

outright despite being in receipt of GMC approved PDP plans and references from her new employer. A fourth company has agreed cover at the cost of £16 000 per annum.

The first three companies have been anonymously approached to provide their assessment criteria for return to practice applicants and copies of their policies for those on I&R schemes. None have yet responded.

She has now been waiting a month for a comment from the GMC on this position; their continuing delay in responding perhaps indicates that they do not have a policy of dialogue with medical indemnity companies, or to their own customer service commitment, that promises a reply within 10 days.

The country is desperately short of doctors experienced in primary care and particularly short of mature doctors who have met the most recent and rigorous standards for practice through their professional body, the RCGP, and its Returners Scheme.

Surely it cannot be true that medical indemnity companies have more influence than the GMC on return to practise for the UK's GP workforce.

The Author can be contacted via the BJGP office

This letter was sent to the General Medical Council, the Medical Defence Union and the Medical Protection Society all of whom declined to comment.

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As the government launches its consultation on medical performers list (MPL) regulations, it seems timely to review the assessment of those returning to UK general practice after a period away from clinical practice. An issue that causes considerable controversy.¹

The evidence of specific patterns of deterioration of clinical skills after absences from the workplace is thin, and not directly applicable to primary care.² Practitioners vary both in their baseline clinical knowledge, and in the rate of deterioration during their time away.

Severn Deanery launched a 'Returners' Scheme' in 2007.

Entry is restricted to those out of practice in excess of 2 years. It includes a structured interview with a senior GP educator, and a national computer-marked knowledge test and simulated surgery. Each is standard set by experienced GP trainers following international best practice. Applicants are

Table 1. Severn Deanery induction and refresher scheme activity — 2007–2012

	Time away from UK general practice, years		
	2–5	5–10	>10
Total Number Assessed	17	17	13
Competent	5	1	0
Shortened scheme	7	6	1
Full Scheme	4	9	4
Fail	1	1	8

MPL = medical performers list. Competent = passed comfortably with good scores in all domains. Letter of support for return to MPL. Shortened scheme = borderline result. Short, typically 6–13 week, attachment to training practice with workplace based assessments (WPBAs) before letter of support for return to MPL. Full scheme = weak scores with extensive learning needs. Full training programme (6 months) and comprehensive WPBAs before letter of support for return to MPL. Fail = learning needs beyond the scheme's capacity and patient safety standards for supervised practice.

required to achieve a minimum entry score before progressing (Table 1).

A recent review of the scheme provides some evidence of the educational value of the programme.³

Primary care organisations are responsible for ensuring that the competency of practitioners admitted to their MPL. Our data suggests that many are not, after 2 years away from the workforce. This proportion increases with additional time away.

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Work and health reforms unattainable?

The recent editorial encouraging the integration of occupational health and primary care¹ was inspirational but seems a long way from any reality in England.

When Dame Carole Black reported her findings and proposals on work and health it was difficult to resist the rhetoric. Work is good for you in determining your self and worth as long as the work is 'good'.

Charles Handy² describes the characteristics of organisations and individuals in organisations using four dimensions, four Greek Gods as their embodiment, and how the cultures they represent interact and have impact upon individuals within the organisation. He describes how social values and expectation have changed from the post war acceptance of authoritarian structures/organisations (The God Apollo). Increasingly we all want to be valued and have a share in the 'fruits' of our collective effort (The God Dionysius).

In the context of health and work, he describes how the great efficiency driver of Apollo, the bureaucratic organisation, so devalues the members that they resort to disruptive behaviour and demonstrate ill health. In Apollonian organisations, where members have little control or discretion about the work, the impact cannot be good,

that is, good work is squeezed out. This undermines Dame Black's central tenet. If getting clients back to work is to succeed the work has to be good or else it results in further dysfunction and ill health. The challenge of her work requires a revolution of workplace culture to humanise the workplace without compromising its viability.

This editorial reinforces my experience in general practice that change will not be achieved by indoctrinating/forcing GPs to fill in a different form (Med3) in the hope that employers will do what is right and good for the client.

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Audit awareness among practices

Ken McLean states that a 'basic lack of awareness of basic audit Methodology' is 'especially concerning as the ability to carry out a full audit once every 5 years is a requirement for revalidation'.¹

As part of the Appraisal Team in Kent and Medway, closely involved in the preparation of GPs for revalidation, I would like to draw attention to the GMC Guidelines for supporting information for appraisal and revalidation. It uses a clinical audit as one of five examples of supporting information that can be used in the section 'Quality Improvement Activity'. It may well be that certain members feel that a full audit cycle is the only way to demonstrate quality improvement but the requirements for revalidation can include various other methods of reviewing and assessing one's practice and how one is improving year on year.

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ME/CFS and *Blastocystis* spp or *Dientamoeba fragilis*, an in-house comparison

In their Global Health editorial *BJGP* (October) on exotic infections, Behrens and Coltart did not mention the more mundane high prevalence of protozoal infections in warmer climates.¹ We caught the anaerobic protozoa *Blastocystis* spp and *Dientamoeba fragilis* in Burma, however they are already common in UK, but little known to practitioners.

Blastocystis was the most common enteric parasite (6.9%) found in routine stool samples in a study in Wales² and *D. fragilis* was found in up to 16.9% of samples submitted to alternative practitioners.³ However, the detection of both parasites is difficult and requires specialist laboratories; even then they may not be found. Faeco-oral seems their likely mode of transmission.

The pathogenic nature of *D. fragilis* is now more accepted,⁴ but two forms are known,⁵ while nine different subtypes of *Blastocystis* have been reported, observed disorders appear to be subtype dependent.⁶ Both protozoa have been linked to IBS.^{7,8}

Treatment of *Blastocystis* is varied and metronidazole has shown resistance.⁹ For *D. fragilis*, only secnidazole¹⁰ and paromomycin¹¹ gave very low treatment failure rates. Although both medicines are old, and both are registered and used within the EU, neither is registered for any use in UK.

My wife and I presented common severely debilitating symptoms of chronic fatigue and inability to concentrate for extended periods. I initially had severe diarrhoea, followed by soreness in the lower bowel, while my wife showed almost no intestinal disturbance or discomfort, however when we both had the same diet, the symptoms were the same. Later, headaches became more prevalent. The addition of milk (2% fat) plus cereals, particularly wheat based, increased the bowel disturbance. We had many blood and stool tests, with essentially no adverse findings. After many months and over 10 stool samples from each, I was diagnosed with *D.*

fragilis and my wife with *Blastocystis*. Both had been found by microscopic examination of preserved stained specimens.

The parasites were treated: *D. fragilis* with paromomycin (750 mg tid) for 10 days (28 mg/kg) and *Blastocystis* with nitazoxanide (500 mg bid) for 3 days. Bowel disturbance continued for several weeks in both patients.

Our experiences, although limited, do offer direct comparisons between the parasites and support the conclusion that both can be pathogenic and the effects of both organisms can be similar, giving the ME (myalgic encephalopathy) symptoms of chronic physical and mental fatigue, with bowel disturbances related to cereal/milk diet. However, for patients and practitioners, the biggest problem is lack of efficacious approved drugs in UK.

I wish to thank the laboratory staff in the Department of Medical Parasitology at the London School of Hygiene and Tropical Medicine for making the diagnoses.

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