Letters

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Revalidation

Greenhalgh and Wong's editorial[1] on revalidation is timely and important. I have just completed a so-called 'Strengthened Medical Appraisal' or SMA, and found the experience not only infuriatingly clumsy in terms of its online functionality, but pathetically irrelevant to my own sense of what it is to be, I hope, an adequate GP. And, just as Greenhalgh and Wong foresee, the requirement for this annual exercise is very likely to dissuade me from continuing in practice part-time following my retirement in May.

At the heart of the appraisal process is the matching of 'supporting information' to 12 'attributes' clustered into four 'domains', the idea being that by filling in all the gaps over the 5-year revalidation cycle one thereby demonstrates oneself to be a fully-rounded and competent practitioner. Each year the 'personal development plan' is designed to fill in the missing gaps, while conscientious 'reflection' serves to consolidate the learning process. The problem, for me at least, is that this approach bears absolutely no relation to how I have spent my past quarter-century.

I believe myself to have internalised professional standards, imbued through training and subsequent experience, that I would find difficult to put into words (although I did try a few years ago[2]), but whose maintenance is a matter of personal pride. I expect to be judged by colleagues and patients, and like to think that I am aware of my shortcomings. As for my professional development, I have pursued various interests down the years, including a spell as a trainer, but rarely have I had a clear plan; chance and opportunity have played a greater part.

By all means let us build audit, significant event monitoring, and some form of feedback into our practice organisation; and let us admit that a regular objective test of our knowledge-base should be a requirement to continue in practice. But let's not allow ourselves to be cowed into the bureaucratic, prescriptive, painting-by-number exercise that is currently being foisted on us.

I cannot resist ending by pointing out that SMA is also the name of an infant formula. Coincidence or rich irony?

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Trainees working in psychiatry

We welcome the attention to psychiatric training for future GPs, that seems important when there is still no requirement for trainees to undertake these placements.

However, we are concerned that the advice by Burkes *et al*[1] focuses too much on the minutiae and risks missing the real skills that they may need for a career in general practice. These include:

- To understand that the specific health needs of those with severe and enduring mental illness. This group has poor health outcomes exacerbated by lifestyle choices and the same medication that contributes to the improvement in their mental health.[2] There is a need to develop ways to tackle this major issue by working in partnership with secondary mental health care.
- To develop skills in assessing risk effectively in a short period of time, knowing when to continue to manage situations in a primary care setting, and when to involve mental health services.
- After a number of years of specialisation of mental health services, the awareness and understanding of the care pathways, and interlinking of different teams is vital knowledge.
- Mental health, perhaps uniquely among other medical specialties, offers trainees a chance to work in truly multidisciplinary services when medical knowledge is counterbalanced and enhanced by other professions and their expertise.

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Questionnaire severity measures for depression

The paper by Leydon *et al* illustrates the continuing tension between two important elements of generalism: the biotechnical (use of the measures PHQ9 or HAD-D introduced as part of QOF) that the authors refer to as 'hard technology', and the biographical (a narrative-based approach to diagnosis, based on the patient's context) referred to as 'soft technology'.

Concern about the current extent of the contractual focus on QOF, and its potential to undermine the strength and complexity of the doctor–patient relationship, that supports quality at a deeper level, was one of the drivers behind the 'Essence of General Practice' project led by RCGP Scotland. This concern is confirmed by Leydon and colleagues in their paper when they suggest that, in some cases, the use of these tools causes dissonance within the consultation and may in some way 'trivialise' the consultation. However, the article also provides some reassurance that the evidence-based debate on the merits and problems associated with some