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Ethnicity did not predict performance in GP licensing of doctors entering GP training

We thank Drs Bhatti and Nayar for responding to our study.¹ They present no evidence to contradict our findings and, despite misunderstanding our analysis and interpretation, reach similar conclusions.

Our study challenges their assertion, that ethnic minority trainees, in particular UK-trained ethnic minority doctors in GP specialty training, fail MRCGP because of their ethnicity. We showed that this was not the case in our cohort.² Their focus on racial discrimination in the workplace and during training implies the non sequitur that differential attainment must be due to unfair discrimination by examiners and examinations, or educators in the case of workplace-based assessment. In doing so they denigrate the many ethnic minority doctors in specialty training who pass MRCGP, supported by educators.

Increasing numbers of ethnic minority and overseas-qualified doctors complete the MSRA, a computer-marked assessment of clinical knowledge and judgement, and enter specialty training for general practice. They claim that we '*do not seem to have ... taken into account ... differential attainment in the MRSA exam*', but this is exactly what we have done.

The GMC report *Tackling Disadvantage in Medical Education*, which shows differential attainment in trainees in all specialties, by separately analysing characteristics such as ethnicity, gender, and disability,³ does not contradict our findings. We used multivariable models taking into account intersections between these attributes to elucidate independent predictors of performance in licensing assessments. Attempts to conflate differential attainment with racial discrimination in assessments, could itself stereotype doctors and will do little to improve their self-worth or educational outcomes.

*Fair Training Pathways for All*⁴ explores the importance of the educational environment, and we welcome educational initiatives to reduce differential attainment, but these do not undermine the reliability of

the data or analysis. Increasing inclusivity of selection to GP training means that educational programmes need to be designed accordingly.

Our conclusions are similar, that '*GP trainees should receive educational support appropriate to their needs, whatever their ethnic group or other demographic characteristics*', but we also refer to '*doctors admitted to training with low selection scores who may need additional support to maximise their chances of successful licensing*'.

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Competing interests

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Short stature – what specific test should we request?

Thank you for this article,¹ but I was miffed to see under investigations that there are none specific for growth hormone or other specialised tests. Getting bloods tests for children can be upsetting, and should we not get all the initial tests done at one time? So, may I ask what blood tests do you request when you first see a short child and why can't these be done pre-referral so that the whole process can be streamlined? I accept that there may be a huge variation in interpretation of results, and many may need specific times of day or circumstances for a useful result. Coupled with the editorial about inequalities and the huge problem of GP scarcity, does it not make sense to get the correct tests done early?

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Author response

We are grateful for your letter and agree that it is vital to avoid unnecessary additional testing in children. The basic investigation scheme in our article is based on published consensus guidance.^{1,2} This panel of tests was recommended as a screen to identify conditions that could potentially be managed in primary care (avoiding unnecessary referral) and/or to direct referrals appropriately. More 'specialised' tests included in the baseline assessment (but not in the article as they may not be universally available or difficult to interpret) are karyotype in short girls to exclude Turner syndrome and serum insulin-like growth factor-I (IGF-I) as a marker of growth hormone (GH) secretion.

It is vital to exclude Turner syndrome in short girls as it has an incidence of 1:2000, short stature is present in 98% of Turner syndrome individuals, and is the most common presenting feature in childhood. If karyotype is not available, follicle-stimulating hormone (FSH) at ages <2 and >9 years may be helpful as this could identify primary ovarian failure, another common finding in Turner syndrome.

A random or 'baseline' growth hormone (GH) level is not merited as GH is secreted in a pulsatile manner. GH deficiency (GHD) is formally excluded by provocation testing only undertaken in specialist centres equipped to undertake endocrine dynamic testing. Serum IGF-I is a marker of GH action and can be helpful. However, it is usually a secondary-level investigation, as interpretation can be challenging, particularly if there are associated nutritional issues.

Additionally, more moderate GHD can be associated with normal IGF-I values. Therefore, an IGF-I level within the normal range does not necessarily exclude GHD and this needs to be carefully considered when there is a high clinical suspicion of GHD.

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GP wellbeing is more than a tick box exercise

New Quality and Outcomes Framework (QOF) indicators in England seek to reward GP wellbeing through absence reporting, access to support services, and options for flexible working.¹ Practices must also participate in peer review of a wellbeing quality improvement project.¹

This activity will increase workload for GPs and practices already under enormous strain and its responsibility fall on the shoulders of overstretched GP partners and managers. No increase in overall QOF remuneration is on offer in return, potentially leaving GPs feeling pressured to misrepresent their wellbeing in order to maintain practice revenue. This could conflict with burned-out GPs' duty of probity or leave them fearing professional consequences of 'not coping'.

More broadly, the new targets risk becoming a stick to beat GPs: by either gifting evidence for government that morale is high or by placing responsibility for low morale squarely upon GP practices. Measures that become targets famously cease to be good measures.² GP negotiators must beware subterfuge and seek transparent alternatives that address the specific and systemic challenges facing frontline primary care employees. GP wellbeing is more than a tick box exercise.

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DOI: <https://doi.org/10.3399/bjgp23X732969>

Corrections

GPs' willingness to prescribe aspirin for cancer preventive therapy in Lynch syndrome: a factorial randomised trial investigating factors influencing decisions. Kelly E Lloyd, Louise H Hall, Lucy Ziegler, et al; the Aspirin for Cancer Prevention group. *Br J Gen Pract* 2023; **73(729)**: e302–e309. DOI: <https://doi.org/10.3399/BJGP.2021.0610>. To rectify a production processing error, 'sex' has been replaced with 'gender' throughout the text.

DOI: <https://doi.org/10.3399/bjgp23X732981>

Patient experience and satisfaction with symptomatic faecal immunochemical testing: an explanatory sequential mixed-methods evaluation. Natalie Gil, Helen Su, Kirandeep Kaur, et al. *Br J Gen Pract* 2023; **73(727)**: e104–e114. DOI: <https://doi.org/10.3399/BJGP.2022.0241>. Stephen Duffy's affiliation has been corrected to read 'Wolfson Institute of Population Health, Queen Mary University of London'.

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