Letters

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Editor's choice

Hard chairs

I take a cushion with me when I visit the doctor. It is placed on the very hard plastic seat I now have to sit on. There are no arms to the new type of chair, the frame of which is metal. Without anything to ease myself down on to the seat or push myself up when leaving I have great difficulty as my knee and other joints are in a bad state and painful.

My own doctor and other GPs are opposed to the introduction of this type of chair. The reason for the change is hygiene — as cited by the health centre manager. I don't know why she would wish older, or any other disabled people, to experience this quite unnecessary pain and difficulty when for many, many decades a plain, two-armed chair has not been an extra hazard. Most chairs in the waiting room are now without arms and disliked by patients in general. Welded together, it brings people that much closer.

I feel this quest for hygiene is being taken out of all proportion and yet piles of magazines are available for anyone to leaf through. Surely they carry germs and in any case, germs can be airborne.

My uncle, a doctor in the regular army since WWI, and back from being a POW in Thailand after WWII, was astounded at the introduction of everything being sterilised for babies. (He was happy to see his first baby daughter playing with coal in the then usual coal bucket). His comment was 'People will not have natural immunity to anything soon'. He was CMO, Southern Command, Wilton, at the time of his tragic death.

I would be interested to know where this 'patient's chair' directive came from. I understand they are quite expensive.

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How much do trainers know about the CSA exam?

Despite the MRCGP having three components, GP trainees spend a lot of time worrying about, and preparing for the CSA. Anecdotal reports from them would suggest that there are significant differences in the amount and quality of support they get from their educational supervisors (ES) which is specifically aimed at this exam. Many ES assume that much of the preparation for it is done on the day release courses.

Despite the high pass rate for the exam in Severn (92% overall pass rate for all attempts in the latest statistics¹) we thought it would be interesting to find out how much ES actually know about the CSA (most of whom will not have taken it). At a recent ES conference we did a brief quiz to assess knowledge of the structure, cost, and marking criteria for the exam. Forty ES answered the quiz.

The results showed that 25% did not know what CSA stood for, although 90% did know about the exam format, and that it takes place at the RCGP headquarters in London; 63% knew at what stage of GP training the CSA could be taken.

Fifty per cent knew what the CSA cost, but otherwise greatly underestimated the cost. This was particularly true for the cost of re-sits (65% underestimated), and only 15% appreciated that there is a maximum of four times that the CSA can be attempted.

Perhaps more worryingly from the trainees' point of view, less than one-third knew about the marking domains and allocation of marks: obviously important to understand in order to give constructive feedback for CSA preparation.

Lastly, around 60% of ES thought that the pass mark was lower than it is, which was reflected in over-optimistic views about the percentage of candidates who pass the exam!

Overall, the above seems to reflect that ES are not aware of the high costs, lower pass rates, and limited number of re-sit attempts, all of which are obvious causes of concern to candidates, and why it looms so large in their ST3 year.

In terms of helping candidates with CSA preparation, lack of knowledge about how the exam is marked has implications for how effective ES feedback can be. The results of this mini-survey would seem to justify the anecdotal concerns of differences in support that candidates may receive from their ES, and is therefore an area that needs to be addressed.

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Should we charge for A&E?

I recently spent 3 weeks in Florence, Italy, in an emergency department at the regional trauma centre where, within a triage system of red, yellow, green, and white: white cases are non-urgent primary care complaints such as coughs, constipation, and earache. Patients over 14 years of age in this category are charged €25 when they have been seen, to discourage patients with non-urgent conditions, encouraging them to seek advice from their GP instead, and recouping the costs of unnecessary attendances.

With A&E attendances in the spotlight and NHS budget constraints such a topic of public debate, are we on the way to charging for some services? Would a charge for unnecessary attendances help to relieve pressure on A&E departments or

would it discourage patients from seeking help and put them at risk of harm? Would this just increase GP workload even more? Could it be that patient education, instead of charging, is the way to reduce unnecessary attendances? Are charges of this kind becoming inevitable in the NHS?

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Quality assurance of appraisal summaries

Objective assessment of whether doctors meet the General Medical Council (GMC) standards for revalidation^{1,2} is a new challenge. In Hertfordshire GP senior appraisers started to quality assure appraisals in January 2013 with the aim of ensuring that they were up to sufficient standard to enable the responsible officer to base revalidation recommendations on their outcomes. A quality assurance form was developed, and all appraisal summaries were allocated to one of seven senior appraisers to be checked against the form. After 3 months the senior appraisers were sent (without knowing it) the same appraisal summary to ascertain whether this process was accurate and objective. The results showed surprising lack of unanimity.

In some areas there was total agreement, for example: whether last year's personal development plan had been reviewed; whether it covered the scope of the doctors work; whether a balance of different types of educational activity was maintained; and whether patient and colleague surveys with reflection were present. However there were complete splits on issues that we had expected to be cut and dried. There were 5:2 splits on whether learning credits were discussed and verified, whether complaints/audits with review and reflection were present, and whether statements were objective and supported by evidence. There were 3:4 splits on whether last year's appraisal summary had been reviewed and discussed, and whether two significant events were present with reflection and learning points.

This is a work in progress. We have discussed these results and revised the wording and the statements on the QA form. Furthermore this is a tiny sample, of one appraisal summary and seven senior appraisers' views of it. However, revalidation is now with us, and our findings suggest that application of the GMC minimum standards for revalidation decisions may be problematic.

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The Wow test in quality

There is usually a Wow factor in the very highest quality. But there is often a Wow factor in the poorest quality. An editorial¹ that suggests that the RCGP first started to define excellence in 2008, focuses on a process of remuneration (the Quality and Outcome Framework) as the current zenith of quality measurement and wants more research so that the concepts of quality should be tested until a consensus emerges of the key domains of components, passes the Wow test.

In 1985 the RCGP *What Sort of Doctor* report was published. This followed 4 years of developing systems to assess the quality of care by matching individual performance against defined and agreed criteria of competence. In the same year, the College published a major policy document *Quality in General Practice*. Subsequently, and for the last 20 years, other RCGP quality schemes with evolving measures of

quality like the Fellowship of the RCGP by Assessment, the Quality Practice Award, and the Practice Accreditation Scheme have continued to do all that is suggested in this new paradigm. It was good idea in 1985 but it's not a new idea in 2013. All that remains is to convince government to reward these schemes that have 30 years experience trying to 'capture general practice quality in all its richness and complexity'.

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Measles targets and herd immunity

Measles epidemics occur in populations with sufficient numbers of susceptible individuals for each infected person to meet and pass on the virus to one or more other susceptible individuals. Herd immunity suggests that if enough people are rendered immune such meetings will be rare enough for the virus not to be passed on and the whole population to be protected. If immunisation rates for the population were high enough we should therefore prevent epidemics such as the current one in south Wales. So if general practice can and does deliver high measles immunisation rates from ages 2–5 years, why do we currently have a problem?

Unfortunately both the model of herd immunity and our immunisation rate markers are flawed. Human communities do not consist of randomly moving particles bumping into each other by chance, they cluster in social groupings. Equally just because 90–95% of 5-year-olds are immunised over a 10-year period does not mean that 95% of people under 15 have been protected. If unimmunised people move into a community the coverage will drop. Moreover if the newcomers cluster together they will form a subgroup at high risk of an outbreak.

In our small inner-city practice in an area of high turnover and immigration,