Letters

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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 challenging[1] 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.

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DOI: https://doi.org/10.3399/bjgp19X704729

Does doctor burnout harm patients?

Hall and colleagues' use of structured equation modelling[1] 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.

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DOI: https://doi.org/10.3399/bjgp19X704765

Gender incongruence: not representative of current knowledge and evidence, and nor of best practice

This article falls startlingly short of the quality and evidence base I would expect from a journal editorial.[1] Where claims are backed by citations, often these are a misreading or misrepresentation of the cited material. One claim is that *'... there are no robust contemporary cohort studies of younger female-to-male outcomes ...'*, citing a paper by Butler *et al*. However, Butler *et al* note there has been one study.[2] This had a natal male to natal female ratio of 1:1.7, and included 201 adolescents referred to the Gender Identity Development Service in London between 2010 and 2014.[3] Another is that charities and non-NHS groups are *'using inaccurate information, including exaggerated risks of suicide'*, which cites a blog post from the organisation All About Trans.[4] There is no inaccurate information in the blog post. It does say that hormones can be *'life saving'* for young people, but as studies consistently report poorer mental health and increased suicidal ideation in transgender young people, and at least one has shown that transgender children who are supported in their identity revert to developmentally normative levels of mental health issues, this cannot be described as inaccurate.[5]

It states that there are no UK guidelines for generalists, but fails to note the clear guidance in Scotland that patients should be referred by their GP to the local Gender Identity Clinic (GIC).[6] The suggestion of seeing the patient over a number of appointments without mentioning referral implies that this would be prior to referral to a GIC, which would be poor practice.

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DOI: https://doi.org/10.3399/bjgp19X704741

Gender incongruence in children, adolescents, and adults: response to Dr White

We are delighted to clarify the evidence in our editorial for Dr White[1] (a full point-by-point response is available online).[2]

White states there is *'no inaccurate information'* from All About Trans[3] when countering our claim that charities and non-NHS groups use *'inaccurate information, including exaggerated risks of suicide'*. The blog post claims that *'hormones can be "life saving" for young people'*. It describes a volunteer saying *'hormone blockers'* were *'life saving and empowering for young people'*. The site states *'Attempted suicide amongst trans people in the UK is 48% ...'*.[4] This figure (not confirmed via medical records) comes from a subgroup of 27 people responding to a survey, whose average age was 38, with a third considering themselves disabled. This is unlikely to be a representative, relevant, or generalisable relevant sample.[5]

We support children being able to dress and present in the way they wish. The study White cites as supporting children in their socially preferred gender role, and showing benefit of social transition,[6] is exactly that: it refers to social, not medical, transition. No medical treatments were used. If anything, it suggests that medical intervention in this group was not necessary and points to socially assigned gender roles being harmful.

It is vital that doctors do not foreclose discussion by distorting the little evidence base that does exist. Admitting uncertainty is uncomfortable, but is the vital step to obtaining better research data to improve the care of current and future patients.

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DOI: https://doi.org/10.3399/bjgp19X704753