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Training in general practice: the other side of the coin

Sir,

Despite continuing concerns about the quality of the hospital component of vocational training, few general practitioners appear to oppose it in principle.[1,2] Most hospital specialists, however, seem to experience considerable anguish at the idea that any serious or suitable trainee for their discipline could possibly consider spending a period in general practice, much less that they could actually gain from this experience.

My own specialty, accident and emergency medicine, has enormous overlaps with the practice of family medicine; its relevance to general practice training was discussed in a recent letter to this *Journal*.[3] Nevertheless, most accident and emergency trainees spend only a few weeks at the most in a general practice, usually during their time as a senior registrar. A recently issued job description for such a post minimized even this brief experience by offering 'visits to local health centres', comparable perhaps to reducing the hospital component of vocational training to visits to local outpatient clinics and wards.

General practice is a major specialty in the United Kingdom, attracting some of the best medical graduates and utilizing its own independent body of knowledge. Until hospital consultants and general practitioners alike recognize that the flow of information, training and personnel between hospital and community should be a two-way process, both sides of this great divide will remain comparatively unaware of the other's assets and requirements.

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General practice at the coal face

Sir,

Clinical medicine is one of the very few professions where those who teach must also practice, unlike for instance teachers and nurses. This means that all general practitioners in university departments work as principals, either in a university-based practice or increasingly as partners in other practices. Clearly time is allowed for teaching and research, but so is time allowed for other activities by general practitioners.

Those in university departments are well aware of the pressures and problems of general practice, not only because of their continued involvement but also because there is a constant movement of general practitioners in and out of such departments. It is important for this clinical commitment and flexibility to continue if the profession of general practice is to flourish as a discipline and so maintain some independence from political pressure.

Unfortunately this task is made more difficult by the views expressed by Dr Sterland and Dr Hooper in their letters about general practice at the coalface (April *Journal*, p.170). While such concerns are understandable, it is not helpful to disparage a group of colleagues, most of whom work hard without favourable conditions or special relationships as advisers to the mine owners.

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Longer booking intervals in general practice: effects on doctors' stress and arousal

Sir,

The paper by Wilson and colleagues (May *Journal*, p.184) would seem to be flawed by considering consultation length during a surgery in isolation from the rest of the day.

If the same number of patients were seen in an experimental surgery with longer consultation times as in a control surgery, the general practitioner must have finished the surgery later. (The authors omitted to mention whether control and experimental surgeries contained the same number of patients or if the doctor saw less patients with a longer consultation time in the experimental surgery.) It would have been interesting to know what the doctors' stress and arousal scores were later in the day when hurrying to do visits and other commitments with less time than usual.

The authors concluded that running late may be a major cause of stress for general practitioners which would be obviated by longer consultation times. However starting visits and other clinics late because of extending their surgery consulting hours might cause general practitioners to be even more stressed during the rest of the day. A hurried surgery may be the lesser of two evils.

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Curettage and cautery of skin conditions in general practice

Sir,

Dr Jackson's letter (May *Journal*, p.213) was interesting and useful to all those doing minor operations in general practice. A further technique is that of curettage and cautery. I use this extensively as a clinical assistant in a hospital dermatology department and now in general practice. It is quick, easy to perform, effective and combines biopsy and removal in one procedure which patients prefer.

Conditions which are suitable for this treatment include basal cell carcinoma, squamous cell carcinoma, keratoses of all types, pyogenic granuloma, keratoacanthoma and warts which do not respond to liquid nitrogen.

Of course some lesions are not suitable, for example, multifocal basal cell carcinoma, very large lesions and some of those very close to the eye. However, patients of all ages can be treated using this method.

Equipment needed is a Volkman spoon and cautery machine. Lesions are locally anaesthetized and curetted carefully then cauterized. The procedure is repeated once and perhaps twice if necessary. The whole procedure takes between five and 10 minutes and gives extremely good cure and cosmetic results.

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