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Editor's choice

Absence of intellectual challenge in medical schools

The finding that only 3% of medical students see general practice as intellectually challenging¹ is the biggest wake-up call for British medical schools since 1948. Medical schools are taking many of the most able students of their generation for 5 years, but this powerful evidence shows they are failing to introduce their students to some of the most interesting medical research in the world. Students are being denied proper opportunities to analyse this research, although higher education prioritises intellectual analysis.

GPs are the biggest branch of the medical profession and the NHS wants half of all medical students to choose general practice.² GPs face the widest range of clinical problems, see the social determinants of health more than other doctors, have the most complex consultations,³ while having the longest and deepest working relationships with patients in British medicine.

This educational tragedy has occurred through the hidden curriculum and the non-verbal signals from British medical schools, especially by not examining the principles of general practice in their final examinations. This signals to students that the intellectual content of general practice is irrelevant.

General practice has its own distinct body of research,^{4,5} separate from the medical specialties, which all students need to learn. Even in 2019, the GMC is approving medical schools that neither teach general practice as a research-based discipline, nor examine its principles in their finals. Medical school final examinations and the new planned national licensing examination should include 15% of questions on these principles.

Denis Pereira Gray,

Former Chair and President, Royal College of General Practitioners; Former Chairman, Academy of Medical Royal Colleges; St Leonard's Practice. Email: denis.pereiragray@btinternet.com

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Does doctor burnout harm patients?

Hall and colleagues' use of structured equation modelling¹ to study burnout increases our understanding of its origins but contributes less to our knowledge about its consequences. The problem is that patient safety — often said to be at risk when professionals are burnt out — was perceived by practitioners rather than measured independently. A systematic review and meta-analysis of mostly cross-sectional studies of low to moderate quality, and with a high level of heterogeneity,² showed that self-reported patient safety incidents were significantly associated with burnout symptoms, but the association between physician burnout and system-recorded safety incidents was not statistically

significant. One possible explanation is that those with burnout are more self-critical, honest, and likely to report having made errors even when they had not. Lawson argues strongly that researchers, medical journals, and medical leaders should not infer that burnout is associated with, let alone a meaningful cause of, preventable adverse events.³ The interventionist view that too much is at stake and that urgent action is needed, even if knowledge is imperfect,⁴ is challenged by Schwenk and Gold, who argue that action is being proposed for a symptom without an understanding of its pathophysiology, origins, consequences, and effective treatments.⁵ As for urgent action, after nearly 50 years of study of burnout there are many proposed solutions to it but little evidence of their effectiveness. Further exploration is needed, but we should make haste slowly.

Steve Iliffe,

Emeritus Professor of Primary Care for Older People, University College London, London.

Email: s.iliffe@ucl.ac.uk

Jill Manthorpe,

Professor of Social Care and Director of the Health & Social Care Workforce Research Unit, King's College London, London.

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