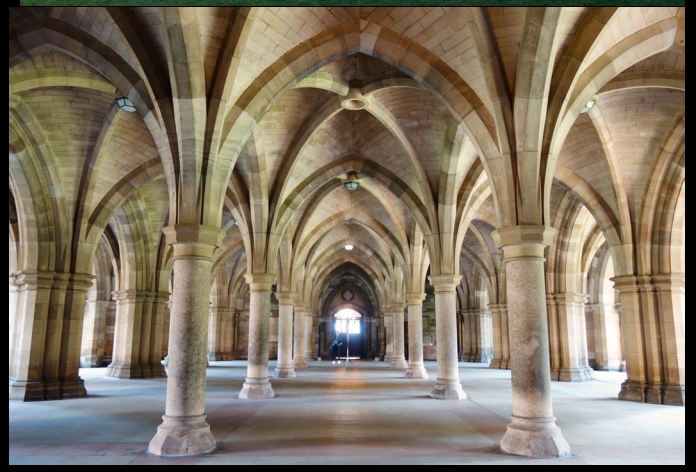
AT THE DEEP END : HOW FAMILY PHYSICIANS CAN BUILD CONNECTION, COMMUNITY AND CHANGE

GPs at the Deep End







Graham Watt
Emeritus Professor
General Practice and Primary Care
University of Glasgow
Scotland, UK


Greenland
Iceland
CANADA
UNITED STATES
MEXICO
CUBA
DOMINICAN REPUBLIC
GUATEMALA
HONDURAS
NICARAGUA
COSTA RICA
PACIFIC OCEAN
NORTH ATLANTIC OCEAN
Norway
Sweden
Finland
Ireland
United Kingdom
Germany
Poland
Ukraine
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Italy
Portugal
Spain
Greece
Turkey
Morocco
Tunisia
Mediterranean Sea
Algeria
Libya
Egypt






WASHINGTON







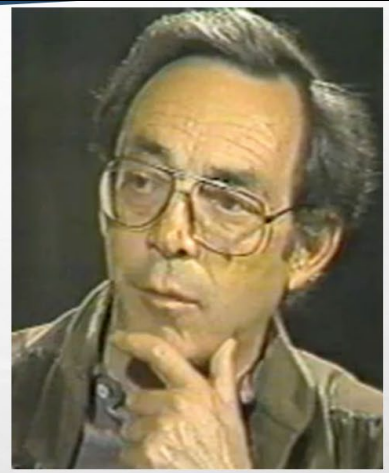






HONORING OUR HEROES

H. JACK GEIGER



WWII VETERAN, PHYSICIAN, CIVIL RIGHTS ACTIVIST, AND CO-FOUNDER OF PHYSICIANS FOR HUMAN RIGHTS AND THE MEDICAL COMMITTEE FOR HUMAN RIGHTS

Community Oriented Primary Care

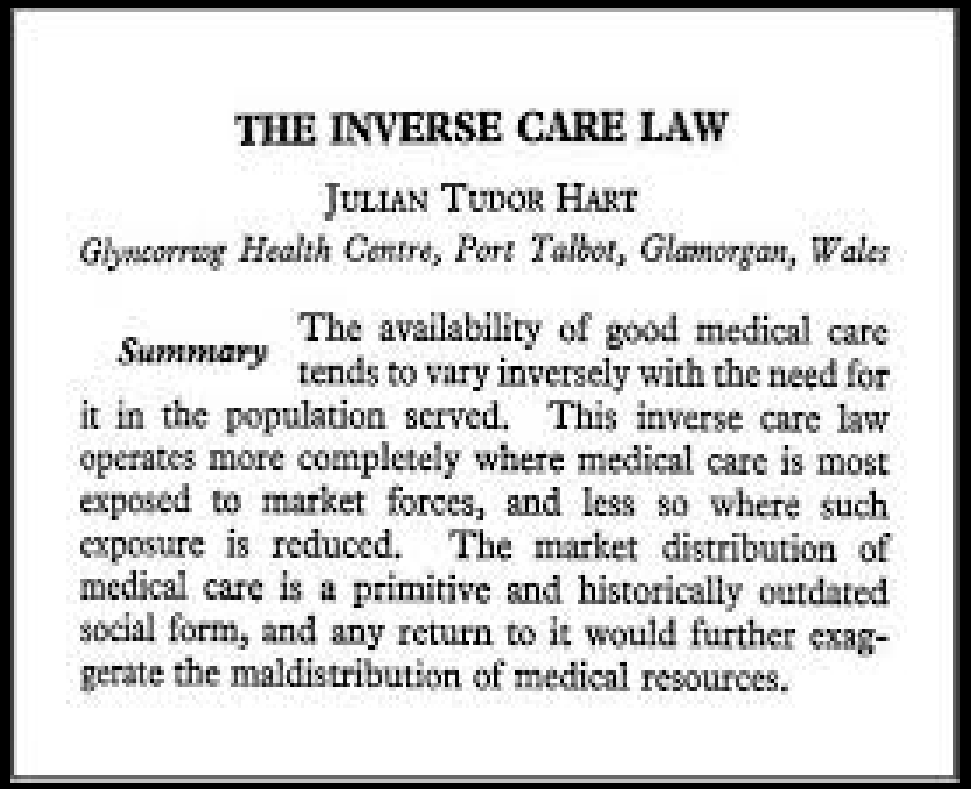
An Overview

Fitzhugh Mullan, M.D.









THE INVERSE CARE LAW

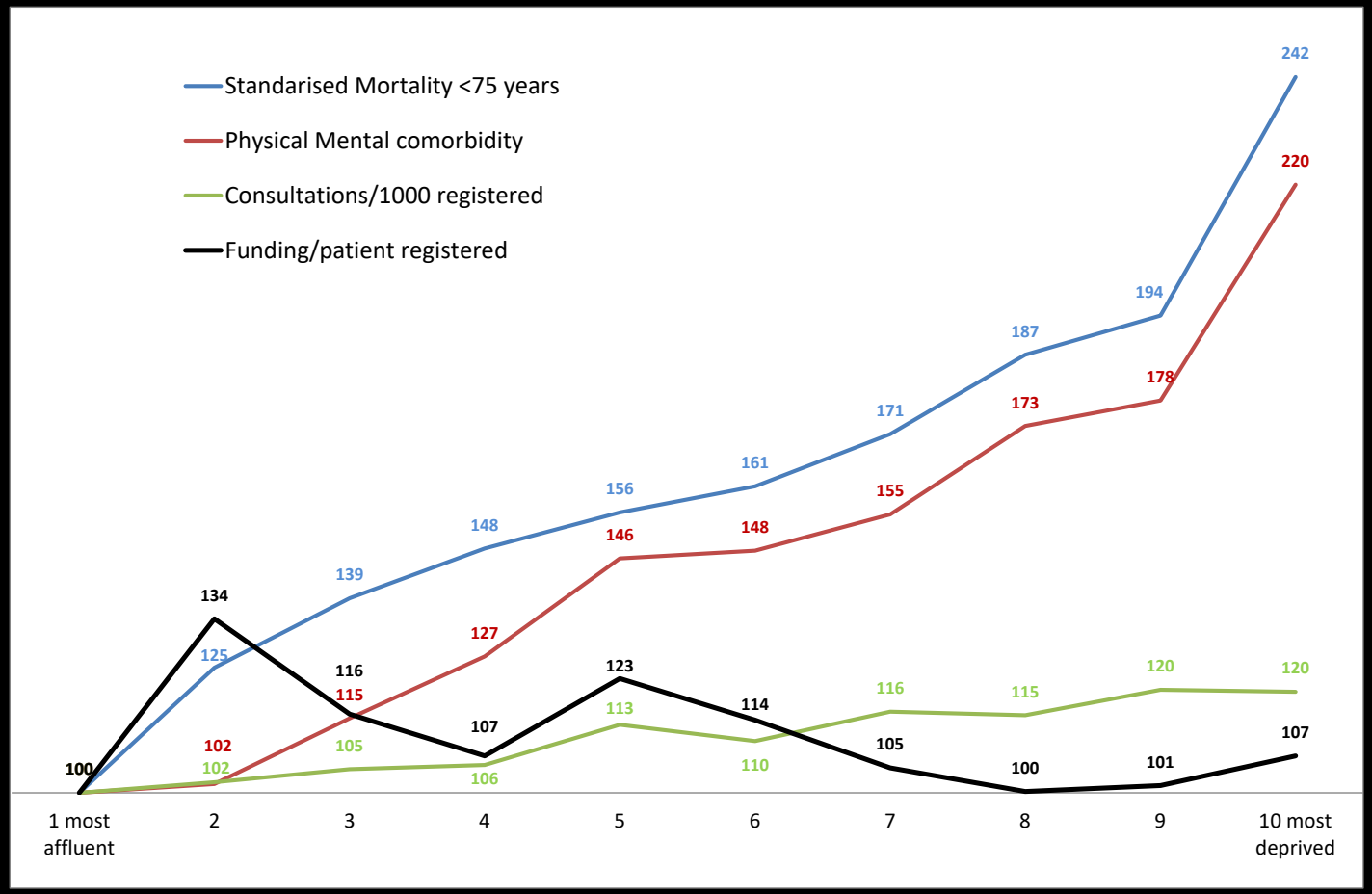
JULIAN TUDOR HART
Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales

Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

The availability of good medical care tends to vary inversely with the need for it in the population served

Julian Tudor Hart, Lancet 1971;i:405-407

% DIFFERENCES FROM LEAST DEPRIVED DECILE FOR MORTALITY, COMORBIDITY, CONSULTATIONS AND FUNDING



British Journal of General Practice 2015:doi:10.3399/bjgp15X687829

CONSULTATIONS IN DEPRIVED AREAS

Multiple morbidity and social complexity

Shortage of time

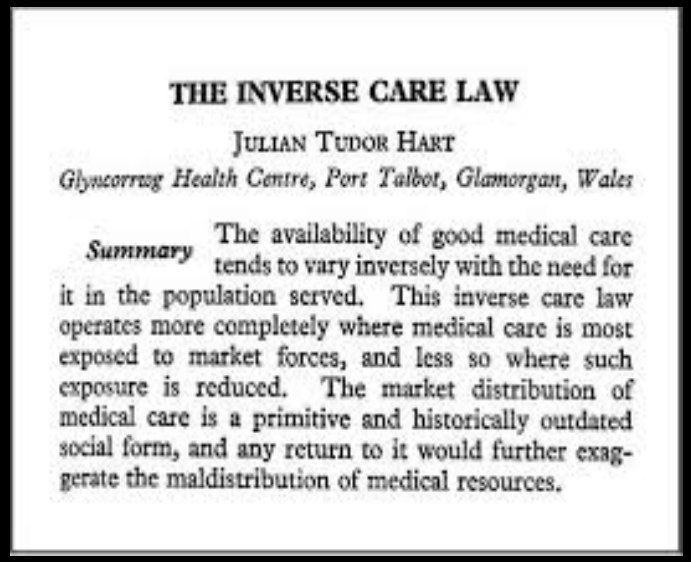
Reduced expectations

Lower enablement (especially for mental health problems)

Poorer outcomes after 12 months

Poorer health literacy

Practitioner stress



THE INVERSE CARE LAW

JULIAN TUDOR HART

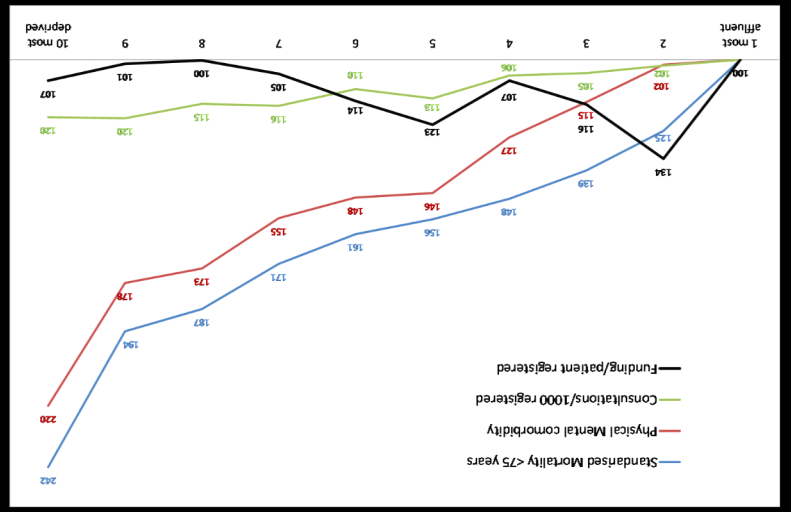
Glyncorrwg Health Centre, Port Talbot, Glamorgan, Wales

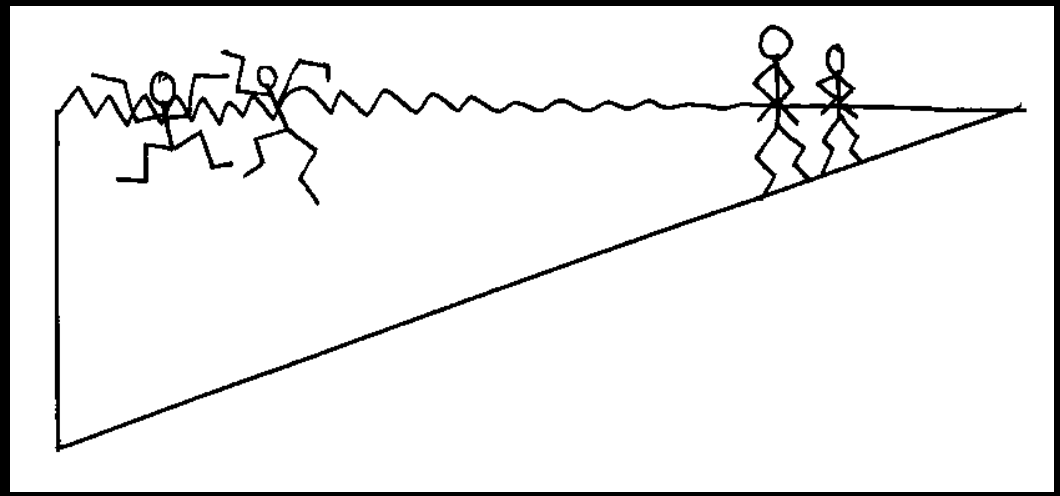
Summary The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.

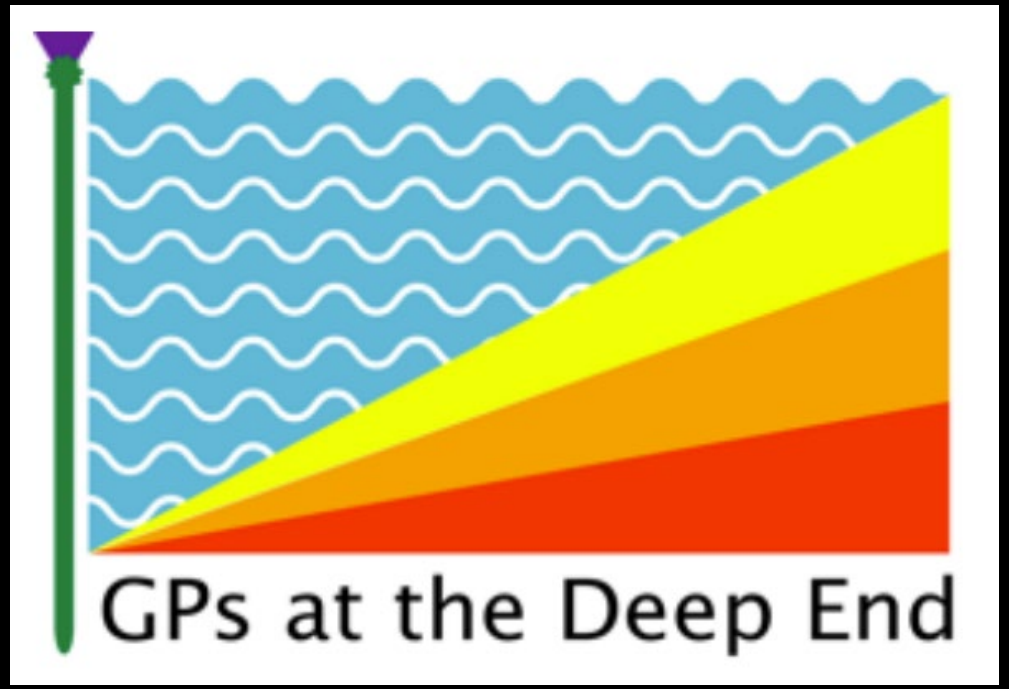
Mercer SM, Watt GCMW : clinical primary care encounters in deprived and affluent areas of Scotland
Annals of Family Medicine 2007;5:503-510

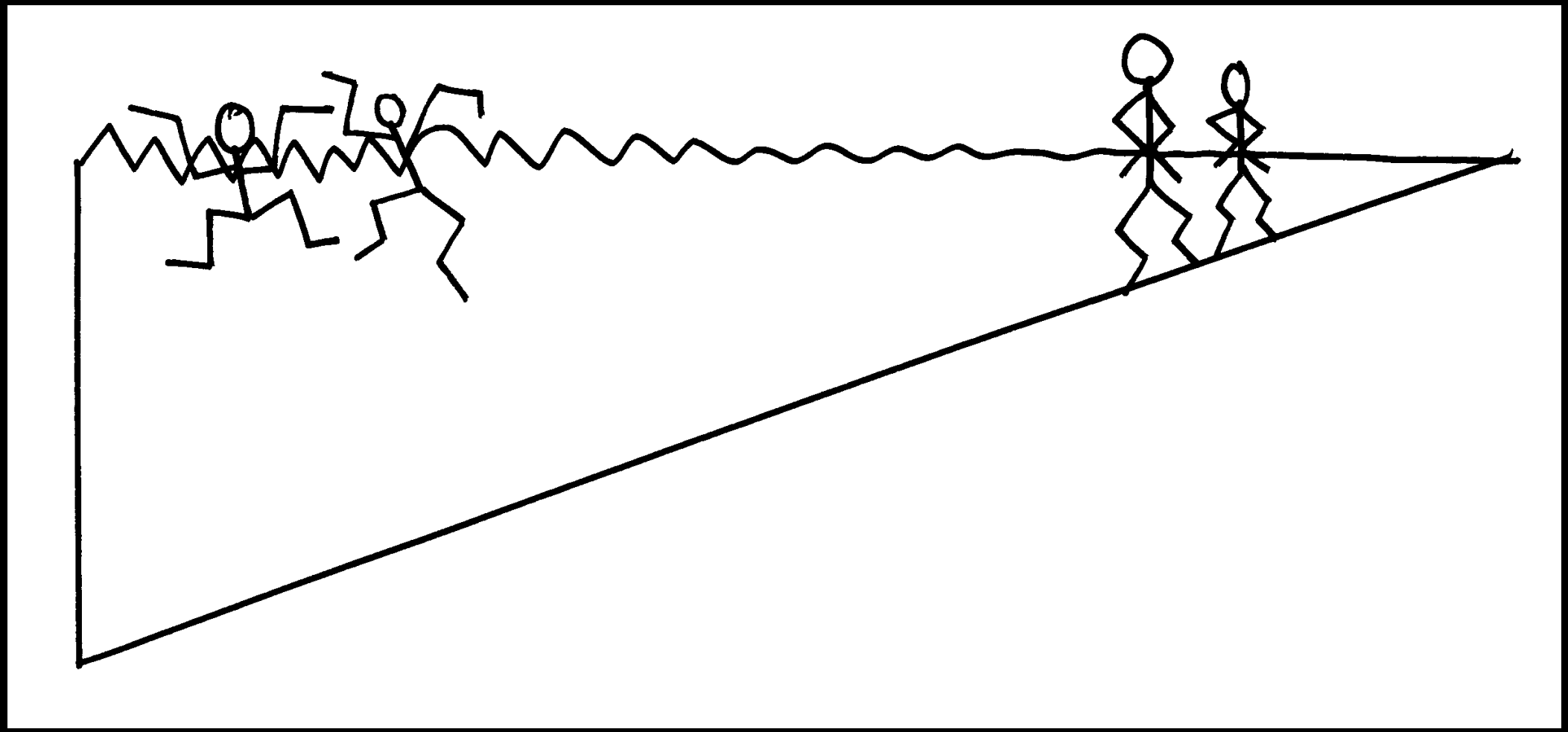
SPECIALISATION	V	GENERALISM
CENTRALISATION	V	HEALTH IN THE COMMUNITY
PRIVATISATION	V	FREE HEALTH CARE AT THE POINT OF USE

GENERAL PRACTITIONERS AT THE DEEP END






GPs at the Deep End







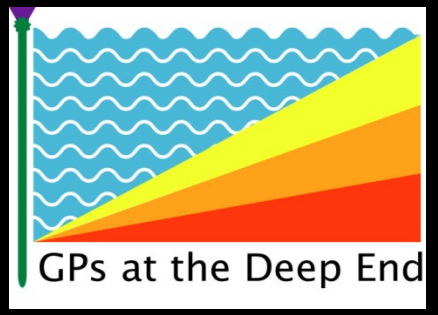
GPs at the Deep End

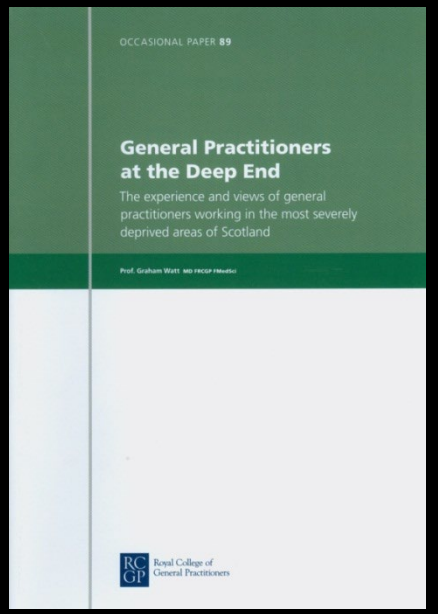
General Practitioners at the Deep End

Final report of a special meeting held on 16 September 2009 at Erskine Bridge Hotel

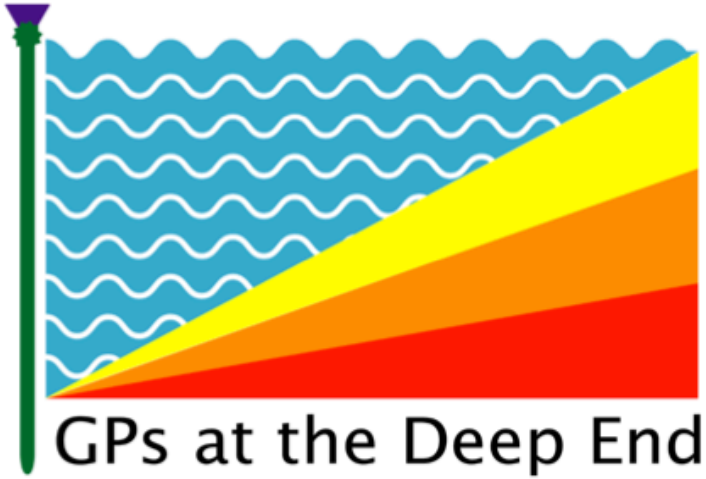
36 DEEP END REPORTS (www.gla.ac.uk/deepend)

1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
13. The Access Toolkit : views of Deep End GPs
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce health inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues in very deprived areas
27. Improving partnership working between general practices and financial advice services in Glasgow : one year on
28. GP recruitment and retention in deprived areas
29. GP use of additional time as part of the SHIP project
30. A role for members of the Scottish parliament in addressing inequalities in health care in Scotland
31. Attached Alcohol Nurse Deep End Pilot
32. 8 years of the Deep End Project
33. Increasing undergraduate education in primary care in areas of socio-economic deprivation
34. The Deep End Project for 2019-22
35. Plans for advocacy and engagement by the Scottish Deep End Project
36. General practice in the time of COVID-19









Deep End Report 42

What can General Practice do to Strengthen Continuity of GP Care for those who Need it Most?

On Tuesday 25 June 2024, the Deep End GP group hosted an in-person roundtable discussion on relational continuity of GP care for vulnerable and deep end populations. The discussion reviewed the strong evidence base and the challenges to implementing this, before focusing on possible solutions.

October 2024

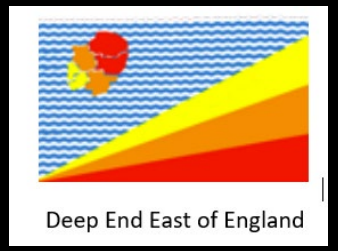
DEEP END PROJECTS AND INITIATIVES

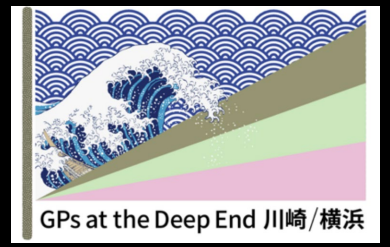
Extra time for consultations

Link workers

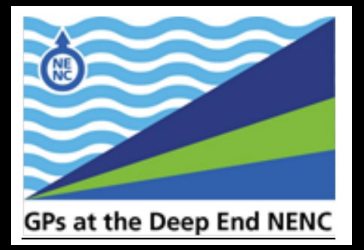
Financial advisors

Pioneer Programme

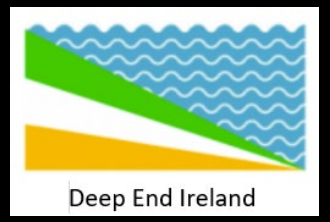

Deep End East of England


GPs at the Deep End 川崎/横浜

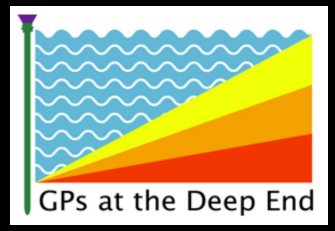

London Deep End Health Equity


NE
NC
GPs at the Deep End NENC

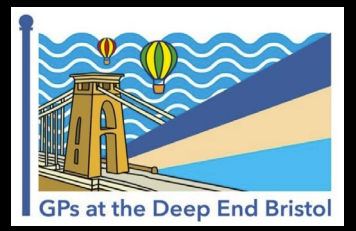

Deep End Greater Manchester


Deep End Ireland

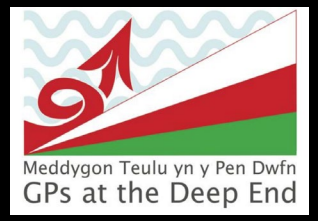

YORKSHIRE/HUMBER


GPs at the Deep End

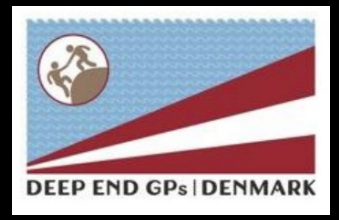

Deep End Canberra

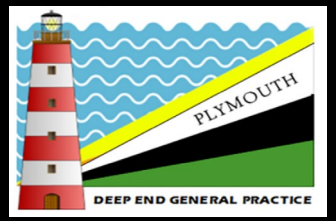

GPs at the Deep End Bristol

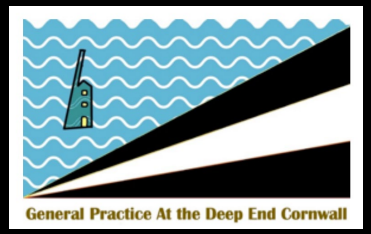

General Practice at the Deep End
Nottinghamshire


Meddygon Teulu yn y Pen Dwfn
GPs at the Deep End

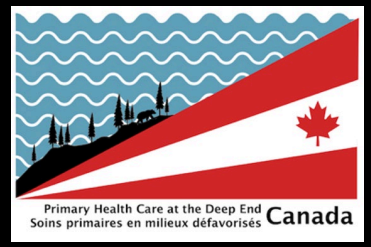

Deep End Cheshire & Merseyside


DEEP END GPs | DENMARK


PLYMOUTH
DEEP END GENERAL PRACTICE

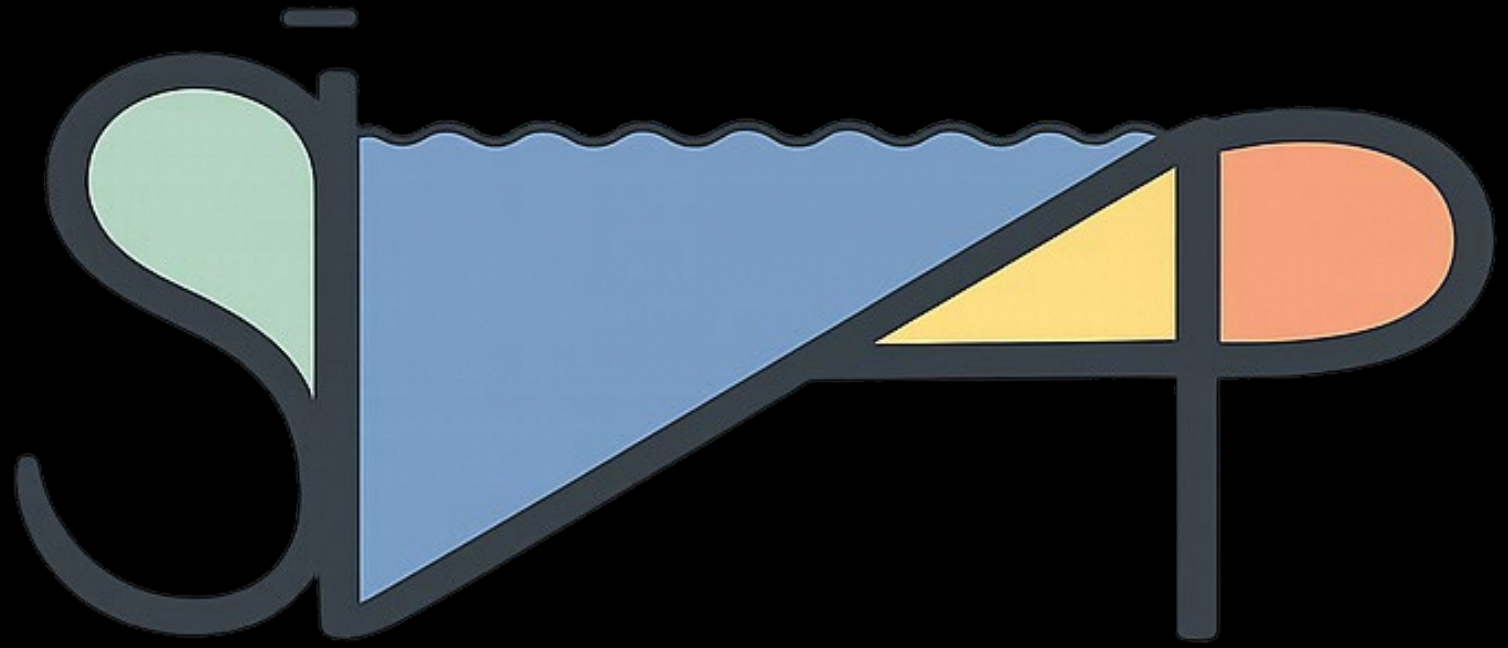

General Practice At the Deep End Cornwall


Deep End Living Lab
FRANKSTON, AUSTRALIA


Primary Health Care at the Deep End
Soins primaires en milieux défavorisés
Canada


Emergency Medicine
at the Deep End


Deep End GP Northern Ireland

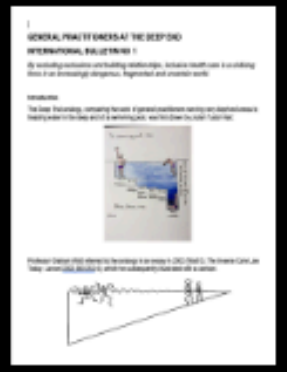



GPs at the Deep End 川崎/横浜

DEEP END INTERNATIONAL BULLETING NOS 1-10

www.gla.ac.uk/deepend

News from : Scotland, Ireland, Yorkshire/Humber, Greater Manchester, Canberra, Australia, Plymouth, Northern Ireland, London, North-East and North Cumbria,Nottinghamshire, Bristol,East of England, Cornwall, Japan, Denmark, Cheshire and Mersey, and Wales



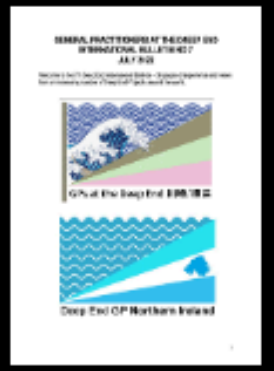
















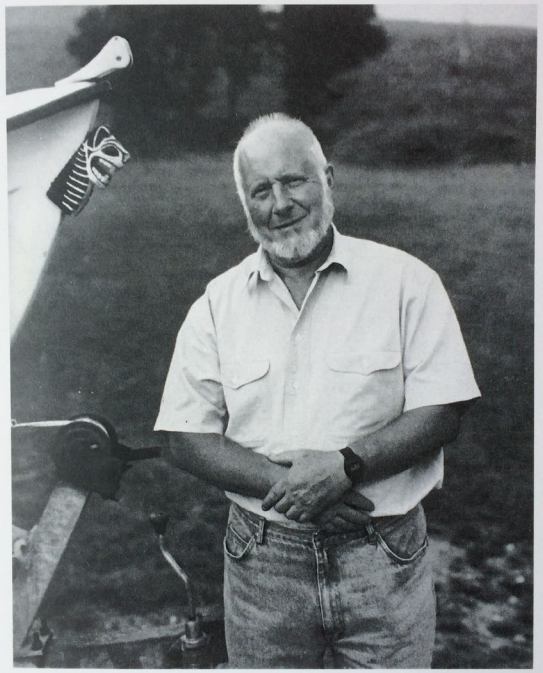




PRESENTATIONS FROM

SCOTLAND
IRELAND
DENMARK
CANADA
JAPAN
AUSTRALIA
WALES
ENGLAND
- London
- Bristol
- North East and North Cumbria
- Cornwall
- Plymouth
- East of England

An Appreciation
for the Experimental Life of



Dr. Julian Tudor Hart
1927–2018



JULIAN TUDOR HART GLYNCORRWG, SOUTH WALES

NOT ONLY

Evidence-based medicine

BUT ALSO

Unconditional, personalised, continuity of care, provided for all patients, whatever problems they present.

Applying the CARE measure and Patient Enablement Instrument (PEI) after general practice consultations

YOU CAN GET EMPATHY WITHOUT ENABLEMENT
BUT YOU NEVER GET ENABLEMENT WITHOUT EMPATHY

Mercer SW Jani BD Maxwell M Wong SYS Watt GCM
Patient enablement requires physician empathy:
a cross-sectional study of general practice consultations
in areas of high and low socio-economic deprivation in Scotland
BMC Family Practice 2012, 13:6

THE EXAMPLE OF JULIAN TUDOR HART

Working in, with and for a local community

Staying long enough to make a difference

Building knowledge, confidence, agency and trust

Initially face to face, moving to side by side

The last patient as important as the first

Measuring what you do, being honest with the result

Epidemiology the map and science the guiding light



RELATIONSHIPS

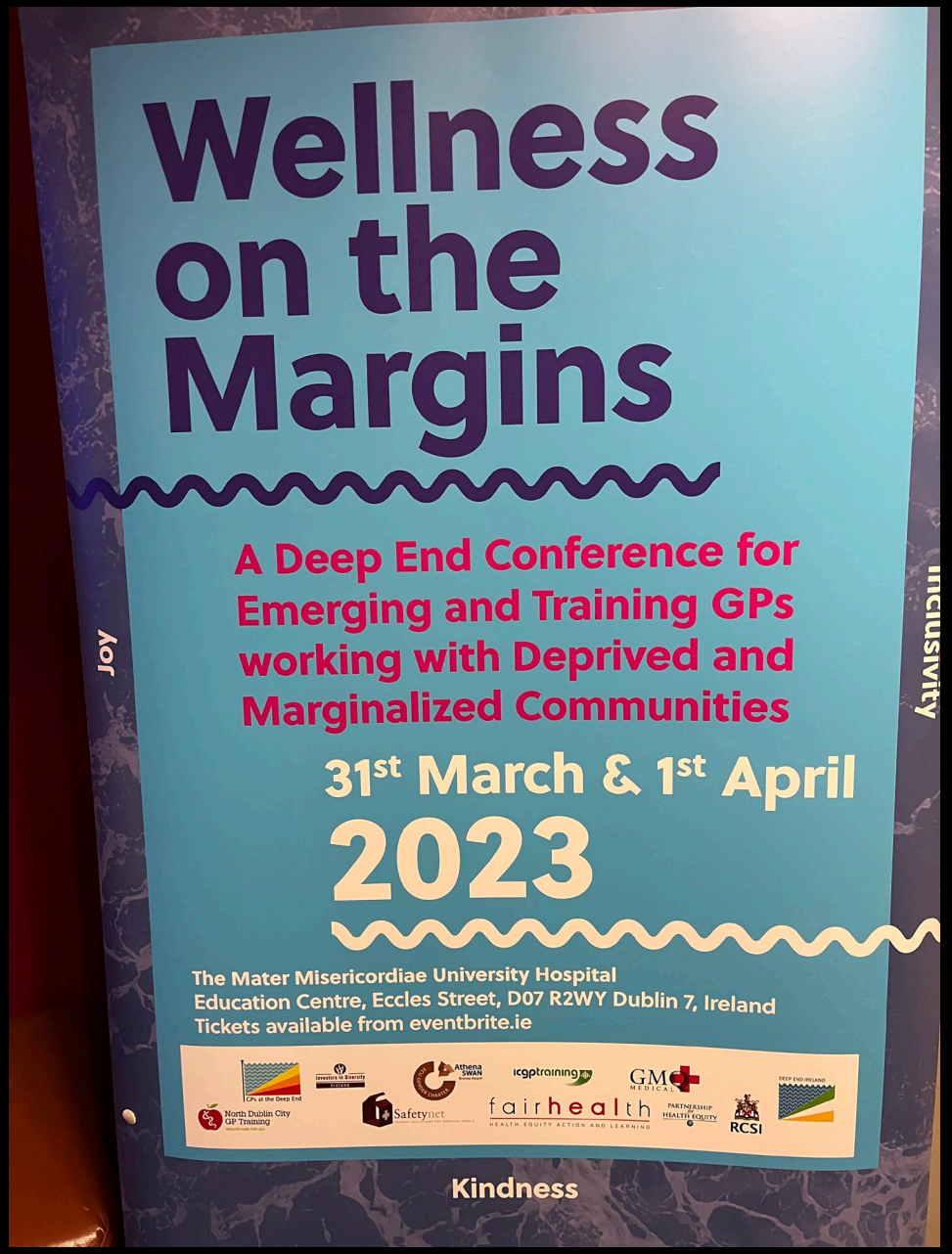
ARE THE

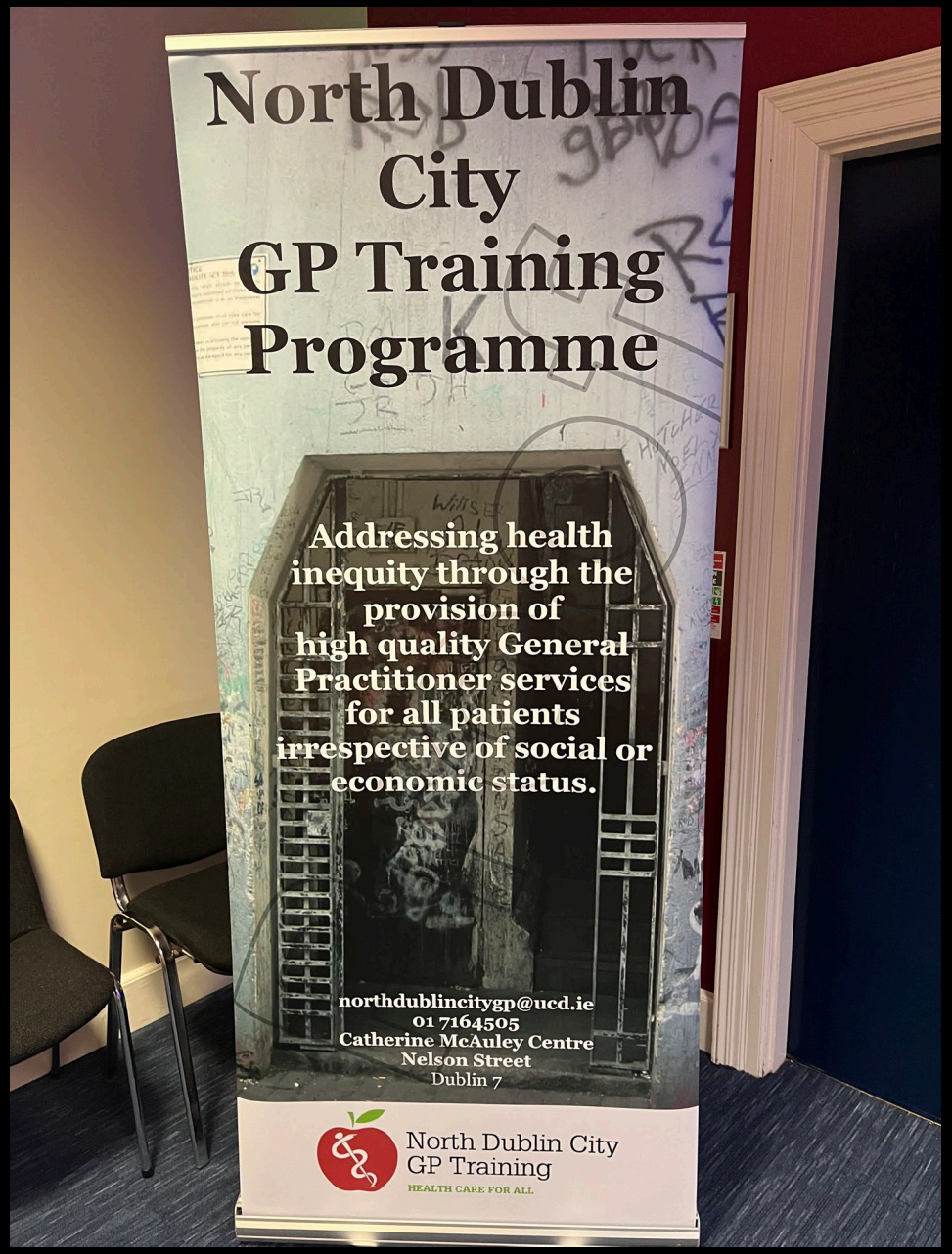
SILVER BULLETS

OF GENERAL PRACTICE AND PRIMARY CARE

3 BUILDING PROGRAMMES

1. A COMPENDIUM OF PATIENT STORIES
2. STRONG LOCAL HEALTH SYSTEMS
3. NETWORKS OF LOCAL SYSTEMS


Wellness on the Margins
A Deep End Conference for Emerging and Training GPs working with Deprived and Marginalized Communities
31st March & 1st April
2023
The Mater Misericordiae University Hospital
Education Centre, Eccles Street, D07 R2WY Dublin 7, Ireland
Tickets available from eventbrite.ie
Joy
Inclusivity
Kindness


North Dublin City GP Training Programme
Addressing health inequity through the provision of high quality General Practitioner services for all patients irrespective of social or economic status.
northdublincitygp@ucd.ie
01 7164505
Catherine McAuley Centre
Nelson Street
Dublin 7
North Dublin City GP Training
HEALTH CARE FOR ALL

WHAT CAN A DEEP END GP DO?

Levels of action

1. Individually when seeing patients
2. With colleagues within a practice
3. Looking outside the practice to work with local colleagues
4. Collectively as part of a network of practices



Our health service should be at its best where it is needed most

SCOTLAND has an admirable record of providing comprehensive health care which is free at the point of use, and has been steadfast in protecting its NHS from the ravages of market competition, which continue to threaten the NHS in England.

However, as the continuing statistics on health inequality show, NHS Scotland has still to address the inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served.

While NHS resource distribution formulae and general practitioner contracts have recognised for a long time the increased health problems, multiple morbidity and needs for care of elderly populations, they have been much less effective in providing resources to meet the increased health problems, multiple morbidity and social complexity of younger patients living in very deprived areas.

As general practitioners working in the 100 most deprived general practices in Scotland, we are the front line of the NHS in Scotland as it parties with health inequality. We are in daily contact with large numbers of patients, with unrivalled levels of continuity and coverage, and have substantial experience and knowledge of the health problems of people living in Scotland's poorest communities, including vulnerable children, and those struggling with mental health and addiction problems, in addition to physical ailments.

The inverse care law in Scotland is not a matter of good medical care in affluent areas and bad medical care in deprived areas. It is the difference between what general practice and primary care can currently achieve, in meeting the needs of patients in very deprived areas, and what could be achieved if the service were better resourced to address levels of need.

The major issue which must be addressed, and whose solution requires political action, is the shortage of time within consultations to address a patient's needs in very deprived areas. Although other measures are needed, without this essential building block, the NHS will continue to fail in its attempts to narrow health inequalities.

Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.

The NHS has many challenges to face, but should be at its best where it is needed most. We call on political parties contesting the forthcoming election to commit themselves to eliminating the inverse care law in Scotland. Their first step should be to provide general practices in the front line with additional time for patient consultations.

Members of the Deep End Steering Group: Georgina Brown, GP, Springburn Health Centre; John Budd, GP, Edinburgh Homeless Practice; Peter Cawston, GP, Drumchapel Health Centre; Margaret Craig, GP, Powell and Springburn; Susan Langridge, GP, Possilpark Health Centre; Stewart Marcus, Professor of Primary Care Research, University of Glasgow; Caroline Morton, GP, Craigmillar Health Centre; Anna Mullin, GP, Govan Health Centre; Jen O'Neill, GP, Lightburn Medical Centre; Euan Patterson, GP, Govan Health Centre; Petra Sambale, GP, Keppoch Medical Centre; Graham Watt, Professor of General Practice, University of Glasgow; Andrea Williamson, GP, Glasgow Homeless Health Service.

GPs at the Deep End

Manifesto
for the
Scottish Parliament
election 2026

Our Vision:

We believe everyone in Scotland deserves fair, compassionate, person-centred healthcare - no matter where they live or what they earn.

Strong general practice is the backbone of the Scottish NHS.
If properly supported, general practice has enormous potential to reduce health inequalities and transform lives.

NHS general practice should be at its best where it is needed the most.

ADVOCACY

The social causes of illness are just as important as the physical ones.

The medical officer of health and the practitioners of a distressed area are the natural advocates of people.

They well know the factors that paralyse all their efforts.

They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?

Henry Sigerist, Johns Hopkins University

HOW DO DEEP END GENERAL PRACTITIONERS SEE THEIR ROLE ?





The smallest act of kindness

is worth more than the grandest intention.

OSCAR WILDE



The Inverse Care Law on the Political Agenda



Prime Minister Mette Frederiksen's New Year's Address 2026

Allow me to share a striking paradox: There are fewer doctors in places where there are more sick people. It's time to do something about it!

WHAT ARE WE TALKING ABOUT ?

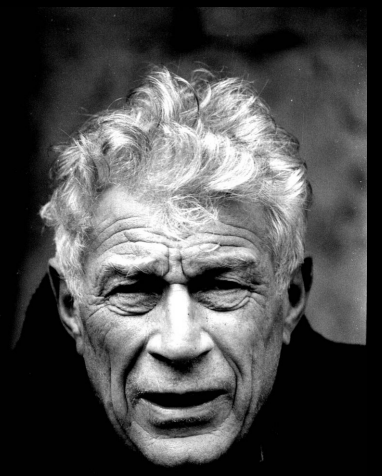
Inclusive health care ?

A support mechanism to avoid gaps in care ?

Part of measures to address health inequalities ?

Shifting the balance between primary and secondary care ?

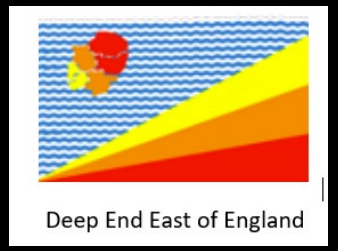
A resistance movement - preparing for a better future?

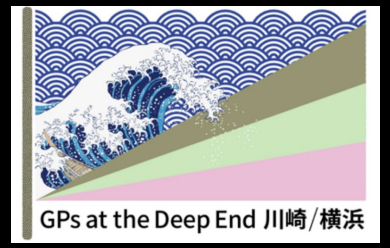


…in the dark age in which we are living
and the new world order,
the sharing of pain is one of the essential preconditions
for a re-finding of dignity and hope.

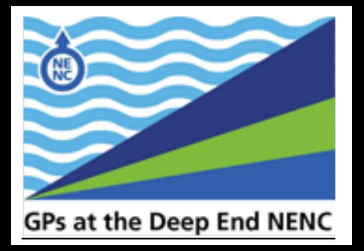
Much pain is unshareable.
but the will to share pain is shareable
and from that inevitably inadequate sharing
comes a resistance.

John Berger

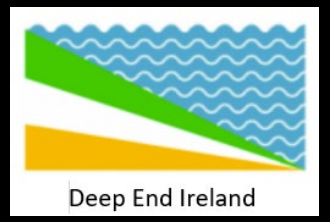




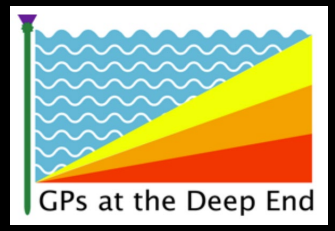




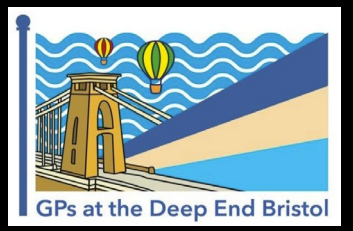




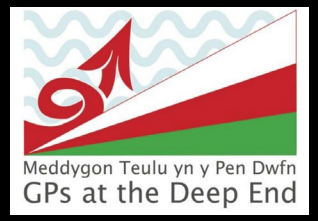




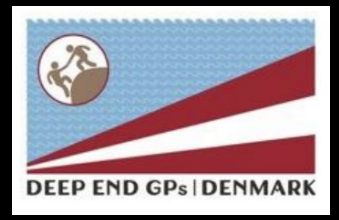


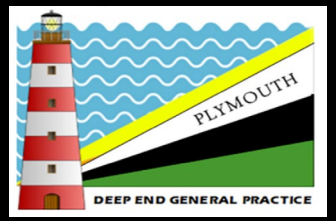


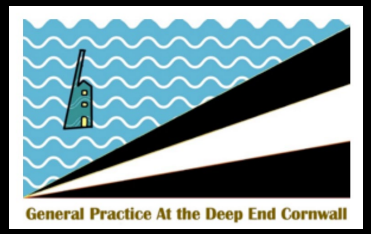




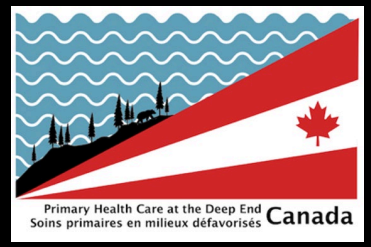












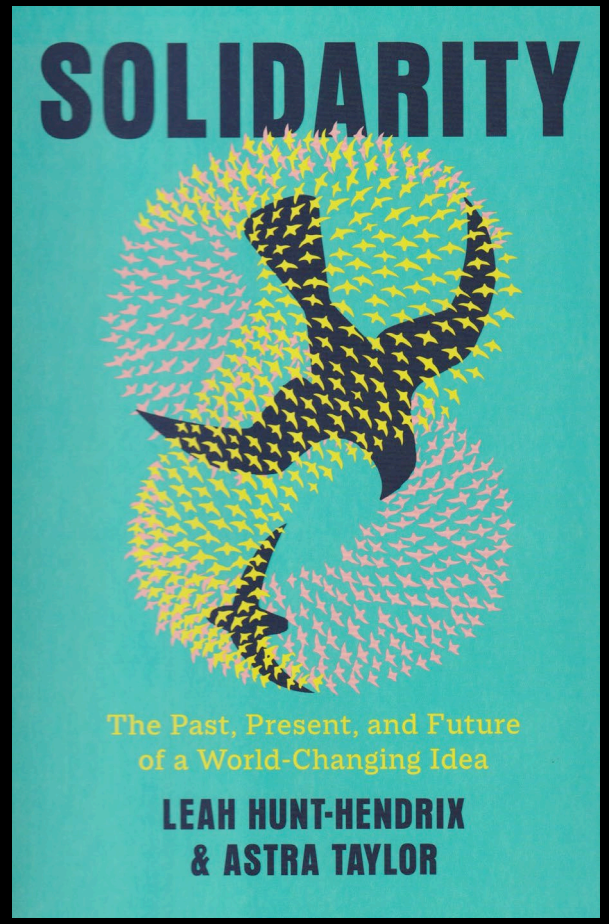




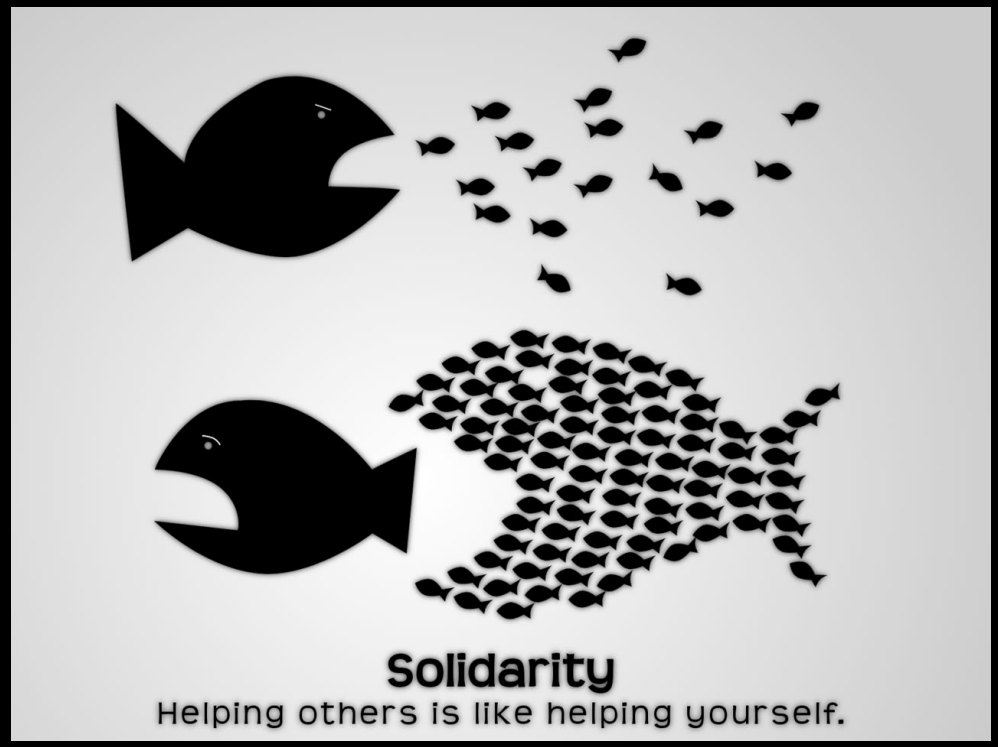
"By excluding exclusions and building relationships, inclusive health care is a civilising force in an increasingly dangerous, fragmented and uncertain world."

The Exceptional and Equitable Potential of General Practice

Organising is a kind of alchemy:
it turns alienation into connection,
despair into dedication,
and oppression into strength.



Astra Taylor and Leah Hunt-Hendrix
Solidarity: The Past, Present and Future of a World-Changing Idea
Pantheon Books, 2024


Solidarity
Helping others is like helping yourself.

The Scottish Deep End Project



www.gla.ac.uk/deepend

GPs at the Deep End

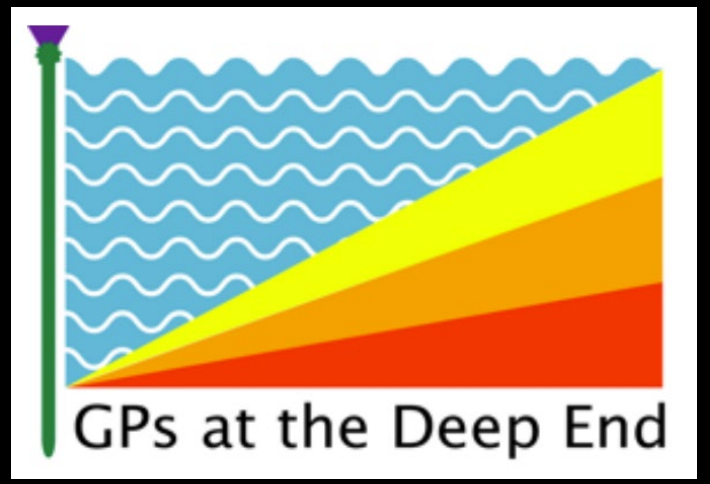
ESSENTIAL INGREDIENTS OF DEEP END PROJECTS

1. Engagement with practitioners
2. Shared activities - advocacy, service development
3. Central coordination – continuity and communication
4. Shared learning
5. Readiness and opportunity
6. Perseverance – lots of small steps

AT THE DEEP END

HOW FAMILY PHYSICIANS CAN BUILD CONNECTION, COMMUNITY AND CHANGE

"Organising is a kind of alchemy:
it turns alienation into connection,
despair into dedication,
and oppression into strength."



Website of the Scottish Deep End Project www.gla.ac.uk/deepend

Past issues of the Deep End International Bulletin
https://www.gla.ac.uk/schools/healthwellbeing/research/generalpractice/deepend/international/

Thank you for listening

And now, some Q&A