Letters

All letters are subject to editing and may be shortened. General letters can be sent to **bjgpdisc@rcgp.org.uk** (please include your postal address for publication), and letters responding directly to *BJGP* articles can be submitted online via **eLetters**. We regret we cannot notify authors regarding publication.
For submission instructions visit: **bjgp.org/letters**

GP point-of-care ultrasound in the UK

The editorial by di Martino and colleagues[1] asks whether there is a role for point-of care ultrasound in UK primary care (GP PoC-US), and we agree with the authors that the time is right to explore and develop its use.

Quite apart from the advantages that an early practice-based scan can bring, many scans are requested on patients who are frail, for whom a trip to the local hospital can be a major undertaking. We are also aware of individuals living in residential care who have missed imaging appointments because of the failure of complex transport arrangements.

The skills to carry out a safe ultrasound can be acquired by training, supervision, and practice, and form part of the training of some specialists. GPs, given our vital role in early diagnosis across multiple clinical disciplines, and the varied community settings in which we work, stand to benefit at least as much.

We have set up a GP PoC-US training programme in Somerset, through a collaboration between the Radiology Department at Yeovil District Hospital and the GP practices who were involved in the Symphony Vanguard project (now collectively known as Symphony Healthcare Services).

We chose four initial scans to learn, for their relative simplicity, and their clinical utility: DVTs, bladder scans (for retention and residual volume), abdominal scans for ascites, and chest ultrasound for pleural effusions. We adopted the Royal College of Radiologists' training guidelines, with logbooks to record scanning experience. A portable ultrasound machine was acquired and configured to be able to upload images to the hospital PACS server. Training has been delivered by a consultant sonographer and his team, with direct teaching, observing scans, scanning under supervision, and training in reporting.

We are now also working with the local palliative care team to develop a community paracentesis service.

We hope, through a process of audit and reflection, to contribute to the evidence that GP PoC-US is effective, safe, and of benefit to our community. One day it could be the 'new normal'.

Christopher G Krasucki,

GP, Somerset, and Research Lead, Symphony Healthcare Services.
Email: Christopher.Krasucki@YDH.NHS.UK

Steve Savage,

Consultant Sonographer, Yeovil District Hospital.

REFERENCE

1. di Martino E, Aakjaer Andersen C, Mengel-Jørgensen T, *et al.* Is there a place for point-of-care ultrasound in UK primary care? *Br J Gen Pract* 2020; DOI: https://doi.org/10.3399/bjgp20X710801.

DOI: https://doi.org/10.3399/bjgp21X714677

MRCGP Recorded Consultation Assessment — the hidden fourth construct

The MRCGP Recorded Consultation Assessment (RCA) uses recorded consultations, ostensibly to assess three skills: inter-professional; data gathering, technical and assessment; and decision making and clinical management. These are entirely reasonable constructs for an assessment of readiness for safe independent practice.

However, the RCA has a hidden fourth construct: candidates must select cases that align with the examiners' view of reasonable level of 'challenge'. The latest Examiners' Reports highlight that case selection continues to be a major issue, and some candidates have probably failed for this reason.

This alludes to a problem of construct validity: is the skill of identifying 'suitable RCA cases' really a prerequisite for safe, independent general practice? If not, can we justify continuing an assessment that has this hidden fourth construct as a prerequisite skill? Indeed, can 'level of challenge' of a GP consultation even be judged reliably? Even the latest candidate guidance appears somewhat vague in its definition. Furthermore, some candidates are likely to have greater difficulty collecting cases to choose from, with part-time trainees, those in smaller practices, and those in areas with large non-English-speaking populations likely to be at a particular disadvantage.

We are now past the early stages of COVID-19 and the ongoing use of the RCA is surely problematic, especially for high-stakes 'fail' decisions. Perhaps the RCA should instead be used as a screening test with unsuccessful RCA candidates then sitting the Clinical Skills Assessment (CSA). Smaller numbers of CSA candidates would ensure adequate social distancing. This approach would benefit potentially good candidates with fewer opportunities to record cases or who simply struggle to choose cases that align with the examiners' particular view of 'challenge'.

Chris Williams,

GP and Trainer, Rosebery Medical Centre, Loughborough; Senior GP Educator, Tutor Development and Quality, University of Leicester, Leicester.
Email: cdw4@leicester.ac.uk

DOI: https://doi.org/10.3399/bjgp21X714689

Extracting smoking data from GP electronic health records

Although health promotion data such as body mass index have been extracted from GP records for many years, there has been far less interest in tabulating numerical smoking data. Focus seems to be on stopping smoking (which is excellent in itself) rather than using smoking information to predict disease at either an individual or population level. This is probably due to the lack of recommended software recording standards for smoking in the computer systems available. This is a