

flawed, or that the CSA is not a reliable, fair, and valid test. The flaw in selection may be that it is impossible to reconcile the need for the recruitment process to fill all the training posts every year, and ensure that all these recruits pass the MRCGP examination within their 3 years of training. Any worries that the MRCGP examination is not a good test of competence needs to be addressed by the Royal College of General Practitioners (RCGP).

Although the RCGP has always wanted a longer training scheme, the recruitment process needs to select candidates who are likely to pass the MRCGP exam within their 3 years of training. The Mencken-defying improvement may be to link their selection to the results of taking real or mock modules of the MRCGP examination. These modules could be taken online at a convenient Applied Knowledge Test examination centre, remotely by reviewing the candidates' existing ePortfolios including work-place based assessments, and by a CSA at nearby GP-training practices. The candidates could pay a fee to take these assessment modules. Only those candidates with qualifying scores would be eligible to apply for GP training.

The results of these tests could inform the training of recruits to improve their chances of success in the MRCGP exam. Weaker candidates may need a few attempts over a couple of years to qualify for GP training. Perhaps the best of these weaker candidates could be offered any unfilled training posts on an ad hoc basis, but they would not be in the 3-year GP training scheme.

Educators and learners may be reluctant to concentrate their efforts on passing a test, but the RCGP – GP curriculum statements already point in this direction. The RCGP regularly updates a curriculum that describes what a GP needs to be able to do to work in general practice for the first 5 years and conducts a membership examination that should be a reliable, fair, and valid test of that ability. After the first 5 years, the RCGP's (and General Medical Council's) regular revalidation should ensure that GPs have the competencies to practice for the rest of their careers.

Mencken also advised 'a judge is a law student who marks his own examination papers'.² This may describe the continuing difference between our confidence and competence in our assessment of the ability of others.

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Jumping (or being pushed) from maternity care?

I read with interest the recent editorial entitled 'Jumping (or being pushed) from maternity care'.¹ The overall conclusion that GPs should still play a role in maternity care is something that is echoed by the findings of a recent study I undertook following the Kings Fund report entitled, 'The role of GPs in maternity care — what does the future hold?'.²

I issued a postal questionnaire to 50% of GPs ($n = 338$) in the Leeds PCT, in the north of England; 65% ($n = 200$) replied. The aim was to elicit the views of GPs on their role in maternity care. Of the GPs, 61% ($n = 134$) 'disagreed' with the statement that they had a major role in the care of a pregnant woman, 11% ($n = 24$) 'strongly disagreed'.

The editorial by Jewell stated there is a trend to omit obstetric content in postgraduate GP training programmes,¹ a finding that was confirmed in my study. Forty per cent ($n = 88$) of GPs felt that they do not have adequate current knowledge of maternity care and many stated that they have become deskilled as maternity care has been taken over by midwives; 71% ($n = 145$) felt that the best

way to gain up-to-date knowledge would be to attend a postgraduate course; and 17% ($n = 35$) suggested an e-learning scheme, as this would allow them to work through the programme at convenient times, and they would gain certification on completion.

In his editorial Jewell stated that 'even if midwives assume responsibility for all routine care, there will always remain the possibility of GPs being presented with obstetric emergencies'.¹ Many GPs who replied felt that it was important that they were still involved in maternity care, so they are able to recognise difficult cases and deal with them adequately.

This is an important topic and I would strongly recommend a larger study to see if my findings can be duplicated on a national scale.

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Community orientation in education

Higher education is already feeling the effects of funding reductions, and medical education is likely to be squeezed too. It is crucial that medical educators demonstrate the quality and value of graduates and show that 6 years of extensive experience for young people in the highest academic bracket produces a workforce of considerable and unique value.

Rees and Stephenson write¹ that there is a continuing move for more health care to be delivered in the community, requiring more qualified doctors working in the area, leading to an increase in the proportion of the graduates training for

general practice. The career aspirations of students change during training and after graduation and are affected by their experiences and by the role models they encounter. Students need to experience these environments early and through their undergraduate training.²⁻⁴

The apprenticeship model of general practice teaching also has its advantages and must remain a key element of training. Environmental, social, and economic crises put a great responsibility on medical educationalists to prepare young doctors and strengthen their resilience and resolve to face these challenges.

The General Medical Council with the latest version of *Tomorrow's doctors* underlines a danger that undergraduate assessment would become more a record of competency than that of understanding and a broad education.⁵

The development and assessment of professionalism would allow wider thought on behaviour and reflection. In this context we must simply underline and reinforce what The European Academy of Teachers in General Practice and Family Medicine (EURACT) did, and what the Royal College of General Practitioners agreed.

In the European Definition and the EURACT Educational Agenda we fully describe the comprehensive, community orientation, and holistic aspects.⁶ We have these documents and we must use them to define clearly the actual and future family doctor. We need to be guided and helped to teach these topics, and assess the level of learning by students who are the next family doctors in the community.

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Self-monitored blood pressure measurements

I wish to make a few comments on a paper published in the September issue of the *BJGP*¹ that question its methodology and, therefore, the reliability of its conclusions.

First, the number of patients is small at 163 participants. This study is a secondary retrospective analysis of data from a failed clinical trial of a herbal product (asparagus) that was being tested for an antihypertensive effect.¹ The participants were not randomly selected from the population, but were recruited by advertisements and word of mouth. The assessments occurred in 'a small city-centre clinic'.

Second, I have searched the British Hypertension Society list of validated home blood pressure measurement devices and cannot find the 'Boso-Medicus Prestige' device that was used in the trial. Is it possible that this machine has not been clinically validated and, therefore, may be inaccurate?

Third, I have not seen the coefficient of variation used in other blood pressure studies. I suspect that it was used here mainly to reduce the level of variability of the results and, therefore, help to get the figures to look more respectable.

Fourth, Table 3 is very difficult to understand with the columns showing duration of monitoring, and the rows displaying intervals.

Last, in the discussion section it is worrying to see that the authors try to explain their findings using a made up 'example' rather than using data from the trial to explain itself.

For all these reasons I do not believe

that the unusual findings from this trial are real and applicable to my patients.

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Diagnostic classification in patients with deep venous thrombosis

I enjoyed and learned from the paper in the October issue comparing GPs' judgement with the Oudega decision rule for referring patients with suspected deep venous thrombosis for ultrasonography.¹ One technical point about the Oudega rule variables puzzles me (see Table 1). The caption to the Table states, 'The score could range from 0 to 14...'. The heaviest weightings are given to abnormal D-dimer results (6 points) and calf swelling ≥ 3 cm (2 points). The six remaining variables are weighted as one point each. Scoring on all eight variables indeed produces a score of 14, but to do so a patient would need to be of male sex and also use oral contraceptives.

Perhaps the range of the Oudega rule should be stated as 0 to 13, with one point scored for male sex OR oral contraceptive use.

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