Letters

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Editor's choice

In the November edition, Abbt and Alderson discussed the falling numbers of GPs, the new recruits and the old hands respectively. I would argue that the growing numbers of middle-aged female GPs who want to work part-time but who are electing not to work at all is a more pressing issue. In my small training practice two out of the three GPs, both in their 30s with children, resigned soon after I finished; neither was going to another job. If this is a general trend and 60% of the GP workforce is female then it should be ringing alarm bells amongst partners about the sorts of jobs they are offering. When you have an already expensively trained and often highly skilled and ambitious workforce why aren't you employing them? Insisting on full time working when many women and increasing numbers of men want to work part-time will not fill posts. Only advertising salaried posts often in very uninspiring ways, will not work either. What professional equal really wants to work for less pay, less holiday, less influence and no prospect of progression? More part-time partnerships with shared personal lists, or salaried jobs with a more creative approach to working, using bonuses or responsibility allowances, should be made available. CCGs should be petitioning NHS England for funds to do this. Partners are so fixated on dwindling profit margins they have forgotten what makes a job worth doing. Surely, an atmosphere of collegiate responsibility, a sense of united purpose and a sense of commitment to each other and the patients make for a happier working life? If anything is going to keep the consortia and private companies out, gathering your allies close will.

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1. Abbt N, Alderson S. Why doesn't anyone want to be a GP: and what can we do about it? *Br J Gen Pract* 2014; **64(628):** 579.

DOI: 10.3399/bjgp15X683053

Why doesn't anyone want to be a GP?

Abbt and Alderson remark 'how little time we spend in general practice … perhaps 8 weeks over an entire degree' but at Imperial College London and probably at most other medical schools, this represents greater time allotted than for many other specialties. We suggest the focus in medical schools should shift towards improving the quality of general practice placements and promoting the integration of primary care and specialist teaching, rather than consuming more time in an already overstretched curricula.

We feel that prestige has never been the main incentive for pursuing a specialty. Our own experience is that many medical students are attracted to a career in general practice because of other factors, such as a good work–life balance, continuity of care and career flexibility. With many GPs now concerned about their workload, this inevitably influences students and junior doctors in their career choices.[2] Another key factor is the funding that a specialty receives: recently, the proportion of the NHS budget spent on primary care has decreased and the income of GPs has fallen. To recruit more GPs, medical schools should improve the quality of students' experiences in their primary care placements. However by itself, this will not be sufficient to improve recruitment and the onus falls upon the NHS to once again make general practice a rewarding career for doctors.

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2. Majeed A. General practice in the United Kingdom: meeting the challenges of the early 21st century. *J R Soc Med* 2013; **106(10):** 384–385.

DOI: 10.3399/bjgp15X683065

Physical health indicators in SMI

We are grateful to Mitchell and Hardy for highlighting their recent publication in *Psychiatric Services*.[1] We agree that we should have cited this paper in our article in the October *BJGP*, but we were unaware of it (possibly because it was published around the same time that we were preparing our manuscript for submission). For this omission we unreservedly apologise.

However, we do not entirely agree that our UK-wide comparisons of QOF data were 'almost identical' to their work. Although there are obviously some similarities in these papers because both made use of the same publicly-available QOF databases, our paper is different in a number of important regards.

Our analyses were cross-jurisdictional, with data from Scotland, Northern Ireland, Wales and England (Mitchell and Hardy considered only England). We specifically calculated population achievement rates, along with payment and exception rates, and reported differences in rates using a sign test, while Mitchell and Hardy calculated differences in achievement rates before and after exclusions only, using χ^2 tests at a patient level. Mitchell and Hardy compared screening for BMI, blood pressure (BP), cholesterol and HbA1c/glucose between those with severe mental illness (SMI) and those with diabetes. We compared BMI in diabetes versus BMI in SMI, and also BP in chronic kidney disease versus BP in SMI. We agree wholeheartedly that we need new approaches to addressing health inequalities in SMI. Analysing routine data across the UK in coming years will remain very important.

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DOI: 10.3399/bjgp15X683077