nMRCGP/JCPTGP exam by demonstrating only 2 years in hospital posts, plus 1 year in GP-land, plus passing the exam, BUT many trainees in practice recognise that this is a basic core requirement, not a maximum requirement, and indeed, so do many potential
GP-employers.

Until very recently, secondary care specialists (in other words, all specialists other than GPs) were appointed by people outside of their speciality, or even outside of medicine, but new GPs were appointed by other, senior, GPs, well-versed in their same speciality (except of course in ancient times, when anyone who failed to successfully complete medical or surgical training could set up as a GP, but even then might not do so well at it!). Still, even now, the majority of new GPs are employed by more senior fellow professionals, who supervise them to a varying extent (according to need) for varying periods of time. Most new partners start their partnership life as junior partners. But back to training length. I am not sure I know any of my contemporaries who went from a minimum length training scheme into a senior GP job!

I myself did two posts as house doctor of very good experience level I believe, followed by an additional 6 months in A&E, before entering a '3-year' scheme; following that I took additional posts in general medicine, A&E, a full year in paediatrics with O&G, 22 months in joint A&E with medicine, rehab, and a little surgery at senior hospital doctor level, and then 18 months locum GP work. I then joined a (training) practice part-time while still doing locum work for another year, before becoming full-time in a rural training practice with responsibility for covering A&E and acute care, later moving to include in my portfolio posts, as representative on the LMC and RMC. If I were looking for a new partner for our practice now, I would be looking for well-rounded and additional experience beyond the minimum required to ENTER for the nMRCGP exam. Of course, now the exam includes modules in audit and videoing, it is often found that trainees cannot complete all the modules during the 'minimum-duration' scheme, and very many do additional posts while completing the exams. Taking into account the recent changes that mean all medical graduates now do 2 years at pre-registration level, I think this means that many will complete GP qualification with experience and study similar to that of hospital specialties, if not more. Trainees are putting in a lot of extra work towards examinations in their own time, and gaining experience outside of approved scheme posts, because they feel it is needed (and so do their potential employers). With this situation driving the quality, and indeed the (un-measured) length of an actual GP's training, I feel the preservation of flexibility in the system is a huge bonus: it encourages maturity in self-directed learning and evaluation (at least when properly encouraged) that fits trainees well for the continual educational development they will face in real general practice.

An argument used all along against lengthening GP training is the fact that hospitals want to hijack the extra compulsory time to get more cheap service provision work out of trainees, while I, and many others, remain convinced that this is still a significant risk.

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REFERENCE

1. Jones R. Questions for the GP curriculum. *Br J Gen Pract* 2010; **60(574):** 314.

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Frontline innovation is free but not easy

Delaney's final conclusion on his editorial on cutting-edge information technology struck a chord with my work over the last 8 years. He suggested that in the future such IT will have to be freely available and with universal standards.[1] So far I have received no monetary grants for my work and have made my ideas and programs freely available to other like-minded GPs.

My first frontline idea incorporated the reasons for drug use on the repeat prescription screen of the IT system. This modernises the delivery of medicines and is described in detail on the website,[2] it is called clinical indications. The second idea (shared with my specialist practice nurse) was the development of a smoking calculator to calculate a pack-year number, that is, overall total smoking exposure for individual patients. This can be difficult to do due to changing smoking patterns and remembering the basic pack-year calculation. This calculator has been given freely to all on the web[3] and there is an embedded version within general practice IT systems. This is available from Informatica Systems (Contract Plus module) and has in-built disease associations. Our names are on our calculator for standardisation purposes and this may be the first working frontline team to have their names actually shown within the modern general practice IT system! My most recent general practice program is a children's dose calculator for using liquid dexamethasone in croup. The latter is available free on contacting my email address. Fortunately, through prize money from national competitions, I have been able to set up websites and develop my ideas, but at times this can be a stressful and unpredictable way to get the necessary funding!

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REFERENCES

1. Delaney B. General practice at the cutting edge of information technology, or failing to keep pace? *Br J Gen Pract* 2010; **60(573):** 239–240.
2. Masters N. *Learn about clinial indications.* www.clinicalindications.com (accessed 11 May 2010).
3. Masters N, Tutt C. *Smoking pack years.* www.smokingpackyears.com (accessed 11 May 2010).

DOI: 10.3399/bjgp10X502245