Performance of ethnic minority versus White doctors in MRCGP assessment

In reviewing the performance of ethnic minority versus White doctors in MRCGP assessment (2016–2021), Siriwardena et al conclude that ethnic background did not reduce the chance of passing GP licensing exams once sex, place of primary medical qualification (PMQ), declared disability, and MSRA scores were accounted for.1 This conclusion is not in keeping with the recent GMC report2 that found that UK graduates of Black/Black British heritage have lower pass rates in specialty exams (62%) than UK White (79%), Asian (68%), and mixed-heritage trainees (74%). Having a non-White ethnic background may in itself be an over-simplification and further granularity of the data is required to reach any meaningful conclusions.

Further, there is differential attainment in the MRSA exam, ‘upstream’ so to speak, which mirrors that seen in the GMC report. In the MRSA proportionally more Black and Muslim candidates do less well, findings similar to those in the MRCGP, whether UK or non-UK graduates. The disparities in attainment due to ethnicity seen in the MRSA do not seem to account the lived experience reported by mixed-heritage trainees (74%). Having a non-White ethnic background may in itself be an over-simplification and further granularity of the data is required to reach any meaningful conclusions.

The conclusions in this report should not detract from the fact that differential attainment exists and that ethnicity is a key contributory factor whether qualifying here or abroad. We need to ensure that we level the medical education field and that all trainees regardless of their background receive the support they need to reach their full potential.

Vijay Nayar,

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Early identification of rheumatoid arthritis

We read the editorial on early diagnosis of rheumatoid arthritis with pleasure.1 Early identification of RA in general practice is a true challenge. Consultations for non-specific musculoskeletal symptoms are part of every regular practice day of the GP. The proportion of these patients developing RA is very small. Any diagnostic test that might help the GP to earlier identify patients who will develop RA will be welcomed in general practice. A prerequisite of this diagnostic test should be that the number of false positives and false negatives are at an acceptable level, preventing both over- and underdiagnosis. Because of the high number of consultations in general practice for non-specific musculoskeletal conditions, the number of false positives (low PPV) will be an important limitation. Anti-CCP might be a very promising test to be used in general practice. However, as stated in this editorial, much is still unknown. Who am I going to test using anti-CCP among the large proportion of patients consulting with non-specific musculoskeletal symptoms? And if this test is used in this population with a very low prior probability for RA will it indeed lower the number of unnecessary referrals to secondary care without underdiagnosing patients?

We are not sure whether a new condition such as ‘pre RA’ will be received with much applause in the general practice community. A GP wants to know whether they can either exclude RA with acceptable certainty (high NNP) or has to refer the patient to a rheumatologist for further management. The large number of non-specific MSK consultations might lead to unnecessary labelling of a proportion of these patients as having ‘pre RA’ without properly knowing what to tell these patients and what to do next.

That said, we consider this editorial interesting and relevant. The authors mention all potential barriers and their conclusion is well balanced and indicates that using anti-CCP in general practice cannot yet be recommended. We agree and suggest the introduction of anti-CCP in general practice may be too early and future research needs to identify the benefits, harms, and costs.

Patrick JE Bindels,
Professor in General Practice & Head, Department of General Practice, Erasmus MC Rotterdam, Rotterdam.
Email: p/bindels@erasmusmc.nl

Sita Bierma-Zeinstra,
Professor, Department of General Practice, Erasmus MC Rotterdam, Rotterdam.

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