

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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DOI: 10.3399/bjgp13X675322

## 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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DOI: 10.3399/bjgp13X675331

## 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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DOI: 10.3399/bjgp13X675340

## 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

supervision while in the low resource country. For our OOPes who go to KwaZulu/Natal, we have a former senior GP educationalist who is able to visit them and supply some in-country support. Importantly, we also provide individual debriefing for returning OOPes to help with their re-integration into the NHS.

The sparsity of opportunities that Franey *et al* describe within GP schools is, I think, due to the perceived disruption of GP rotations in a short 3-year training programme. I would strongly argue that this a very small price to pay for the definite learning experiences for these trainees, who are high flyers and potential clinical GP leaders of the future, whether in the UK or overseas. We would encourage all GP schools to promote these OOPe placements, particularly in low resource countries.<sup>4</sup>

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DOI: 10.3399/bjgp13X675359

## Diagnosing somatisation in adults in the first consultation

My only caveat to Wilson and Mann's article on medically unexplained symptoms<sup>1</sup> would be the use of the word 'stress'. I use this term very frequently, simply because my patients seem to identify with it easily and recognise the implied medical connotation. As with all things in general practice, I suspect that adequate and appropriate empathy will balance negative implications.

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DOI: 10.3399/bjgp13X675368

## Cardiovascular safety of non-steroidal anti-inflammatory drugs

The Medicines and Healthcare Products Regulatory Agency have directed that diclofenac is now contraindicated in patients with congestive heart failure (New York Heart Association classification II–IV), ischaemic heart disease, peripheral vascular disease (PVD) and cerebrovascular disease, due to the increased risk of arterial thrombosis.<sup>1</sup> Patients on diclofenac should see their GP at their next routine appointment to be switched to an alternative treatment.<sup>1</sup>

We carried out an audit in an urban general practice of 13 000 predominantly white patients in Yorkshire to establish the number of patients affected by these recommendations and the subsequent impact on GP workload.

We identified 933 patients with one or more of the diagnoses recognised as contraindicating the use of diclofenac. Four hundred and eighty patients had ischaemic heart disease alone of whom 21 had been prescribed diclofenac in the last 12 months, with 10 on repeat prescription. Thirty-three patients had congestive heart failure alone of whom only one had been prescribed diclofenac (not on repeat prescription). Sixty-one patients were diagnosed with PVD alone; four had been prescribed diclofenac of whom one required a repeat prescription. One hundred and ninety-three patients had a diagnosis of cerebrovascular disease alone; 11 had been given a prescription of diclofenac, six on repeat prescription. One hundred and sixty-six patients had more than one of these conditions, and four had been prescribed diclofenac on repeat prescription.

In total 41 patients with any of the relevant diagnoses had been given diclofenac in

the preceding 12 months, of whom 19 had diclofenac on repeat prescription. Our results are somewhat reassuring as only 0.3% of our patient population have been exposed to diclofenac in the last 12 months with only 0.1% having diclofenac on repeat prescription. Although the service burden of these new recommendations is slight, the impact that the discontinuation of diclofenac will have on patients requiring them (particularly those that use diclofenac routinely) cannot be discounted.

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1. Medicines and Healthcare Products Regulatory Agency. *Drug Safety Update. Vol 6, issue 11*. London: MHRA, 2013.

DOI: 10.3399/bjgp13X675377

#### Correction

In the August issue of the *BJGP*, the letter Gibney DR. Should we charge for A&E? *Br J Gen Pract* 2013. DOI: 10.3399/bjgp13X670543 included address details that should have instead been presented as: 4th Year Medical Student, Manchester Medical School. E-mail: daniel.gibney@student.manchester.ac.uk. The online version has been corrected.

DOI: 10.3399/bjgp13X675638