LETTERS

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IAN MILES/ALAMY

DISCRIMINATION IN THE MRCGP EXAM

Racial discrimination should be first variable investigated

When differences in health status, healthcare, or health professionals' performance are found for minority populations, the most uncomfortable, and arguably most important, interpretation is that the cause is racial discrimination.[1] Considerations of racial discrimination in medicine, whether for staff or patients, are hardly new,[2] but it is good to have a fresh opportunity to examine the matter.[3]

Esmail and Roberts found population subgroup differences in failure of the membership of the Royal College of General Practitioners exams.[4] Several findings give insights that might help interpret the data.

Firstly, in all groups more men fail than women. The inequalities transcend race and ethnicity. This raises the spectre of sexual discrimination against men.

Secondly, because more white international and European economic area medical graduates fail than UK black and minority ethnic group graduates, the inequalities are not merely crude racial prejudice, based on physical features such as colour.

Thirdly, UK graduates in the black and ethnic minority group do worse on the machine marked applied knowledge test. Esmail and Roberts point out that the interpretation of this is complex. Clearly, the results relating to the clinical examination are equally complex.

Fourthly, on resitting the exam, UK ethnic minority graduates do as well as white UK graduates, although not in further attempts. If racial discrimination was the main cause of the initial failure, this ought to be reflected in the second sitting.

Esmail and Roberts proposed a hypothesis of racial discrimination. The medical profession would do well to prioritise this explanation as the first one to be considered and studied in depth.

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Competing interests: I am a life member of the British Association of Physicians of Indian Origin (BAPIO).
Full response at: www.bmj.com/content/347/bmj.f5662/rr/668160.

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3 Bhopal RS. Racism in health and health care in Europe: reality or mirage? *Eur J Public Health* 2007;17:238-41.
4 Esmail A, Roberts C. Academic performance of ethnic minority candidates and discrimination in the MRCGP examinations between 2010 and 2012: analysis of data. *BMJ* 2013;347:f5662. (26 September.)

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Why good doctors might fail the CSA exam

Many of my GP colleagues spend over half of their time consulting in Gujarati, Urdu, Hindi, and Punjabi. I work with doctors who fail the clinical skills assessment exam, many of whom are deemed to be good doctors in their work place assessments and some of whom have been offered jobs in their training practice. I think that the evidence indicates that the clinical skills assessment exam is reliable, but why are good doctors failing, particularly international medical graduates?[1]

This question is for our whole profession—General Medical Council, deaneries, and Royal College of General Practitioners. My suggestions include:

1 Many international medical graduates have never trained with a role player or been taught consultation skills before specialist trainee year 1
2 Many international medical graduates and doctors from British minority ethnic groups commonly consult during training in other languages.[2] The exam is in English. Switching to an Asian language is, anecdotally, often accompanied by patient expectations of more doctor centred consultations
3 The exam is not "real," but simulated. The doctor must "suspend disbelief." UK trained doctors seem to find this easier than international medical graduates
4 Role players behave differently from real patients, asking more questions, saying more[3]
5 Women with "female problems" more commonly present to female GPs in real life practice. Male candidates are therefore less accustomed to managing such problems when they meet them in the exam
6 Examination power dynamics are different from the clinical environment, with institutional power residing with the patient and the exam, not the doctor. This might have a greater impact on those accustomed to hierarchical healthcare systems
7 Differing cultural ethical approaches[4]—for example, using relational approaches to autonomy versus individual approaches
8 Medical jargon is often seen as good practice outside the UK.

These eight points outline possible reasons why ethnicity, training experience, and sex can disadvantage certain candidate groups in a high stakes simulated environment. Like a juggler, the more balls a candidate has to juggle, the harder the exam becomes to pass. Should doctors who perform well in the real environment fail this exam because they cannot perform in a simulated environment?

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Full response at: www.bmj.com/content/347/bmj.f5662/rr/664516.

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Changes in exam and candidate selection lie behind failures

The high failure rate of ethnic minority and international medical graduates in the clinical skills assessment exam between 2010 and 2012 may seem like racial discrimination

by the examiners, but was the unintended consequence of the way candidates were selected and examined.[1]

The fundamental problem was communication in spoken English.

Between 2007 and 2009, deaneries were incentivised to increase training numbers. Rather than have vacancies, they accepted candidates with lower scores than in previous years—many of whom had repeatedly failed to get into GP training. As they progressed through training, it became apparent that many of them in the West Midlands had worse English language communication skills than previous cohorts.

At the same time the Royal College of General Practitioners raised the standard of communication needed to pass the exam. Many candidates who would previously have been "good enough to pass" began to fail. In my opinion, the clinical skills assessment is the most difficult spoken English communication exam of any professional qualification in the UK. It is very difficult to pass if British English is not your first language.

The consequences were catastrophic for the 2007-09 cohorts: many had been accepted into training with little chance of passing the exam three years later and were charged £6000 (€7043; $9694) for four attempts. This amounts to unintended institutional racism.

The data need to be re-analysed to expose the importance of language skills. British graduate ethnic minority groups contain a wide variety of language skills: some are native English speakers, whereas others entered the UK only after sitting A levels abroad. International medical graduates also vary greatly—those who are native English speakers do better in the exam.

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Competing interests: I am a GP trainer.

1 Esmail A, Roberts C. Academic performance of ethnic minority candidates and discrimination in the MRCGP examinations between 2010 and 2012: analysis of data. *BMJ* 2013;347:f5662. (26 September.)

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COLLABORATION WITH INDUSTRY

Transparency lack is alarming

One disturbing aspect of doctors' groups endorsing pro-industry guidelines is the "spin" and denial indulged in by the great and good of the medical world who colluded in producing this dodgy dossier but will not admit error.[1] Evans for the Royal College of Physicians says the group needs to change and evolve. You cannot change and evolve something that no longer exists. The colleges and other authorities involved in production and endorsement have almost all refused to say how and why they did that. So much for "transparency."

Refusal to give details of the last meeting is bound to raise the suspicion that the medical bodies wanted to produce a revision that would not suit the Association of the British Pharmaceutical Industry (ABPI). Why do those bodies not produce their own revision? Could it be that the ABPI has embarrassing information about its past, mutually beneficial, collaborations with doctors to promote ABPI's products in the guise of postgraduate education? Such unworthy suspicions might be dismissed if these people behaved with the transparency that in other forums they claim to require from drug companies.

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Competing interests: I am a fellow of two of the colleges listed as collaborators and am dismayed at their conduct.

1 Arie S. Doctors' groups are criticised for endorsing pro-industry guidelines. *BMJ* 2013;347:f6066. (9 October.)

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The *BMJ*'s stance

Goldacre asks how so many health organisations signed misleading guidelines for collaboration with the drug industry.[1] Let me explain how this happened at the *BMJ*.

We asked the Association of the British Pharmaceutical Industry (ABPI) to sponsor two co-branded seminars—on access to clinical trial data and the role of industry in medical education. Working in partnership with a commercial sponsor was new for the *BMJ*. Both meetings went well, with lively debate from an invited audience.

The *BMJ* was not a member of the Ethical Standards in Health and Life Sciences Group (ESHLSG), had published an editorial criticising this initiative's first report,[2] and had not signed the earlier guideline on relations between doctors and industry. However, it was put to me that it would be good if the *BMJ* signed the clinical trial transparency guideline, which could then be launched at the first BMJ/ABPI seminar, the date of which had been chosen with this in mind. I read the document and thought it uncontroversial if unambitious. I was glad industry seemed to be engaging with these issues. I saw that other health organisations had signed. The meeting was fast approaching. The *BMJ* not signing would be awkward. I signed.

This was a mistake. The document contained importantly inaccurate statements,[3] which, as Goldacre says, gave false reassurance that all was well.[1] As the *BMJ* continues to point out (www.bmj.com/open-data), all is not well.

This has been an important reminder of the need for vigilance against commercial influence and collegial chumminess. It is my second personal experience of "industry capture"—the first was with the tobacco industry in relation to a series I wrote about WHO.[4] The latest episode has led us to clarify and strengthen our policy. "The *BMJ* accepts sponsorship and partnership at the editor in chief's discretion. Sponsorship is hands off: the journal retains full editorial control. We partner only with organisations with whom we share a common mission and values. The roles of all parties are fully declared."

The ESHLSG was, for many involved, a genuine attempt to address the extraordinarily difficult question of how medicine and industry should interact. Its unravelling provides an object lesson in the need for transparency and independence, without which we will never achieve an evidence base for medicine that doctors and the public can trust.

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Competing interests: I am editor in chief and a director of the *BMJ*, which is a wholly owned subsidiary of the BMA. *BMJ* receives revenues from drug and device manufacturers in the form of advertising, reprint sales, and sponsorship. I receive a bonus based in part on the financial performance of the *BMJ*. The *BMJ* is an open access journal that charges author fees for publication of research articles. I have campaigned on issues of research transparency and integrity for quite a few years. The *BMJ* is a founding member of Alltrials.

Full response at: www.bmj.com/content/347/bmj.f6100/rr/667057.

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NHS HEALTH CHECKS

Why are local authorities commissioning NHS checks?

McCartney's article continues the debate on the evidence for and against NHS health checks and whether they constitute a screening programme.[1] These discussions fit comfortably within the context of an NHS provided service.

However, I believe that a more fundamental question needs to be considered first: why is this programme a mandated programme to be commissioned by local authorities? Who decided this? Where is the spokesperson from the Local Government Association in this debate? Many local authorities, including Derbyshire, are faced with draconian cuts in their budgets over the next few years, which are already affecting public health programmes.

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Competing interests: None declared.

1 McCartney M. Where's the evidence for NHS health checks? *BMJ* 2013;347:f5834. (2 October.)

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