prospect sent me into paroxysms of indifference.

As to Dr Norell's complaint that I gave no clue to the book itself, I can only surmise that this despicable paragraph engendered such indignation that he could read no further. I hope he has since read the book and enjoyed it.

JOHN MILES
Meiklie House
Glenurquhart
Inverness.

CONSULTING TIME

Sir,
There is a current mood that general practitioners should improve their standards. 'Self-audit' is the vogue. And the Ombudsman lurks in the background to consider the grievances of a more critical and enlightened public.

All this is very fine but may I make a plea for the obverse side of this new coin? The plea is for more time to interview and examine my patients.

I have worked in general practice in Canada and New Zealand. In both countries patients were given 15-minute appointments and there was a 'fee-for-service' payment. This meant that the more that you did to help your patient, the more you were remunerated. The reverse applies in general practice in the UK at present.

Could not the College make a start by advocating extra fees for extra services to our patients, such as ECG examination, long interviews, speculum examination, suturing of cuts and removal of cysts, taking of swabs and blood samples? This alone would do a great deal to raise our standards.

It would be interesting to have the views and suggestions of other general practitioners, especially those who work in busy practices and with fairly full lists.

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AN INDEPENDENT DISCIPLINE

Sir,
I have read and re-read the first paragraph of your editorial on "Clinical work in general practice" (December *Journal,* p.707) and feel I must stand up for general practice as an independent discipline not only in mine but my father's generations, if not earlier still.

My father was a general practitioner in Kensington throughout my childhood but he later became specially interested in eyes (as James Mackenzie in hearts) and left general practice to practise as a consultant in Wimpole Street, being at the same time on the honorary staff of the Western Ophthalmic Hospital. His brother was never in general practice but, being on the honorary staff of two London hospitals, practised as a consultant in Harley Street. Their uncle was in general practice in Gloucester and was, I believe, treated as a con-