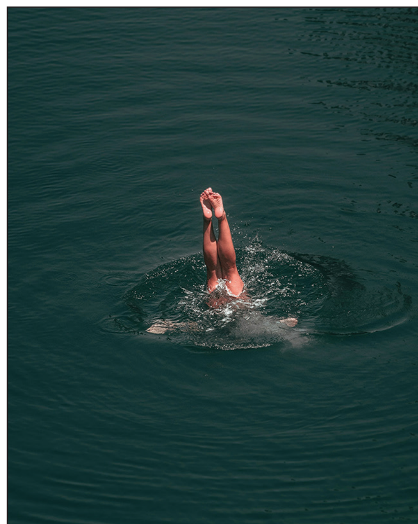
GP careers:
diving in at the Deep End?

For GP trainees approaching the end of vocational training, there are big decisions to make and questions to ask. What do I want the next few years of my clinical career to look like? How many sessions a week can I manage? Do I want to take a salaried job or be a locum? Do I want a portfolio career? Do I even want to stay in medicine?

For those deciding to go down the 'traditional' route of in-hours practice-based primary care, one important question is what sort of surgery do I want to work in? Job adverts talk about competitive salaries, friendly working environments, daily coffee meetings — it's hard to differentiate practice A from practice Z without insider information or going in to have a look for yourself. There are key points that should be available including appointment length, patients per session, contacts per day, admin burden, and salary. There is also the bigger picture of setting and which patient groups you will predominantly be working with.

During training, I have been lucky enough to work in several locations: a rural dispensing practice; an inner-city practice with high levels of deprivation; and a suburban practice with an affluent population. All of these have brought their rewards and challenges, and the experience of each job was predominantly related to systems of work and colleagues rather than patient groups. When I think of what sort of practice I would like to work in, the answer is not immediately obvious.

The inverse care law, that people who most need health care are least likely to receive it, still pervades our primary care system over 50 years after it was first described by Julian Tudor Hart.[1] The Health Foundation, in their 2022 report, *Tackling the Inverse Care Law*, describes how practices in the most deprived areas have higher healthcare usage (demand), lower funding per need-adjusted patient, fewer full-time equivalent GPs per 10 000 patients (supply), and lower Quality and Outcomes Framework



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points and Care Quality Commission ratings (quality) than those in the least deprived areas.[2] This suggests there is a clear moral imperative to work in Deep End or deprived area practices, to go where the need is greatest.

However, the reality is there are significantly higher rates of burnout among GPs in the most deprived practices,[3] with clinicians describing feeling like a *'wrung out rag'*, going *'around and around in circles'* with *'constant worry'* about the *'burden of failing to meet demand'*.[4] Is it better to do the 'right' thing, working where the need is highest but risk shortening your career, or work in less demanding areas but feel guilt for not stepping up?

> *"Is it better to do the 'right' thing, working where the need is highest but risk shortening your career, or work in less demanding areas but feel guilt for not stepping up?"*

Providing health care outside the areas of highest need is not an unjust thing to do: there are people in need of a GP everywhere and working in areas of deprivation is not for everyone. To use David Benatar's asymmetry argument,[5] the absence of a good thing (working where the need is highest) is not bad, but the absence of a bad thing (another GP burning out and leaving medicine) is good. Should individuals feel the weight of this moral equilibrium, or should we all be advocating for systemic policy changes to address the inverse care law — a review of general practice funding allocations, an improved workforce strategy, and redistribution of GP training posts — and work where we feel able to have a sustainable and fulfilling career, wherever that may be?

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