Sir,

Professor Howie and colleagues are to be congratulated on their paper which provides further evidence of the benefits of longer consultations (February *Journal,* p.48). Apart from questioning the working practices of many established general practitioners it also challenges our approach to doctors' vocational training.

In 1987 vocational trainees in the north west of England region undergoing their general practice year completed a questionnaire which collected details of their surgery workload at both the start of the practice year and at the time of the study. Replies were received from 140 trainees out of a possible 177, giving a response rate of 79%. The rates at which patients were booked into trainees' surgeries are shown in Table 1. The booking rate at the time of the study was not dependent on the stage individuals had reached in their training. At the time of the study, all trainees had completed at least two months of their training, and 100 trainees (71%) had completed nine months or more.

Table 1. Comparison between surgery booking rates at start of trainees' practice attachment and at the time of the study (*n* = 139).

	Number of patients booked per hour (% of trainees)				
	⩽4	5–6	7–8	9–11	⩾12
Start of attachment	27	40	18	11	4
At time of study	0	4	29	32	35

n = total number of trainees. Data missing for one trainee.

When the day release course was running, 101 trainees (73%) were taking seven or more surgeries a week. At the time of the study 71 of these trainees had bookings at a rate of nine or more patients per hour. If one assumes seven two-hour surgeries a week booked at 10 patients per hour, then at least half of the trainees in this study were seeing 140 patients a week.

The average consultation length for experienced general practitioners is between seven and nine minutes.[1] The likely outcome for those trainees with higher booking rates is that surgeries persistently run late; this is stressful for doctors[2] and is not popular with patients.[3]

At present the 'ideal' surgery booking rate for trainees is decided rather arbitrarily. It depends on factors such as trainee preference, practice workload, and the local 'training culture'. The north west of England region's training guidelines stated that in the latter half of their practice year trainees should see a minimum of 75 patients a week. Unfortunately no upper limit for the number of patients seen has been set. The results presented here and the evidence for the benefits of longer consultations from Howie and others[4,5] suggest this is the more pressing requirement.

Howie and colleagues propose that the ratio of long to short consultations could be seen as a proxy measure of quality of care. Perhaps one could argue that the same ratio when applied to trainee general practitioners could become a proxy measure of the quality of their training.

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General practice at the coalface

Sir,

In response to Dr Bichard's editorial (January *Journal,* p.4), I think it is useful to examine the 'coalface' divide and the circumstances surrounding 'miners' and 'geologists'.

The coalmine owners recently decided they needed more productivity and told the miners at the coalface that they must work longer and harder for the same wage. In addition, the coal seems to be so much harder to dig these days. Some of the miners used to take an interest in measuring how much coal they were producing and assessing its quality, but now they are just too tired and fed up.

Meanwhile, the geologists maintain their favourable working conditions and relationship as advisers to the mine owners. Certainly they have to put in a few sessions underground but they do not experience the real grind and responsibility.

Some miners say that the geologists recently gave the owners poor advice — they told them there were rich seams of coal where the miners claim there is only rock. But the miners have been told to dig there anyway or leave.

I have given the 'miners' view of why some general practitioners are suspicious of academics who are now bound to submit even more material for publication than their colleagues.

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Sir,

I was interested to read John Pitts' letter (January *Journal,* p.34) about the change in origins of the first authors of articles in the *Journal* over the past 10 years. I had made the same observations myself and felt the same anxiety. Indeed, I was about to embark upon an identical study.

My own experience in writing an article for the *Journal* made me realize the need for a competent statisticical method, a skill perhaps rare in doctors of my generation. I fear that this deficiency may inhibit many service general practitioners from making what might otherwise be a valuable contribution to research.

Furthermore, I was not convinced by Alison Bichard's editorial (January *Journal,* p.4) in defence of the *Journal.* For instance, to state that 'all general practitioners in university departments see patients under normal general medical services conditions' is doubtful; the pressures and priorities are quite different. It would be interesting to compare the consultation rates in academic and service practices.

I fear we are in the process of producing two kinds of general practitioner: the service general practitioner and the academic, and that they are becoming more and more disparate. Perhaps the contract for academic general practitioners should stipulate that every five years or so, they work for a year in an ordinary service practice, in exchange with a principal in that practice. Could not the Royal College of General Practitioners organize a scheme to implement this suggestion?

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Sir,

I would like to comment on the letter from Dr Pitts (January *Journal,* p.34) and the editorial by Alison Bichard (January *Journal* p.4), on the above subject. The real problem with papers in the *Journal* is not their origin, academic or otherwise, but the fact that virtually without exception they are seriously boring.

A glance at the contents list in the January *Journal* illustrates the point; not one of the papers advances our knowledge of medicine in general practice or clinical medicine generally. They are deeply uninteresting; they are based on question-