Defining and measuring denigration of General Practice in medical education

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Abstract

There is a workforce crisis in NHS general practice (GP). It is estimated that in order to meet future health care needs around 50% of current medical students will need to choose a career in GP. Positive role modelling is an influential factor in medical students' career choice, but denigration of primary care during medical training may undermine aspirations of students considering GP as a career. This article discusses the importance of medical schools detecting and managing denigration of GP in their curricula and, for the first time, suggests an objective approach to the measurement of denigration. Four facets of what constitutes denigration are discussed and proposed as a collective measure. These are: language used about GP, proportion of curriculum time spent by students in GP, accurate representation of the clinical content of GP and equity of funding between hospital and GP placements. Furthermore, we discuss the key ethical and legal challenges that are faced by medical schools and, indeed, healthcare settings, that need to be overcome to enable proactive measurement and management of denigration.

There is a workforce crisis in primary care. The King's Fund estimates that, to meet the healthcare needs of the population, there will be a shortfall of 7,000 General Practitioners (GPs) in the next five years.[1] Evidence, however, suggests that the minority of medical students will choose GP as a career.[2] This falls short of the Department of Health and Social Care (DHSC) aspiration of 50% of medical graduates entering the profession to sustain the future GP workforce.[3]

Substantial work is being undertaken nationally to increase the numbers of undergraduate (UG) and postgraduate (PG) trainees who choose a career in GP.[4] One of the significant factors influencing career choice is role modelling by healthcare professionals during training.[2, 5]

Denigration of a medical specialty can be defined as "unfair criticism", "attack of reputation" or "denial of its validity".[6, 7] This has far reaching consequences for trainees. Negative attitudes and behaviours towards GP have the potential to undermine national priorities for GP recruitment, especially if these are experienced by medical students at early stages of their careers. The Royal College of General Practitioners (RCGP) and the Medical Schools Council (MSC) state that even the, often unintentional, dismissive words "just a GP" or "ending up as a GP" are to be avoided during medical training[4] and that such action alone could have significant benefits.[4, 5]

In 2016, the *By Choice-Not By Chance* report recognised the significance of undermining GP within the informal curriculum and recommended medical schools take action to combat such behaviour.[4] Whilst it is possible medical schools are actively engaged in managing potential denigration within their curricula, there remains a paucity of published literature that investigates its construct, its presence within different aspects of the medical curriculum and its true impact on prospective career choice. Positively managing denigration within medical education would firstly require medical schools to identify where and how denigration occurs, and then develop strategies that prevent it. Furthermore, having a recognised working definition and/or construct for denigration would enable the consistent evaluation and monitoring of denigration across institutions.

Therefore, the aims of this article are to discuss how denigration could be defined and measured, and to discuss the wider implications of undertaking work in Higher Education Institutions that determines its presence and subsequent management.

Measuring denigration

How could denigration be measured? Through literature searching for studies that evaluated i) unfair criticism of GP, ii) inequities between GP and non-GP education and iii) lack of validation of the GP specialty in medical education, we identified factors and derived themes associated with denigration of GP in medical education. Using these themes we suggest that denigration could be measured using a construct comprising four criteria, as described below. The evidence to support the relevance of each of these criteria is also provided in each of the sections:

1. Language used about GP in both the formal and informal curriculum
2. Proportion of curriculum time spent by students in GP
3. Appropriate representation of clinical content of GP
4. Equity of funding between hospital and GP placements

1. Language used about general practice

Negative language used by (mostly) non-GP healthcare professionals about GP is the most obvious and intuitive component of denigration. In the Destination GP report by the RCGP/MSC, various negative perceptions about GPs were articulated to medical students by non-GP healthcare professionals including referring to GPs as: “just a GP”; “general practice is an easy career”; “GPs are not specialists”; “general practice is boring”; “GPs are incompetent”; and “GPs have lower status than other medical professionals”.[5] Ajaz et al. in a survey of 960 medical students from 13 UK medical schools found that the most negative comments they had experienced were related to GP and psychiatry.[8] Whilst most students condemned negative language, over 70% reported a belief that this is part of routine practice.

2. Proportion of curriculum time spent in general practice

Both the quantity and quality of representation of primary care in the undergraduate curriculum will inevitably influence students’ perception of general practice. Key recommendations to medical schools in *By Choice– Not by Chance* included reflection of the

patient journey through different healthcare settings, recognition of the breadth and complexity of GP and recognition of GP as a specialty within its own right.[4] Inadequate or under-representation of primary care in UG teaching gives less prominence to GP as a speciality and is likely to affirm negative connotations within the hidden curriculum – if it's not worth teaching then it's not important. RCGP and the Society of Academic Primary Care (SAPC) have recommended that at least 25% of clinical placements should be within GP, recognising both the location of most NHS care and the importance of GP as a specialty.[8] However, the mean proportion of curriculum time students currently spend in primary care across United Kingdom (UK) medical schools is only around 13%.[9] Under-representation or mis-representation of GP in medical schools potentially extends beyond the published curriculum and evidence suggests this bias is presented even before medical students enter training. Macarthur et al in a recent study analysed images within the websites and prospectuses of 33 medical schools in the UK.[10] They found that, of all images analysed (n=650), community placements comprised 2% of images compared to 24% of images depicting hospital placements, suggesting under-representation of primary care and bias towards career choices in hospital settings.[10]

3. Appropriate representation of clinical content of general practice

Whilst traditional ideas may still prevail around GP focussing mainly on minor illness and communication skills, the reality is that primary care is the setting where 90% of NHS health care takes place with approximately 300 million consultations occurring in GP each year.[11] Such patient contacts include managing complex cases, long term conditions and multimorbidity.[12] Therefore, clinical inaccuracies about the care delivered within GP during medical education have the potential to represent falsely the role and capabilities of GPs. In 2018 the RCGP and SAPC jointly published the first national guidance on undergraduate general practice curriculum.[9] This landmark publication detailed important clinical constructs of GP, providing a high-level blueprint for GP education in medical schools.

4. Equity of funding

It has long been recognised that there is an inequity of funding in medical education between GP and non-GP hospital based placements. Clinical placements in GP receive less funding than secondary care placements and this is currently, on average, only about two-thirds of the

funding provided to secondary care.[12] A recent study evaluated the current actual costs of delivering education during undergraduate GP placements. Rosenthal et al. found that the mean actual cost to a practice for hosting one student for a full week in GP was around £1,100, and that this cost is similar to current costings for secondary care placements.[12] Therefore, current evidence suggests that GP placements continue be underfunded than medical student placements in non-GP settings. This underfunding of GP placements devalues GP education, limits the ability of GPs to provide a better quality student experience and potentially undermines the importance of GP as a specialty.

Ethical and legal considerations

There are a number of important ethical and legal considerations for educators to consider in order for medical schools to investigate, measure and manage the presence of denigration. Whilst such work could conceivably be undertaken as part of existing quality assurance processes for teaching there may be barriers to this raised by General Data Protection Regulation (GDPR) legislation in the UK.[13] For example, one barrier to such work being undertaken could be ensuring informed consent to the use of their data for such denigration monitoring purposes is provided by participants whose data is being processed.[13] However, gaining informed consent would likely change individual behaviour when delivering teaching thus biasing the outcomes of course evaluations towards the null hypothesis.

Whilst informed consent may be one legal basis for processing data for the purpose of evaluating denigration, there are other legal bases which within such work could be permitted.

Higher Education Institutions are considered public organisations and activities constituting the delivery of education are regarded as usual tasks within GDPR legislation. Such usual tasks are undertaken as part of the contractual requirements of educators and are performance managed using internal legal and/or legislative frameworks. The regulator of medical schools and doctors, the General Medical Council (GMC), states:[14]

- "You must work collaboratively with colleagues, respecting their skills and contributions"
- "You must treat colleagues fairly and with respect"

- "You must be aware of how your behaviour may influence others within and outside the team"

Therefore routine processing of educators' data for the evaluation of denigration could potentially be undertaken, without explicit consent, using the following legal grounds within GDPR, thus ensuring educators deliver education in accordance to contractual and legislative requirements:[13]

- Processing is permitted if it is necessary for the entry into, or performance of, a contract with the data subject.
- Processing is permitted if it is necessary for compliance with a legal obligation under EU law or the laws of a member state.
- Processing is permitted if it is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller.

Indeed, similar ethical challenges have previously been encountered when investigating discriminatory behaviours in education and 'research by deception' has been a recognised approach to overcome such difficulties. Certainly, one would advocate dialogue with Research and Ethics Committees to safeguard against such institutional challenges.[15, 16]

Wider considerations

The term 'denigration'

The term 'denigration' itself may be perceived as inflammatory and in order to overcome cultural and institutional challenges when trying to detect and/or manage denigration, other terms – such as 'respectfulness' or 'professional medical tribalism' – could facilitate more open dialogue across healthcare professional groups and overcome barriers to change. Furthermore, it is conceivable that overcoming the challenges faced with identifying, measuring and managing 'denigration' extend beyond measurement alone. There are likely to be multiple facets to this challenge including political, organisational and cultural perspectives that equally require consideration. To overcome these challenges, one could question whether use of the term 'denigration' itself becomes a barrier to change and perhaps other terminology could better facilitate change? Nonetheless, measurement of 'denigration'

would be a start in acknowledging its presence and opening a dialogue with stakeholders to develop strategies that overcome it.

Implementation of measuring denigration

Whilst we have suggested the use of four criteria to measure denigration, further work is needed on how to translate these criteria into an objective, replicable and transferrable metric. Intuitively, Likert scale scoring systems may be applied to the criteria and composite scores used to determine a 'risk of denigration'. Of course, such a metric would require internal and external validation. Determining cut-points for levels or risk of denigration experienced would need further consideration and refinement within such scoring systems, but we are of the opinion that any potential for denigration – however large or small – should be regarded as unacceptable. One must also not forget the importance of qualitative research and triangulation of mixed-methods data to provide important information – not only to validate but provide greater in-depth understanding – of the mechanisms and impact of denigration experienced.

Denigration beyond General Practice

Should denigration of healthcare specialties be considered as any other "ism", such as sexism or racism? The British Medical Association states that 'every member must take responsibility for their behaviour and moderate it so as not to insult or denigrate other members and that this may take a conscious effort. So be it'.[17] It could be argued that denigration shows prejudice, stereotyping, antagonism or discrimination based on ignorance, lack of knowledge and insight, or due to ideology, including personal beliefs and attitudes. With this context in mind, we strongly advocate that behaviours and/or activities constituting denigration should not be tolerated in any healthcare setting and within any healthcare professional group and the principles set out in this article should not be solely applied to the General Practice specialty.

Conclusion

Whilst there is some evidence for denigration of GP in medical education, there remains a paucity of literature that objectively determines its presence and impact on career choices. Measuring denigration more robustly and consistently would enable better evaluation and

implementation of preventative strategies both within and across education institutes. Denigration may occur formally, such as the use of negative language about GP, but could occur through other mechanisms such as inadequate representation, clinical accuracy or funding of GP education. Indeed, there are ethical and legal frameworks, such as GDPR and research ethics, that need to be navigated by educationalists within medical schools when conducting work to better understand denigration. However, with careful thought and consideration these can be overcome. It is of paramount importance that Higher Education Institutions focus greater attention towards better understanding of the mechanisms and measurement of denigration, thus enabling better recognition and management of denigration to any healthcare professional group and/or specialty in medical education. Notwithstanding, in the current uncertain times for all medical educationalists and clinicians during the Covid-19 crisis, we are left wondering if this experience will bring greater understanding and mutual respect between primary and secondary healthcare professionals, bringing us closer together in our shared moral injury, or will it further divide us as professional tribalism takes hold? We should remain optimistic and work positively towards the former.

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