

medical professionals and donors in 2011 to support altruistic donation. The website has contact details for the living donor transplant coordinators for those who wish to take matters further.

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## CSA pass rates

We all know the figures published by the RCGP showing differences in male versus female, white versus BME, and UK graduates versus IMGs. However, I have suspected for years that the male/female difference is due to the male inability (relatively speaking), to process several possible outcomes, as opposed to jumping to the most likely and then re-evaluating, is at the centre of this issue. The possible solution to this is teaching exam technique.

I have always been puzzled by the IMG issue, as apparently has everyone else, with suggestions of bias and worse being made; similar differences also occur at AKT.

I suggest a seemingly ludicrous idea, that the difference occurs because of the fact that the data are published.

Malcolm Gladwell's book *Blink* includes the already accepted idea of 'priming'. In brief, the fact that IMG candidates are told (repeatedly and unavoidably) that they have much less chance of success primes them to fail.

As an example, the standardised test for US College entrance was given to two groups of applicants. Pre-test priming by including their race on a pre-test

questionnaire reduced the scores of, in this case, the African-American candidates by up to 50%. Asked afterwards none of them agreed that the pre-test questionnaire had ANY effect.

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## Sustainability, carbon footprints, and dyspepsia

Roger Tisi<sup>1</sup> rightly draws attention to the unnecessary work that GPs have to do with little evidence for benefit. Peter Perkins<sup>2</sup> letter on dyspepsia is interesting only because it makes sustainability even more remote. While Ca125 has a place in investigation, it is of such low sensitivity and specificity<sup>3</sup> that it cannot be routinely used in dyspepsia. When the NICE guidelines on heavy menstrual bleeding were first adopted, one PCT noted that it was spending in excess of £20K on unnecessary TSH tests!

Michael Balint<sup>4</sup> may have had sustainability in mind when he wrote his book, *The Doctor, His Patient and the Illness*. How many GPs still collude anonymously with their patients and colleagues? It is so easily done and often, mistakenly, saves the consultation or helps terminate it!. But 'collusion of anonymity' is wasteful of resources and inimical to sustainability. Above all else it is an illusion of good medicine and perpetuates the myth of the 'nice' doctor.

One is also persuaded by the power of the doctor as the most potent therapeutic intervention in the consultation. GPs no longer seem to have the time to discuss risks/benefits with patients, but now need to be willing and able to reclaim their professionalism and engage more with patients. Therein lies the key to good medical practice and sustainability.

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## The postcode lottery of GP training: Time Out of Programme

I was encouraged to read the article by Franey *et al*<sup>1</sup> about the undoubted value of an international Time Out of Programme Experience (OOPE), particularly in a low or middle income country. In the Severn School of Primary Care (Severn Postgraduate Medical Education) we have been promoting this activity for 5 years, inspired by the Crisp report.<sup>2</sup> The many gains<sup>3</sup> that accrue have informed our selection criteria: how will the OOPE benefit the candidate's career progression, general practice in the NHS, and the health of the country of the placement, and why does the OOPE need to be taken at this particular time?

To date we have had overseas OOPE doctors (OOPEs) in Uganda, Malawi, Madagascar, KwaZulu-Natal, Solomon Islands, Zambia, Northern India, Costa Rica, Nicaragua, and the Cook Islands. Short descriptions of their inspirational experiences are available on our website: <http://www.primarycare.severn deanery.nhs.uk/training/trainees/out-of-programme-experience-and-opportunities-oope/our-recent-oope-trainees-and-what-they-got-up-to/>

We finance placements for our intending OOPEs on a local 3-day course in overseas medicine, which is aimed at doctors and nurses preparing to work in low resource countries. We provide a series of in-house meetings where returning OOPEs share their experiences and potential OOPEs have an opportunity to discuss preparatory arrangements. We emphasise and try to ensure that all our OOPEs have clinical