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## Prescribing parkrun

A fantastic and inspiring article on the power of prescribing parkrun.<sup>1</sup> Our practice based in South London has recently signed up as a parkrun practice and reading the success stories of how parkrun has transformed patients' lives is exactly why we joined this initiative.

There is something for everyone at parkrun and the examples used show the vast range of health benefits it can have from cardiac rehab and weight loss to reducing social isolation and mental health problems. For a GP surgery it helps to form closer links with the local community, as well as health promotion for staff.

The main barrier we have had to overcome is convincing patients and staff that it is not just an event for 'runners' but is inclusive for all. That Saturday morning buzz can be had by walkers, joggers, and volunteers, who are essential in running the events. Colleagues and patients have said that it can seem quite intimidating on the first visit and I would encourage parkrun to continue to focus on inclusivity and breaking down these barriers to involvement.

We are fortunate in our practice to have volunteer health champions who run a 'Couch 2 5K' programme from the surgery twice weekly. Our hope is that patients can then graduate from the couch to a full 5 km parkrun. We have started to see small success stories already, such as an overweight patient who previously had never run, managing a steady jog and even a short sprint when she had thought she had been left behind!

As a GP trainee at the start of my career it

is great to hear from the author that parkrun and all the associated health benefits *'is the best medicine I can prescribe'*. I know that exercise for health will always be part of my health promotion at work.

If you have never given parkrun a go, I would strongly encourage you to sign up to your local event, print your barcode, and walk, jog, volunteer, or run! I guarantee that you will feel the buzz and see the smiles all around, whatever the weather.

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## Are we propagating the inverse care law as GPs?

Watt<sup>1</sup> is right to acknowledge the disconnect between the political rhetoric of addressing health inequalities and the reality of limited healthcare provision in areas of greatest need. He has however failed to acknowledge the role that we as GPs have in propagating the inverse care law. Recognising our influence as GPs in workforce planning, policy, and medical education is important in addressing the gaps in provision. Bespoke resilience training,<sup>2</sup> leadership, and pastoral support would improve job satisfaction in disadvantaged settings, rather than limited-efficacy 'golden handshakes'.<sup>3</sup> Offering academic GP training in disadvantaged communities presents another means of supporting GP recruitment and raising the profile of academic general practice. Directing research towards Cinderella specialties, that is, mental and public health, presents an opportunity for an upward cycle of community health understanding, engagement, and improved health outcomes.

As recognised in the editorial by Blythe,<sup>4</sup> integration of a proactive GP curriculum in undergraduate medicine is essential, encouraging recruitment and incorporating social accountability in health care. This should go beyond taught theory, with hands-on participation in health promotion

and research projects in disadvantaged communities.<sup>5</sup> Achievement will necessitate more research-active practices outside university cities, and greater collaboration with third-sector organisations. Experiencing a 'Tudor Hart' positive impact will challenge students to consider working in such areas. In contrast, the status quo of increased practice workload in disadvantaged communities risks negatively impacting on GP trainers' ability to engage and inspire medical students.

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## Teaching general practice

Andrew Blythe's recent editorial on teaching general practice reminds us of the opportunities to teach diagnostic reasoning, the management of uncertainty, and therapeutics, which appear under-taught in many schools.<sup>1,2</sup> There is also an opportunity here for a patient safety focus in consulting, in terms of discussing diagnostic reasoning, how diagnostic errors arise, and how to manage diagnostic uncertainty more safely.<sup>3–5</sup>

The World Health Organization states that *Trainees would benefit from explicit*

training in clinical reasoning, patient safety, human factors, critical thinking, managing uncertainty, cognitive heuristics and biases, test limitations, probability concepts, reliability science and systems thinking. Training focused on the causes and impact of diagnostic error might help providers become more competent in error prevention. Simulations and feedback can be a helpful way to learn.<sup>3</sup>

Communication skills teaching is a core subject in undergraduate medical education, whereas teaching future doctors about the need to adopt a patient safety-focused approach to the clinical assessment, diagnosis, and management of patients receives surprisingly little attention. Consultation skills teaching should include not only communication skills but also the principles of practices of safer consulting, including risk assessment in clinical decision making, managing diagnostic uncertainty, and safety-netting skills.<sup>4,5</sup> An online educational programme that covered diagnostic reasoning and how to reduce the risk of diagnostic errors, along with methods of managing diagnostic uncertainty safely, could be developed by the RCGP/SAPC to support both GP teachers and students on their primary care attachments, and has the potential to deliver safer doctors to the workplace.

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## Spiritual care is stagnating in general practice

The embedded model suggested is currently functioning in several UK practices and being rolled out into local clusters.<sup>1</sup> These practices have a chaplain fully integrated within their multidisciplinary teams providing spiritual care in line with the biopsychosocial-spiritual model<sup>2</sup> and modern-maladies approach.<sup>3</sup>

Research has shown that such chaplaincy provision improves spiritual wellbeing to a similar extent as antidepressants while reducing GP consultation rates.<sup>4,5</sup> These results justify the place of chaplaincy within our MDTs at this time of workload realignment.

Chaplaincy has also been shown to be responsive to multimorbidity and undifferentiated illness, both of which are core presentations that the expert medical generalist encounters.<sup>5</sup> Such generalists are ideally placed to refer on to the specialist chaplain within the MDT.

Snowden has developed a patient-reported outcome measure (PROM) to both facilitate spiritual conversations and measure the impact of spiritual interventions.<sup>6</sup>

It is agreed that there is an ongoing need for training but the above evidence suggests the tide is turning on spiritual care and assessing its impact in general practice in the UK.

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## Competing interests

Gordon W Macdonald is lead for chaplaincy provision in Regent Gardens Medical Practice.

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## The resilient general practice: working as a pack

How true these conclusions are,<sup>1</sup> informed also by Eley *et al*'s study.<sup>2</sup> The desire to work in a 'supportive team' is a major factor in career choice of younger GPs.<sup>3</sup> To provide this in a busy practice requires the recognition that clinicians' informal time together is essential, not a luxury item.

Personal continuity of care has been shown to improve patient outcomes,<sup>4</sup> and in building mutually trusting relationships between doctor and patient is likely also to offer greater professional satisfaction. (Think cine films versus albums of random snapshots!)

I am minded to ask if the job of a modern commuting, sessional GP, under constant pressure to deal with 'snapshots', and harassed by QOF screen reminders, is as professionally rewarding as it might be.

Only in-practice leadership can create a supportive team, and facilitate personal continuity of care (where appropriate) through a carefully constructed appointment system, difficult though both may be.

Personal and practice resilience are inextricably entwined, requiring shared values, mutual support, and professional satisfaction. Returning either individuals or organisations from the wrong side of the stress–performance curve is extremely difficult: too often GPs on the wrong side of the curve leave their practice ... or the profession.

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