The nature of general practice and the interpersonal skills of many general practitioner undergraduate teachers enables them to make substantial contributions to the pastoral care of medical students as well as to the clinical curriculum.[24,25] The need for more medical student teaching to take place in the setting of general practice is increasingly recognized as more and more patient care takes place entirely in this context.[20,21] This will enable general practitioner teachers to help future doctors to appreciate the importance of recognizing and coping with the stresses that they encounter in their professional lives, and to develop the skills needed for this at an earlier stage in their careers than happens at present. More appropriate methods of undergraduate education could help prevent the damaging effects of burn out later in a doctor's career.

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General practice in deprived areas: problems and solutions

THE *Health of the nation* identifies key areas and targets for improvement of health.[1] All the causes of preventable ill health and premature death mentioned are most prevalent in deprived areas. However, the provision of health promotion clinics and their use by patients is lower in such areas.[2-5] To produce changes in attitude and behaviour among people in these deprived areas requires commitment from a wide range of health and community workers operating together to achieve agreed objectives.[6]

Building an effective primary care team in areas of poverty represents a considerable feat of ingenuity usually brought about by a small number of motivated health care professionals. If the team is successful personal rewards can be high. However, mobility of staff can lead to instability within practices, and recruitment and retention of doctors and staff are major problems in such areas.[7,8] Some district health authorities do not recognize the importance of practice attachment of nursing staff, and few make sufficient allowance for the additional workload health visitors carry in deprived areas compared with those working in more affluent communities.[9] General practitioners from deprived areas should be employed by health authorities on a sessional basis to provide advice on health policy. In particular, they could draw attention to workload implications and needs based on attainment targets.

Difficult problems require practice staff of high calibre. To overcome recognized recruitment problems it may be necessary to offer reimbursement of staff salaries at higher levels than the current 70%, even 100% in some circumstances. An extension of the role of primary care facilitators, and concentration by them on deprived areas would raise the profile of these issues at the level of the family health services authority, enabling justification of resource diversion.

The focus on competition between practices in the new contract for general practitioners,[10] with income highly sensitive to changes in list size, offers little help to general practitioners or their patients. Whether doctors with smaller lists give better care

has been debated but the arguments have been confused as there are few parameters of quality. Doctors with smaller lists seem to do more preventive care, but this could be carried out by nurses.[11-14] Higher levels of physical illness lead to more frequent consultation.[15] Personal experience convinces us that small list sizes are essential to permit more time to reveal, assess and manage the many social and psychological problems prevalent in poor communities and to allow non-consultation based health activities, for example organizing health fairs in local community centres and visiting day nurseries to talk with mothers, and schools to talk with school children. A salaried option for general practitioners is attractive because it would enable doctors to concentrate on using their medical skills without having to devote time to financial concerns.[16]

The terms 'deprived area' and 'inner city' are often used synonymously. In many cities the greatest areas of poverty are to be found among post-war housing estates on the edges of towns. Deprivation payments were introduced in 1990. They are a recognition by the government that additional resources are required by doctors working in poorer areas. However, it is unclear whether these payments are intended to allow doctors in deprived areas with small lists to enjoy a similar level of personal income to doctors in prosperous areas or whether they are the resources to employ additional staff. The Jarman underprivileged area score, used to distribute the payments, was never intended for resource distribution.[17,18] It is a composite score and includes variables which are not necessarily related to deprivation. It was developed to measure areas of high general practitioner workload but fails to identify all practices that should receive payments.[19,20] Alternative scoring systems have been devised and advocated as more appropriate for the task of distributing payments.[21] To ensure greater sensitivity and specificity any deprivation index used in future should correlate well with morbidity and mortality statistics, so that resources are directed to areas of proven rather than perceived need.

An important aspect of health promotion in deprived urban areas is for general practitioners to reach out beyond the surgery door and become active in the community.[22] General practitioners may need to work with community representatives, teachers, benefit rights workers, councillors and the local clergy to establish health education projects. By forming such a network it is then possible to attract patients to health care in a proactive rather than reative way.[23] Doctors are able to draw the attention of local opinion formers and decision makers to the effects of poor housing, diet and poverty on health so that these wider issues are not neglected.

Violence is often directed in frustration at health care providers. Studies have shown that verbal abuse is experienced by all general practice staff in deprived areas almost every day of the week.[24] It is important that staff feel that their working environment is secure, particularly when providing out of hours care. Many requests for visits out of hours may be inappropriate. Such requests for visits occur because patients or the family are genuinely worried and have little family structure or education to cope with the situation themselves. Modern urban environments can be hostile to health workers, especially when visiting at night.[25] Family health services authorites need to adopt a flexible attitude towards out of hours care in deprived areas. In Leicester several solutions have been proposed including extended cooperative rotas, night assessment units and the development of deputizing services under the supervision of family health services authorities. It will be necessary to assess any initiatives carefully as changes have the potential to damage the fabric of daytime care.

Minority ethnic groups often have cultural and language differences. Yet we continue to provide services which may be neither sensitive nor specific to their needs.[26] Longer consultations are required where there are language barriers. There is evidence of the need for more link workers and interpreters in certain areas.[27] Unless we ask the minority populations what their needs are we will continue to provide a service which is unfocused.

A worrying feature for the future of general practice is the lack of commitment of vocational training schemes to the problems of primary care in deprived areas. There is a need for trainees to be enthusiastic about working where they are most needed. There are few training practices in deprived areas (Allen J, organizer, Leicester vocational training scheme 1992, personal communication). Practices need encouragement and a commitment to provide protected time for general practitioners who undertake teaching. The experience that general practitioners have gained working in deprived areas cannot be disregarded. Regional advisers should re-examine some of the criteria used to approve training practices in order to encourage the recruitment of trainers from deprived areas.

The Royal College of General Practitioners has set up an inner city task force which now includes representation from the Association of General Practice in Urban Deprived Areas and the Overseas Doctors Association. Its remit is to identify the problems of patients in areas of urban social deprivation and those who care for them. It intends to find and promulgate effective solutions and make recommendations as to how services can be improved. It is presently taking evidence and intends to report its findings this year. If the task force can reconcile the many viewpoints expressed and present a coherent vision of the future needs and development of primary care in deprived areas it will have performed an invaluable service.

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