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GP training

As a trainers group that meet regularly to discuss issues with GP training in Shropshire we have spent much time recently discussing the suitability of the trainees entering vocational training (VTS). First, we have had some concerns over the standard of the undergraduate teaching from certain universities (sometimes even in the EU) where basic examination techniques and medical knowledge have not been thoroughly taught. Can we as GP trainers really be expected to cover the whole MRCGP curriculum, language, and communication issues as well as teaching all basic examination skills and medical knowledge in the 2–3 hours teaching we have each week? These problems may be avoided by a more detailed look at the candidate's undergraduate experience before allowing them onto the VTS. Perhaps for those deemed to have potential, a preparatory clinical period could be arranged before joining the usual 3-year scheme.

Second, we have found that some trainees do not possess the necessary communication and interpersonal skills to pass the CSA part of the nMRCGP. It has been shown that, statistically, certain groups of doctors are more likely than others to repeatedly fail the CSA, as we have witnessed locally. A trainee who has grown up in the UK must be at an advantage in understanding and using not only the words of language but also the colloquialisms and nuances of speech as well as broader cultural aspects. We understand that the UK does rely heavily on taking doctors from overseas to fill the gap in posts nationally, however, if the UK continues to award training places to doctors who may later struggle (despite their best efforts) we feel it would only be fair to offer increased support with language and communication skills when they are accepted by the NHS or at the latest when they start their specialist training. However, some of us doubt if this can easily be 'taught'. We wonder if the situation is similar over the rest of the country.

The selection process already seems to have altered locally as the West Midlands Deanery did not fill all its vacancies on the GP training scheme in 2011 to avoid taking doctors who were unlikely to succeed. However, we would invite further discussion regarding these issues as we feel at present some of the trainees may have been treated unfairly. The consequences for them as individuals will be life long as they will be unable to work in general practice or retrain for any other speciality.

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Patience is always a virtue

I recently worked in my local general practice during my medical school holidays. The phlebotomist was due to take sick leave and I was asked if I would cover a few of the sessions. During my clinical training in hospital I had taken many blood samples and although slightly hesitant, agreed.

My first day went well: the patients were keen to talk to me about my training and my confidence improved. I called my last patient, a lady in her mid-50s with epilepsy and learning difficulties who was attending with her carer. Her carer noted that it may be a difficult task (the last two attempts to take her blood had been unsuccessful). I noted that she was on carbamazepine and her blood levels had not been checked for some time. The patient had capacity and understood the need to have her blood taken, but refused every time I tried. Repeated sugar bribes from her carer and encouragement from both of us was to no avail.

After 30 minutes I reassured her again and explained it really wouldn't be too painful. She then calmly held out her arm and with continued reassurance from myself let me take a blood sample. Upon reflection I needed the half an hour talking with her to gain her trust. During this time I learnt a lot about communicating with patients with learning difficulties and the value of patience in addressing their emotional needs.[1] The role of GPs in addressing these needs and the skills required are key. A 30-minute consultation slot may be worth many 10 minute slots. Indeed, in this time I learnt valuable skills that will be useful, whatever area of medicine I choose.

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Out-of-hours primary care

John O'Malley's interesting editorial[1] raises many good points and will, I hope, widen discussion about the entire provision of out-of-hours (OOH) care. I believe that the government in 2004 gave away too much in reducing the 24-hour commitment at a time when locally organised cooperatives were already providing excellent care in many areas, tailored to the needs of those areas and not a national blueprint. I write as a former principal in practice for nearly 30 years and one now working limited sessions in OOH.

OOH needs to be seen as a distinct sub-speciality of primary care requiring tailored training and appraisal programmes. This is of special importance at the outset of revalidation. 'Audit' (now an old fashioned word) is not really possible when the outcome of consultations and referrals is not available to the OOH doctor.

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GPs at the Deep End

These 12 articles[1] and Watts'[2] concluding editorial have been inspirational, and for us, like others,[3] have helped validate our experience over a professional lifetime of serving in a deprived post-war peripheral council estate where there were 'very few easy cases'.[4] We recognise each characteristic cited by Watts, as being a true reflection of issues faced by all patients at the Deep End, and the teams who serve them.

Watts *et al* convincingly make the case, again, for additional healthcare resources to deal with the number, severity, and complexity of health and social problems at the Deep End, that are difficult to address with standard resources and in standard consultation times.[5] Despite the shorter life expectancies, and many more years in poor health before death, endured by Deep End patients, any additional healthcare resources directed to Deep End populations do not reflect the additional, potentially preventable, morbidity and premature mortality.

An answer to this mismatch of need and resource is to engineer longer consultation times in deprived areas, either with doctors, or with nurses able to handle the complexity of multiple morbidity, and this model would fit the opportunistic nature of the work. This requires political will and professional support, rather than opposition.[6] It is telling that the *Black Report*, in 1980, was released in small numbers on a Bank Holiday weekend, and that this important series of articles from GPs at the Deep End has, to date, generated only three letters to this journal. The blind spot to which Watts refers is real. His point that Tudor Hart's Inverse Care Law is a man-made construct, that restricts access to care based upon need, is well made. The point, as he says, is not that poor areas get bad GPs while rich areas get good ones, but that good GPs in poor areas are prevented from maximising what they could do by failure of provision of the resource that would give the deprived 'an average chance of health'. The issue is not doctor workload, but resource to reach all the potentially treatable morbidity.

Twenty-one years ago we wrote a series of articles for this journal (they appeared in *Connexions*) about the need to target resources to the 'forgotten areas of deprivation' to give our patients an 'average chance of health'.[7] Over 65 years, between us, of service within socio-economic deprivation, it was our clear experience that advocacy on behalf of the health resource needs of patients, needs to be a constantly repeated teaching theme. Resource providers start out not understanding, learn in dialogue, then move on and the educational process has to start all over again.

The mutual support that Deep End group participants have experienced is relevant for Deep End workers everywhere. The involvement of policy advisers from the Scottish Government Health Directorate is important. We look forward to hearing more about the trajectory of this initiative. As Watt says: 'addressing the Inverse Care Law is not rocket science', but it is vital to the health of deprived patients. Would that a similar group could establish itself south of the border.

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Patients' views of pay for performance in primary care

In the results section of their research into 'patients' views of pay for performance in primary care'[1] Hannon and colleagues state that, 'the majority of patients were surprised to hear their practice received bonuses for doing "simple things"'. This is a fundamental misconception. The money intended for potential QOF payments was taken out of the guaranteed/secure income to practices and is then paid only on achievement of certain agreed targets. And no one is going achieve 100% so not all the money was ever going to be paid back. Thus QOF payments are in no way 'bonuses': overall the scheme is of pay deductions for not achieving the desired targets. In fact in our practice, payments for QOF achievements equal, in very rough and ready terms, half of partners drawings, so in a very real sense if we don't achieve we don't get paid. Let patients understand the system as 'pay for performance', OK, but, please, not as bonuses.

But things are worse than that. In order to make sure that the targets are achieved GPs often have to create new systems, new clinics, or anyway do more work, and this costs the practice something, hopefully at least paid for by the QOF-related income. Yet now some QOF targets are being 'retired' on the grounds that change has been secured, achievement is the norm. We are expected to carry on with the work needed to carry on the achievement, yet suddenly it is not being specifically funded any longer. The only way for this not to be a net financial loss to a practice is to make 'efficiency savings' somewhere else, or simply stop doing something else. Moreover new targets introduced will mean more new work, and cost.

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