GENERAL PRACTITIONERS AT THE DEEP END: THE EXPERIENCE AND VIEWS OF GENERAL PRACTITIONERS WORKING IN THE MOST SEVERELY DEPRIVED AREAS OF SCOTLAND
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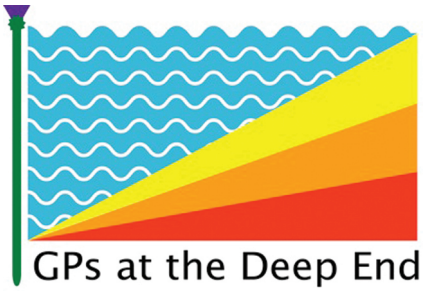
GPs at the Deep End, conceived of by academic and community GPs as a method of addressing the 40-year challenge of the inverse care law, acknowledged that the way forward for doctors practising in the most deprived and challenging social situations should come from the doctors themselves.

The Deep End framework respected the GPs in those communities by putting them front and centre with academics and health service personnel acting as consultants to the process. The resulting Occasional Paper is an authentic and inspiring work that serves as a foundation for organising all of general practice, not just practices in communities which are most at risk. While each of the short chapters of the report merit reading and discussing, a few ideas stood out for me.

We need to be continually reminded that general practice, at its heart, is about relationships built over time that require commitment and openness on the part of both doctor and patient. That long journey is both the promise of general practice and its reward. Our histories with patients are novels not unconnected short stories. A colleague points to how the monastic vow of stability which, more than the better known ones of poverty, chastity, and obedience, defines a monk's life. Stability requires patience, time, and the willingness to persevere through adversity. Stability is about place and identity. So it is for the GPs in the Deep End.

While the ability of health care to change the social conditions that lead to ill health is limited, health care *is* a social determinant and doctors *are* part of the social capital of communities. Surgeries should be places of safety and sanctuary as well as sources of civic mindedness and goodwill. My farewell photo from Julian Tudor Hart's practice in Glyncorrwg when I worked there 30 years ago shows him surrounded by the 18 employees. His practice represented one of the largest employers in the village.



Practices that provide jobs, camaraderie, and hope are contributors to the health of communities and to the people who live in those communities.

One of the enduring contributions of The Deep End Project will be the collaborative, trusting, and energising process itself which created solidarity and an active learning community of Scottish GPs who will continue to contribute to the redesign of general practice. Practices where 'there are very few easy cases' can be isolating as well as enervating, and, in the US at least, doctors in those practices can rapidly burn out, give up, or worse.[1] Enhancing social support is not only necessary for the better health of patients but also for the doctors who serve those patients. A precedent that recognised that GPs could learn from each other, of course, was Balint's work at the Tavistock Clinic in the 1950s.[2] Getting GPs to value themselves as experts in their own work was a new idea then and the lesson, on occasion, needs to be relearned.

The lessons from the Deep End Project are just beginning. We can expect to see ideas and trials to address chronic health problems and prevention — both primary and secondary — coming from the Steering Group over coming years. A process has been in place for over a decade in North Carolina, where community doctors from diverse practices serving low-income patients were brought together to help solve the problems of those patients in their communities. The North Carolina process resulted in creativity and collaboration rather than competition, and has produced cost savings of hundreds of millions of dollars of state and federal funds that was highlighted in discussions of national models for health improvement.[3] The opportunity for the recommendations of the Deep End Project to improve care, save money, and increase physician engagement would be a sound investment for the Scottish NHS as well.

The midwifery of this project by Graham Watt was remarkable. By providing coaching, counselling, and encouragement, his leadership has increased the likelihood that there will be Deep End Projects replicated all over the UK. He and all of the participants are taking the messages of the project to wider policy and academic audiences around the world. The Occasional Paper and the serialised story of the Deep End Project in this Journal is one method to widen the audience.

The six interrelated recommendations in the report are eminently sensible, are driven by experience as well as evidence, and should, without an enormous amount of bureaucratic obfuscation, be implemented and tested. Time for patients, close connections with community services, longitudinal encounters as the basis of work, connection of practices 'across the front line', communication with and support from the NHS, and physician leadership are the prescription. The prescription needs filling and following.

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