

Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to journal@rcgp.org.uk (please include your postal address). Alternatively, they may be sent by post as an MS Word or plain text version on CD or DVD. We regret that we cannot notify authors regarding publication. Letters not published in the Journal may be posted online on our Discussion Forum. For instructions please visit: <http://www.rcgp.org.uk/bjgp-discuss>

Future recruitment of GPs to deprived areas

It was interesting to read Jacky Hayden's editorial where she said, 'future recruitment of GPs to deprived areas will need sustained action'.¹ She is correct, but I am afraid the answer is partly to do with the 'm' word: 'money'. I am painfully aware that medical royal colleges, because of their charitable status, are reluctant to go near 'pay and rations' issues; that is the job of the British Medical Association. However, when pay and rations get to the point that patient care and medical standards are at risk of starting to fall, then maybe medical royal colleges should say something?

It is already in the public domain that a GP with just a General Medical Services contract earns about £20 000 per annum less than a dispensing GP for the same sort of list size, who, by definition in England, are all in rural practices. Working where I do, in an island of deprivation in the centre of an otherwise relatively affluent central southern England, I see a lot of colleagues struggling with an unacceptably high workload for a below average remuneration.

Why is the workload high? Well, we all know that deprivation is linked to pathology, with the Quality and Outcomes Framework (QOF) really not covering the issue properly as we have a high number of defaulters, who cannot always be exception reported (I even hear stories of exception reporting being forbidden in the future!). Add to that the large number of social problems that somehow end up at the GP's door yet attract no QOF points, such as long-term sickness certification, endless requests for letters for appeals

against refusal of benefit, letters regarding housing problems, substance abuse issues, the general 'GANFYD' (get a note from your doctor) society we live in, and one can see why the workload in deprived areas is high and demanding. In Germany, where primary care doctors are paid per consultation, the problem is getting GPs to work in the country areas, as the rural, relatively healthy, population go to the GP less often and income therefore falls.

I am writing this on a Sunday, knowing that already I have 20 patients booked in for tomorrow morning, and 16 for the evening. I shall probably do three visits, and perhaps handle about 16–20 telephone consultations in the day, as well as deal with the usual lab results and scanned letters. I am sure that is a familiar scenario to many urban GPs. For my four-and-a-bit days of work a week, I shall be earning a take home pay before tax of about £70 000 this year. A lot less than the *Daily Mail* headlines. I stay where I am because I work with a great bunch of doctors and staff, and because it currently suits me, but as I get nearer to retirement, the thought of leaving the NHS and going to do long locums in Australia for a couple of years becomes more and more attractive; especially with the current exchange rates. Why would any newly qualified GP want to come and work in an urban environment if they can get a post in a rural/semi-rural practice, or a post in a relatively affluent town?

I am aware that rural communities have their own problems and some degree of deprivation, but where I live just north of Southampton, 'deprived' means you drive a 6-year-old Mondeo rather than a Mercedes. 'Jealous, moi?' No — perhaps just a bit jaded, and fed up at hearing, from some colleagues who should know better, terms like, 'failing urban practices' as a fairly broad-brush term.

John Glasspool,
GP, Victor Street Surgery, Shirley,
Southampton SO15 5SY.
E-mail: john.glasspool@gmail.com

REFERENCE

1. Hayden J. Strengthening general practice in deprived localities. *Br J Gen Pract* 2010; **60**(580): 797–798.

DOI: 10.3399/bjgp11X549027

Selecting GP speciality trainees: squaring the circle?

Irish and Patterson's discussion paper reviewed the current pathway for selecting GP speciality trainees. They ask how it can be improved.¹

Despite Mencken's caution that 'for every complex problem there is an answer that is clear, simple, and wrong',² maybe there is an easier way.

The current structure (The National Recruitment Office for GP Training), the process (a single standardised recruitment system), and the specific outcome (successful completion of GP speciality training), coupled with continuing attempts to improve the process could make the journey to becoming a GP less of a maze and more a motorway to success.

The ideal selection outcome is that the recruited GP subsequently provides high quality care throughout a 30-year career. An optimal outcome may be that the GP provides high quality care for 5 years and then passes revalidation. The minimum outcome is that the GP passes the MRCGP licensure examination by the end of 3 years of training. However, low pass rates in the Clinical Skills Assessment (CSA) module of the MRCGP examination suggest that either the selection process is