attractive to those drawn to primary care in their medical school career but who perhaps also have specialist interests that are often associated with secondary care medicine. However, the undergraduate curriculum seems devoid of any introduction to GPwER, limiting future consideration. As final-year medical students trained in both Welsh and English institutions it is apparent that even during GP placements little information is provided about extended roles and the training available after CCT.

The shortage of GP and allied healthcare professionals is a serious problem.[1] The *NHS Long Term Plan* includes prioritising the increase of community-based health interventions, reducing those carried out in secondary and tertiary centres, stressing the need for more GPs, particularly with extended roles.[2] The duration of each clinical rotation does not necessarily correlate to the future uptake of that specialty. Therefore, increasing the awareness of GPwERs should be considered in medical schools to try to attempt to address the growing need for more GPs.[3]

As the number of junior doctors engaging in general practice training pathways remains low compared with other specialties,[4] ensuring medical students are well equipped with the knowledge of job possibilities in primary care should be a medical education priority. Minor issues including the transition in name from GP with a specialist interest to GPwER are likely to deter students from exploring potential careers in general practice because of sparse and ambiguous information that is difficult to source in a time-critical period of training. This highlights that the devil is often in the detail as a 10-minute 'GPwER GP–student appointment' may help inspire and recruit desperately needed GPs. Heightened awareness of GPwER among medical students is unlikely to solve the staffing crisis but may be a crucial element in a concerted effort to bolster the future primary care workforce.

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DOI: https://doi.org/10.3399/bjgp19X706217

Another marker of underlying pathology

The recent discussion regarding the utility of the inflammatory markers erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), and plasma viscosity[1,2] is very interesting as we have often noted them to be normal despite underlying pathology.

In our local laboratory, serum globulin is presented as part of the liver function test panels calculated by subtracting the albumin concentration from the serum total protein. We have found raised levels of total globulin to be a very useful marker of underlying blood-borne virus (BBV) infections, monoclonal gammopathy of unknown significance (MGUS), and multiple myeloma. In our two South East London practices (total population approximately 15 000) we reviewed two late diagnoses of HIV and myeloma and noted a chronically raised globulin that had been overlooked. We therefore invited patients who had a raised globulin result in their latest liver function tests from the last 3 years for a blood-borne virus screen (HIV, hepatitis B, and hepatitis C) and myeloma screen (protein electrophoresis and immunofixation). The search and recall found that across both practices 223 patients had a raised globulin of >35 g/L with no known cause in the last 3 years. Consenting to the further blood tests were 173 patients. Subsequently 39/173 (22.5%) patients were found to have underlying pathology: seven new cases of myeloma were detected, one of which required immediate treatment, and 15 patients were found to have previously undiagnosed HIV, hepatitis B, or C. The other 17 patients have been diagnosed with MGUS and are now being followed up. Interestingly, most of the above patients had normal CRP and ESR where it had been tested. We believe that this overlooked marker of underlying inflammation deserves further investigation and its utility highlighting. We have noted that there is a trend to remove globulin from routine biochemistry liver profiles as part of demand management and on cost grounds. This could potentially result in missed opportunities to diagnose cases earlier.

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DOI: https://doi.org/10.3399/bjgp19X706229

The challenges of understanding differential attainment in postgraduate medical education

I have two questions about this article's differential attainment in postgraduate medical education.[1] One is the pluralism of evaluation; the other is the fairness of evaluation.

Regarding the pluralism of evaluation, the way mentioned in the article to evaluate achievement is examination. Is this theoretical or practical examination? In addition to theory and practice, should students' achievements

include psychological quality, humanistic quality, scientific research, papers, medical ethics, ordinary achievements, and some other things? I think a good doctor should not only get good grades, but also have many excellent characteristics. We know that the purpose of the exam is not for the exam itself, the score itself, and some achievements cannot be measured by the score. Examinations can be used to find deficiencies. For teaching institutions, it is necessary to find ways to improve the quality of training.

As for the fairness of evaluation, how can we guarantee the fairness of students trained and evaluated by different teaching methods? Although there is no evidence that these differences are related to prejudice, will the unfair distribution of the original educational resources lead to bias in evaluation methods, and will the current achievement evaluation system be more conducive to some people, thereby widening the existing gap?

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DOI: https://doi.org/10.3399/bjgp19X706241

Author response

Our intended meaning was that, currently in the UK, exams are the existing mechanism by which trainees are assessed in relevant competencies defined by curricula. We would agree that exams are unable to consistently reward or notice qualities such as dispositions of character that are also associated with good clinical care. We considered it beyond our remit in this article to suggest alternative approaches, though certainly the nature and type of assessment most able to identify capability is an interesting question.

We mentioned in the editorial that it is unclear what we should tolerate in terms of 'communicative flexibility' to ensure that people from different cultural groups are not disadvantaged by particular exams. We also agree with you that we should consider how to value broad capabilities and strengths.

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DOI: https://doi.org/10.3399/bjgp19X706253

Management of depression and referral of older people to psychological therapies

Frost and colleagues[1] bring up an important — often under-recognised — topic and its associated challenges to our attention.

With the continuity of care allowed, and the knowledge of both a patient's social context and their comorbidities that influence treatment options, there is little doubt that primary care has a central role in the management of older people with depression.

Individualising a treatment plan based on the circumstances of a person is crucial;[2] assumptions on an older person's preferences are likely to be detrimental. Several factors need to be kept in mind when deciding on a treatment strategy: both clinician and patient preferences; manual dexterity; eyesight issues; access to technology; mobility; previous history of anxiety and/or depression (and previous successful treatment options); comorbidities; and polypharmacy.

Exploring all of the above is invariably difficult within the standard 10-minute consultation as the review points out. It is only by investing the time and effort in longer appointments that we can hope to address this often neglected area. Moreover, being attentive to the possibility of depression presenting differently in older people (for example, with somatic symptoms) will help to prevent multiple initial attendances.[3,4] A cursory assessment ending in a prescription for antidepressants is unlikely to be helpful in most instances.

Appropriate services need to exist locally to cater for the needs of the older population. Primary care networks have the potential to help deliver more effective care to patients with mental health problems by locating mental health therapists within primary care and by having practice pharmacists help with medications and pharmacology.[5,6] Patients are likely to appreciate the familiarity and proximity of treatment 'under one roof'. Because of the complex interplay between one's social situation and mental wellbeing, signposting from social prescribers can also help, for example, befriending services, Age UK, U3As, volunteering activities, and bibliotherapy.

Closer cooperation between psychiatry, geriatrics, and primary care can also lead to more effective outcomes.[2] In care home settings, the training of staff by experienced mental health nurses can also increase the confidence in identifying and dealing with mental health issues.[4,7]

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DOI: https://doi.org/10.3399/bjgp19X706265