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-

naires or surveys which could have been done by secretaries or sociologists. The now ritual genuflection to the statistician does not make this 'research' more valuable or generally applicable.

'Research' of this type was pilloried 60 years ago by that great educationalist Abraham Flexner in his Rhodes lecture of 1928. His book published in paperback in 1967[1] is well worth reading even today, especially the hilarious part on the papers which were presented as theses in American universities in the 1920s. Their titles remind me all too readily of those I read in the *Journal.*

Years ago an earlier editor remarked on the lower quality of papers which landed on his desk compared with those submitted to other medical journals, and more recently Conrad Harris had a few caustic words on the same subject in his lecture at the Spring meeting of the Royal College of General Practitioners in Brighton. It may be that what is presently published is the best that can be got from general practice. If so, I suggest that the *Journal* be closed down and the savings applied to reducing the appalling level of the annual subscription to the College.

Before this happens, Dr Pitts might do a final valuable piece of research by resurveying the *Journal* papers of the last 10 years with particular attention to the boredom factor. He would only be required to read the title and summary; more would be too awful. His reaction would be recorded in the best research tradition on a scale from 10 to 0. Ten would mean that he was awake at the end of the summary; nine would equate to a 25% closure of the eyes and so on down the scale to narcolepsy at zero.

I look forward with interest (for once) to reading the *Journal* in which his 'research' is published.

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Editor's note: *Dr Rankin may like to know that closing down the* Journal *will not save very much from his annual subscription. For the year ending March 1990 the main* Journal *cost only 5.6% of the total College income (or 8.5% if* Connection *magazine is included). This represents just £10 per annum from the current subscription fee of £180.*

Sir,

Dr Bichard's article which purports to be a defence of editorial policy (January *Journal,* p.4) prompted by Dr Pitts' correspondence in the same edition of the *Journal,* seems to me to confirm the very point he was making: that the *Journal* is becoming unrepresentative of professional activity overall. Dr Pitts urges a change from strict quantitative methods so that the ordinary general practitioner would see more relevance in the *Journal.* He offers a number of reasons why the broad mass of members are unrepresented. He probably felt it unnecessary to remind you that the College motto is *cum scientia caritas,* or that the *Journal* is part of the public face of our profession.

The defensive tone of the editorial will, I fear, please and fortify the geologists but further alienate the miners. It reinforces the status of the one while reducing that of the other. It did not explore ways of dealing with Dr Pitts' proffered reasons why general practitioners *per se* were less represented. Finally it mentioned only in passing significant aspects of the search for progress which urgently require exploration and reassessment.

The fears expressed in the editorial that the publication of more general practice based and less science based material would lead to 'a two-tiered *Journal*' are

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