Correction!

Sir—In his letter (July 1991) Dr A. M. W. Porter refers to me as 'the late Dr J. Bourne'.

Dead! Far from it; in fact at 85 I am not even old, since, as everyone knows, old age is always 15 years older than you are. I'll let him know when I reach 100.

J. G. BOURNE

Research training

Sir—I greatly enjoyed Graham Neale talking sense about research (July, p188) and putting forward proposals which are long overdue. There is of course nothing wrong with research as such, or with aspiring physicians becoming involved in it, but there has for some years been something badly wrong with the ethos surrounding this part of a physician's training. Everyone wishing to practise clinical medicine should have the opportunity to take part in research to see if they are any good at it. Most people, including myself, are not and it is usually pretty obvious at an early stage who can become professional researchers and who will only be 'amateurs'. I was forced by the system to carry on, thereby spending time on work of dubious value and polluting the journals with papers, whose only purpose was to pad out my curriculum vitae. They were not very good and few of my contemporaries who are now consultants can honestly say that theirs were any better. Sadly, not everyone employs the Gerald Ratner system of self criticism and as a consequence junior doctors are still expected to do what their chiefs did and, even more sadly, I have no doubt that the result will be the same.

Directors of research departments should be able to see within six months who are amateur and who professional scientists. The amateurs should be advised to concentrate on clinical work but continue to attend research meetings. They would benefit from seeing science done properly and by listening to discussions between the professionals and the director. They would then learn how to judge the merit of a project and read a paper critically, without wasting the valuable resources of a laboratory and the time of the editors of journals. Our hospitals have many good scientists and many good clinicians, but the two areas of expertise seldom coincide. Both need to be encouraged rather than forced. What we need are scientifically literate clinicians to become consultant physicians and clinical scientists to devise and direct high quality research. The training programmes should be parallel rather than in series as at present. We might then see the end of the scientist with the clinical ability of a Sherman tank and of the clinician approaching research as though it were a game. Perhaps I am unduly cynical, but I am sure we all know examples of each.

PETER DAGGETT

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Fraud and misconduct in medical research: causes, investigation and prevention

Sir—The report of the working party on *Fraud and misconduct in medical research* (April 1991) starts with the Piltdown man hoax and 'the dubious data on intelligence quotients by (*sic*) Cyril Burt . . .' Sir Cyril Burt died in his eighty-ninth year in 1971. It was five years after his death that it was first alleged that he invented much of his data, especially that on identical twins, first reported thirty-six years earlier in 1943. A great deal of Burt's accumulated research material in University College was lost in an air raid in 1941. If the eighteen eminent members of this working party had read the recent analysis of the Burt affair by Dr Robert B. Joynson [1], they would not have perpetuated what may well be a calumny against a great man.

P. B. S. FOWLER,

Reference

1 Joynson R. B. *The Burt affair.* Routledge, London and New York, 1989.

Medical audit of case notes on one to one basis

Sir—One of the commonly used methods of medical audit is case notes review carried out in a group setting as recommended by the Royal College of Physicians. Objective analysis of published data [1] suggests some improvement in clerking and record keeping with this method of auditing. Our own experience [2] suggests that significant improvement is only achieved when a standardised admission sheet proforma is used to act as an aide memoire for junior doctors.

But not even this achieves complete recording of important information. In view of this and the fact that many junior members of the staff still regard the exercise of audit in a group setting as threatening, we decided to assess the value of auditing case notes on a one to one basis once a week in addition to holding monthly departmental audit meetings.

For the first five-week period the four consultant physicians in geriatric medicine paired with a junior doctor (senior house officer/house physician) working for one of his/her colleagues, to audit the case notes of an inpatient for whom that junior doctor was responsible. The notes were selected at random and the audit carried out using our own check list. For an objective analysis we used a scoring system modified from one we had developed earlier [2].

After five weeks the arrangements were stopped in order to see the effect of this on performance. The auditing was restarted a month later for two weeks.

The results, presented in overall percentage score for each week in Table 1, demonstrate that weekly audit of case notes on a one to one basis can achieve significant improvement in record keeping within one week of introducing this exercise. This improvement is

Table 1. Total percentage score achieved on recorded information in the notes each week

Week	Score (%)
Week 1	73
Week 2	94[a]
Week 3	89[b]
Week 4	91[a]
Week 5	91[a]
Week 9	81[c]
Week 10	89[b]

[a] $p<0.01$
[b] $p<0.05$ with respect to week 1
[c] Not significant with respect to week 1 but $p<0.05$ with respect to week 5.

maintained as long as auditing is continued. However, there is a tendency for the 'old habits' to return as indicated by the fall in recorded information at week 9. This suggests that audit has to be performed on a regular basis to maintain a set standard.

Junior doctors welcomed this method of auditing as it was considered by them to be less threatening and because it allowed them to discuss management with a consultant who was not his/her immediate boss.

We conclude that auditing of case notes on a one to one basis also has a place and recommend that this should be carried out within a department in addition to holding regular audit meetings within a hospital along the lines recommended by the College [3].

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1 Gabbay J, McNichol MC, Spiby J, Davies SC, Layton AJ. What did audit achieve? Lessons from preliminary evaluation of a year's medical audit. *Br Med J* 1990;**301**:526–9.
2 Rai GS, Bielawska C, Sharland DE. A year's experience of auditing case notes. *Care of the Elderly* 1991;**3**:291–2.
3 The Royal College of Physicians. *Medical audit—a first report: what, why and how?* Report of a working party of the Royal College of Physicians, London, 1989.

Who will fund postgraduate education after 1992?

Sir—Dr Griffin's article in the April issue (p128) deserves careful reading.

He refers to a forthcoming Council Directive of the European Commission which defines advertising in such a way as to include 'gift, offer or promise of any benefit or bonus, whether in money or in kind, including invitation to travel or to congresses', and prohibits 'any [such] gifts, pecuniary advantages or benefit in kind'.

Dr Griffin claims that this will 'ban pharmaceutical companies from financially supporting any scientific or medical education meetings for doctors'. He states that 'pharmaceutical companies support close to 40% of postgraduate medical education in the U.K.', and concludes that this support will disappear if the Commission's proposals are adopted.

Postgraduate medical education in this country involves the supervised training of newly registered practitioners, via approved and inspected rotations, through specified examination, to accreditation and appointment to a career post. This operation is undertaken by NHS and university staff under the supervision of Royal Colleges and universities, and proceeds almost entirely independently of the pharmaceutical industry.

If Dr Griffin refers to continuing education of doctors, in particular to support of local seminars, study days, special courses and so on, then certainly the industry has generously supported such events. However, if this support 'is not related to the promotion of specific pharmaceutical products but is an expression of the industry's involvement in health care which recognises the need for continuing medical and scientific education amongst the medical profession' there is no problem. The industry can continue to make these funds available for general purposes to those responsible for postgraduate education at regional or unit level.

International scientific meetings are another matter entirely. These meetings, which may be attended by several thousand delegates, are used by the industry as launch platforms for new products in return for heavy sponsorship of the scientific and social programme. First, a company may buy space to give a display of its products. This is a specific marketing procedure which is unaffected by the Commission's proposals. Second, a company may pay for a hall to give a company-sponsored symposium. This will normally consist of a series of papers by experts of up-to-date review material together with some papers to illustrate the qualities of a new or relatively new drug. The company pays the travel and hotel expenses of its speakers, usually with some form of honorarium. These symposia are partly educational, partly promotional. It may be impossible under the new proposals for a company to make such payments to individuals. Third, a company may provide travel and hotel expenses, and sometimes registration fees and free tickets to parts of the social programme, for delegates who may not be taking an active part in the programme. These initiatives are taken at local (national) level. A large company may sponsor some hundreds of delegates in this way. This will not be permissible under the new proposals. If so, international meetings will be smaller. Fourth, a company may