

REFERENCE

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GP training

As a trainers group that meet regularly to discuss issues with GP training in Shropshire we have spent much time recently discussing the suitability of the trainees entering vocational training (VTS). First, we have had some concerns over the standard of the undergraduate teaching from certain universities (sometimes even in the EU) where basic examination techniques and medical knowledge have not been thoroughly taught. Can we as GP trainers really be expected to cover the whole MRCGP curriculum, language, and communication issues as well as teaching all basic examination skills and medical knowledge in the 2–3 hours teaching we have each week? These problems may be avoided by a more detailed look at the candidate's undergraduate experience before allowing them onto the VTS. Perhaps for those deemed to have potential, a preparatory clinical period could be arranged before joining the usual 3-year scheme.

Second, we have found that some trainees do not possess the necessary communication and interpersonal skills to pass the CSA part of the nMRCGP. It has been shown that, statistically, certain groups of doctors are more likely than others to repeatedly fail the CSA, as we have witnessed locally. A trainee who has grown up in the UK must be at an advantage in understanding and using not only the words of language but also the colloquialisms and nuances of speech as well as broader cultural aspects. We understand that the UK does rely heavily on taking doctors from overseas to fill the gap in posts nationally, however, if the UK continues to award training places to doctors who may later struggle (despite their best efforts) we feel it would only be fair to offer increased support with language and communication skills when they are accepted by the NHS or at the latest when they start their specialist training. However, some of us doubt if this can easily be 'taught'. We wonder if the situation is similar over the rest of the country.

The selection process already seems to

have altered locally as the West Midlands Deanery did not fill all its vacancies on the GP training scheme in 2011 to avoid taking doctors who were unlikely to succeed. However, we would invite further discussion regarding these issues as we feel at present some of the trainees may have been treated unfairly. The consequences for them as individuals will be life long as they will be unable to work in general practice or retrain for any other speciality.

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Patience is always a virtue

I recently worked in my local general practice during my medical school holidays. The phlebotomist was due to take sick leave and I was asked if I would cover a few of the sessions. During my clinical training in hospital I had taken many blood samples and although slightly hesitant, agreed.

My first day went well: the patients were keen to talk to me about my training and my confidence improved. I called my last patient, a lady in her mid-50s with epilepsy and learning difficulties who was attending with her carer. Her carer noted that it may be a difficult task (the last two attempts to take her blood had been unsuccessful). I noted that she was on carbamazepine and her blood levels had not been checked for some time. The patient had capacity and understood the need to have her blood taken, but refused every time I tried. Repeated sugar bribes from her carer and encouragement from both of us was to no avail.

After 30 minutes I reassured her again and explained it really wouldn't be too painful. She then calmly held out her arm and with continued reassurance from myself let me take a blood sample. Upon reflection I needed the half an hour talking with her to gain her trust. During this time I learnt a lot about communicating with patients with learning difficulties and the

value of patience in addressing their emotional needs.¹ The role of GPs in addressing these needs and the skills required are key. A 30-minute consultation slot may be worth many 10 minute slots. Indeed, in this time I learnt valuable skills that will be useful, whatever area of medicine I choose.

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Out-of-hours primary care

John O'Malley's interesting editorial¹ raises many good points and will, I hope, widen discussion about the entire provision of out-of-hours (OOH) care. I believe that the government in 2004 gave away too much in reducing the 24-hour commitment at a time when locally organised cooperatives were already providing excellent care in many areas, tailored to the needs of those areas and not a national blueprint. I write as a former principal in practice for nearly 30 years and one now working limited sessions in OOH.

OOH needs to be seen as a distinct subspeciality of primary care requiring tailored training and appraisal programmes. This is of special importance at the outset of revalidation. 'Audit' (now an old fashioned word) is not really possible when the outcome of consultations and referrals is not available to the OOH doctor.

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