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LETTERS

REGULATING MEDICAL STUDENTS

Misconduct is a behaviour, not a state

In Yates and James's paper on identifying risk factors at medical school for subsequent professional misconduct, "professional misconduct" and "found to have shown professional misconduct" are the same.[1] These are related but not identical outcomes. An alternative interpretation of their findings would be that the British disciplinary process is biased against men from less privileged backgrounds who struggled in the early years of their academic career. Or the profession may be overly sympathetic to misbehaving women from higher social classes who settled into medical school without problems.

Reid's premise that student behaviours should be monitored and responded to[2] is neither supported nor challenged by the observations of Yates and James. We should be careful before we condemn working class young men from schools that prepared them less well for the private school culture of British medical schools. The subtitle, "Fitness to practise should be determined by both academic and non-academic ability," should be recast because the evidence presented only considers responding to behaviours, not abilities.

If students are to be monitored,[3 4] it should be on the basis of clearly identified standards of behaviour and achievement, regulated by an independent and accountable body with a clear and accessible appeal procedure that does not discriminate against those who cannot afford representation.

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Competing interests: AJA was educated at comprehensive school and initially failed first year medical school exams.

1 Yates J, James D. Risk factors at medical school for subsequent professional misconconduct: multicentre retrospective case-control study. *BMJ* 2010;340:c2169. (27 April.)
2 Reid A. Identifying medical students at risk of subsequent misconduct. *BMJ* 2010;340:c2169. (27 April.)
3 Dacre J, Raven P. Should undergraduate medical students be regulated? Yes. *BMJ* 2010;340:c1677. (5 May.)
4 Davies E. Should undergraduate medical students be regulated? No. *BMJ* 2010;340:c1806. (5 May.)

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Reduction to the absurd?

What exactly is the extent of the problem Dacre and Raven think that they are addressing when they argue that medical students should be regulated?[1] The statistics quoted by Davies kick their concerns into the long grass[2]: in 2005 only 16 out of 5833 doctors in their first year of practice were identified as giving "cause for concern." Were the General Medical Council to regulate students, the cost, effort, and time expended would be of minimal benefit.

In the same *BMJ* issue Yates and James investigate risk factors at medical school for subsequent professional misconduct.[3] An easier way to ensure medical students turn into good doctors would seem to be to recruit exclusively privately educated women and kick out those who fail even so much as one exam in the first two years of medical school, as well as those who are ever drunk, incapable, or miss even one lecture. Indeed, why not include reports from primary and secondary schools and exclude anyone from becoming a medical student who has ever done anything bad. The authors may balk at this reduction to the absurd but it is the logical progression of their suggestions.

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Competing interests: None declared.

1 Dacre J, Raven P. Should undergraduate medical students be regulated? Yes. *BMJ* 2010;340:c1677. (5 May.)
2 Davies E. Should undergraduate medical students be regulated? No. *BMJ* 2010;340:c1806. (5 May.)
3 Yates J, James D. Risk factors at medical school for subsequent professional misconduct: multicentre retrospective case-control study. *BMJ* 2010;340:c2169. (27 April.)

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GMC registration is impractical

Most of us changed more during our student years than at any other comparable time in our lives. Should a single standard of behaviour have been applied throughout? If so, should it have been suitable for school leavers with no experience of living independently or for final year students carrying some responsibility for caring for patients?

No one leaves medical school to work alone and unsupervised: plenty of time then to ensure that the very rare unsuitable practitioner who has not been identified before qualification is managed safely and appropriately. The General Medical Council will have its hands full to overflowing with revalidation. It can afford neither the time nor the effort to oversee student behaviour. Let there be no student registration.[1 2]

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Competing interests: None declared.

1 Dacre J, Raven P. Should undergraduate medical students be regulated? Yes. *BMJ* 2010;340:c1677. (5 May.)
2 Davies E. Should undergraduate medical students be regulated? No. *BMJ* 2010;340:c1806. (5 May.)

Cite this as: *BMJ* 2010;340:c2854

Suffer the medical students?

Dacre and Raven argue for a centralised, student register regulated by the General Medical Council with GMC involvement in student fitness to practise issues.[1]

In the past decade I have mentored several doctors through GMC fitness to practise procedures. In all cases the process was slow—never completing in less than 18 months from the original complaint, and often far longer. GMC procedure was pedestrian at best and obtuse and almost deliberately obstructive at worst. All of the doctors were acquitted free to practise, though sometimes so damaged by the process that they found readjusting to clinical life extremely difficult. My inquiries with colleagues in the United States and Europe suggest that the GMC disciplines more doctors than any other regulatory system, and is considerably more expensive to run.

Do we really want to force this cumbersome and costly system of regulation on medical students, fresh from school? Some of my contemporaries at medical school in the 1980s were habitually drunk, late rising, and occasionally disorderly. They managed to combine a fierce intelligence and focus on medicine with enjoying a student lifestyle before entering their next 40 years of GMC regulated bliss. Many have become highly skilled, empathetic, and sympathetic leaders. Who says they were wrong?

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Competing interests: None declared.

1 Dacre J, Raven P. Should undergraduate medical students be regulated? Yes. *BMJ* 2010;340:c1677. (5 May.)

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CARDIOVASCULAR PREVENTION

Go for targeted screening

The benefit of any screening programme is a function of the likelihood that (*a*) patients with a risk condition have already been given a diagnosis or recently been offered a screening test and (*b*) those screened and found to have a risk condition will be treated effectively.[1]

Using these two principles we estimated the benefit of offering non-targeted screening for high cardiovascular risk to those over 40 in our trust, which serves a population of about 270 000. The table shows analysis of clinical data on 102 565 people.

Our findings suggest that the efficiency of screening the 54 850 unassessed people can be increased by 11% by omitting the 6076 registered with practices unable to provide assured high quality care, and that resources for screening these 6076 patients should be directed at improving clinical quality and capacity.

Currently 14 678 people have been screened, and fewer than 2% of men under 50 or women under 75 had a high cardiovascular risk (>20%). Therefore, a combined targeted strategy based on these findings would screen only patients registered with practices able to provide assured high quality care and men over 50, and would be more cost effective. With this strategy only 10 864 of the 48 774 unassessed people would need screening, and about 1200 high risk patients would be identified. However, non-targeted screening of all of the 48 774 would identify only a further 200 people.

Non-targeted approaches to screening for cardiovascular risk should be actively discouraged.[1]

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Competing interests: ACB has been offered shares or royalty rights in the IT programme called Deadly Trio.

1 Chamnan P, Simmons RK, Khaw K-T, Wareham NJ, Griffin SJ. Estimating the population impact of screening strategies for identifying and treating people at high risk of cardiovascular disease: modelling study. *BMJ* 2010;340:c1693. (23 April.)

Cite this as: *BMJ* 2010;340:c2866

COMMUNITY PHARMACY

Appalling bias

"Deregulation and changes to the NHS community pharmacy contract in England and Wales have allowed for the shift of clinical services from NHS primary care to the for profit community pharmacy sector."[1]

So all doctors live on charity alone and refuse to draw a wage, ploughing any and all surpluses back into patient care? None of them is employed by a limited company? I don't think so.

Richardson and Pollock perpetuate the myth that making a living from a day's work in health care is somehow wrong and the exclusive domain of community pharmacists.

An article so obviously and clearly biased in its assumptions should not have been published in any professional journal. And my letter is not nearly as derogatory to the authors and the *BMJ* as this article is to community pharmacy as a whole in its constant, biased emphasis on profit.

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Competing interests: JRM is a locum community pharmacist.

1 Richardson E, Pollock AM. Community pharmacy: moving from dispensing to diagnosis and treatment. *BMJ* 2010;340:c2298. (11 May.)

Cite this as: *BMJ* 2010;340:c2880

Costs of minor ailment schemes

Richardson and Pollock discuss the evidence base for the cost effectiveness of community pharmacy services.[1] Expansion of minor ailments schemes in community pharmacies could save money.[2] Data from six English primary care trusts gave a potential cost saving of £550 717 (€646 000; $793 000) on the basis of 308 199 consultations with a community pharmacist instead of a general practitioner, or £56m by extrapolation for a national community pharmacy minor ailment scheme.

These findings have important implications, given that around a fifth of a general practitioner's workload is inappropriately taken up dealing with minor ailments, community pharmacies are better placed to manage such ailments,[3-5] the NHS is facing a financial squeeze, and healthcare services are being moved into primary care.

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Competing interests: NSS has just completed an MSc in economic evaluation in health care, concentrating on improving the effectiveness and cost effectiveness of medicine use and pharmacy led primary care initiatives.

1 Richardson E, Pollock AM. Community pharmacy: moving from dispensing to diagnosis and treatment. *BMJ* 2010;340:c2298. (11 May.)
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5 Royal Pharmaceutical Society of Great Britain. *The new horizon—pharmacy in the new age*. London: RPS, 1996.

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Benefit of non-targeted screening for high cardiovascular (CVD) risk in 102 565 people aged 40-75 registered with trust teaching practices

Characteristic	Already registered with a vascular disease or identified as having CVD risk >20	Not registered with a vascular disease
Enrolled in a practice with established capacity* to deliver high quality interventions	43 066	48 774
	Cannot benefit from non-targeted screening	May benefit from non-targeted screening
Not enrolled in a practice with established capacity* to delivering high quality interventions	4649	6076
	Cannot benefit from non-targeted screening	Uncertain likelihood of benefiting from non-targeted screening†
Total	47 715	54 850

Data derived form Heart of Birmingham's October 2009 Deadly Trio database.
*Red-amber-green (RAG) rating, based on achievement in the quality and outcomes framework (QOF).
†Three practices rated red, or among the lowest 8% achieving in the UK; practice systems need to be improved before screening is offered.

FAILURE OF MODERN TEXTBOOKS

Memorable textbooks

Medical textbooks were not always as dreary and as bland as they are now.[1] Two examples of lively, first person didactic tomes that come to mind are *Bailey and Love's Short Practice of Surgery* and J L Burton's *Essentials of Dermatology*.[2 3]

Bailey and Love has plenty of footnotes explaining all the eponyms in the text. *Essentials of Dermatology* contains pearls such as, "The Lord Privy Seal is neither a lord, nor a privy, nor a seal" and "'seborrhoeic' warts have no relationship to seborrhoea." Elsewhere it explains: "The simultaneous occurrence of scabies in a doctor and a nurse may mean that they have shared nothing more exciting than a patient with Norwegian scabies."

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Competing interests: None declared.

1 Allen RA. The failure of modern textbooks. *BMJ* 2010;340:c2132. (7 May.)
2 Burton JL. *Essentials of dermatology*. 2nd ed. Edinburgh: Churchill Livingstone, 1985.
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Cite this as: *BMJ* 2010;340:c2857