Not just another primary care workforce crisis ... [letter]

I write in support of David Berger's articulate challenge to the policies of the Committee of General Practice Education Directors (COGPED)[1] over its relicensing of GPs returning from abroad after working within comparable health systems. As the former chairman of the Joint Committee on Postgraduate Training for General Practice (JCPTGP) who presided over the original introduction of summative assessment, a member for 14 years of the General Medical Council (GMC) and a former UK Council member of the College I offer an opinion founded upon experience of such matters.

One of the abiding principles of professional regulation, if it is not to be overbearing and attract profligate opportunity costs for both the regulator and the regulated, is the concept of a risk-based approach to the validation of the necessary skills and knowledge required for general medical practice. This is, or should be, something that is applied to the process of revalidation that the GMC plans to introduce over the next 12 months.

Berger has made several prescient representations to the GP community over recent months that should be heeded lest we experience the unintended consequences for the English workforce he sensibly predicts.

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Competing interests

David Berger and I are both non-executive directors of BMJ Publications Group Ltd.

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Dr Berger produced an excellent letter in May's Journal asking pertinent questions regarding experienced UK trained GPs who have worked abroad in a 'first world' setting for a few years.[1] Consequently having to remain unpaid in limbo and having to jump through hurdles of unproven value to be allowed the privilege of working in the NHS again. This was a succint argument with questions to COGPED and it was very noticeable that Purvis and Irish replied to a second more generalised letter on first name terms and ignored his salient points.[2]

Having worked for a short time in Canada I am well aware of the high standards of GPs there, many of whom have a much wider range of clinical skills than we offer in the UK. The system of revalidation is certainly as useful as here without the layers of computerised bureaucracy.

Cynically one could ask if it is a deliberate policy to discourage doctors working abroad for longer than a year or two.

In the light of the more pragmatic approach in Wales and Scotland would it not be possible to develop a clear national consensus before we lose a cohort of talent to the old Commonwealth?

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Privatisation: an exercise in ambiguity and ideology

I am astonished to read the assertion in the second paragraph of this article that 'the primary purpose of the NHS is to provide citizens with income protection in times of illness'.[1] Our primary purpose is to provide people with health care.

Moreover, Maynard's assertion is unsustainable, since the majority of people who access the NHS have no income that requires 'protection', being children or in receipt of either pensions or benefits.

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Author's response

The provision of a universal system of health care free at the point of consumption is made possible because the NHS provides income protection for patients. Regardless of their ability to pay we treat patients ideally on the basis of need, defined as the comparative cost effectiveness of treatments competing for funding. In countries where income protection does not exist (for example, The US and China) access to health care is based on the size of your wallet. If you adhere to a universalist ideology, which I do, income protection when ill is a primary objective of a healthcare system and this is epitomised by NHS and EU social insurance systems. Without this income protection, funded by taxes and payroll contributions, we would be unable to provide health care for all citizens.

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Integrated approach to prescribing education

Solomon *et al* discuss how strictly enforced prescribing guidelines can limit patient choice and may be detrimental to the doctor–patient relationship and shared decision making.[1] However, in their study many GPs employed a pragmatic approach, being flexible and applying guidelines in the context of individual patients. I feel that this is a skill that needs to start being developed early on in medical training.

The General Medical Council mandates that medical graduates must be able to 'prescribe drugs safely, effectively, and economically'.[2] Prescribing is one of the biggest leaps in the transition of a medical student to a doctor. However, a study done last year found that a large proportion of graduates entering the foundation programme felt under-prepared for prescribing.[3] Moreover, participants reported

that learning in an applied setting would be helpful and increase confidence in prescribing. A recent review demonstrated that current undergraduate prescribing education neglects important factors such as the social context of the workplace and the patient, hindering a real-life integrated approach to prescribing.[4]

Some medical schools have introduced a prescribing exam, and the British Pharmacological Society and Medical Schools Council are currently working together to introduce a national prescribing skills assessment for all graduating medical students in the UK. Having just undertaken my final exams I feel that existing assessments, including the prescribing exam and objective structured clinical examinations, mainly assess safe prescribing. I believe there is a place in the medical school curriculum for training to help students appreciate the 'real-world' applicability of clinical guidelines, including patient refusal, patient demand, and conflicting priorities. For example simulated training with actors and then with real patients on general practice attachments, acquiring feedback in the process, may be particularly beneficial. GPs who tutor students can also provide feedback on their progression in this domain across the attachment.

The art of negotiation and adopting a patient-centred approach to prescribing while practising safe evidence-based medicine is one that takes many years to acquire. Early training may be invaluable particularly for those with future aspirations in primary care.

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In preparing for the MRCGP[INT]

We congratulate Dr Ariffin on passing the MRCGP[INT] Brunei examination. She identifies the problems of an international assessment in family medicine; although there is a universal core to the specialty there are important differences between countries in patient's expectations of their doctor, communication styles, and ethical issues, such as consent and confidentiality, and the legislative framework of health and social care.[1]

We would like to take this opportunity to respond to the issues that she has raised and to clarify the purpose of the assessment.

We collaborate with local examination boards to develop an assessment that we accredit as being of equal rigour to the MRCGP UK examination.

Rather than being a generic international examination, each MRCGP International exam is set locally to reflect the particular epidemiology, population needs, culture, and healthcare system of that country. Our aim in doing this is to assist that country in strengthening both the role of family medicine within it and also local 'continuing medical education' institutions. Successful candidates become international members of the College.[2]

The purpose of the examination differs between countries; in Oman, Brunei, Kuwait, Egypt, and Malta it is an end-point assessment of vocational training. Additionally in Brunei the examination may be taken by candidates who have either worked or trained in family medicine elsewhere.

In Dubai, where many family medicine doctors are graduates from countries without postgraduate training schemes in family medicine, it offers an opportunity to demonstrate the quality of their work and further their career.[3]

The South Asia examination is a consortium representing India, Pakistan, Sri Lanka, and Bangladesh. Preference is given to family doctors across South Asia, as well as expatriate South Asian doctors working in neighbouring countries who intend to return to work in the South Asia region.[4]

Dr Ariffin highlights the challenge of taking the examination in regions where family medicine is undeveloped and there is little provision of vocational training or continuing medical education in family medicine. For many candidates the MRCGP[INT] examination has acted as a stimulus for learning where one did not exist before. Success often comes after a long period of self-directed preparation and international membership enables the College to support these outstanding colleagues in their continuing professional development.

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Competing interests

All authors are members of the MRCGP International Board and have been employed by the RCGP when acting as International Development Advisors and Examination Development Assessors.

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Correction

In the print version of the following article, the year is incorrectly published as 2011 instead of 2012:

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