Blane, D. N. (2019) Commentary: Supporting GP training in areas of socio-economic deprivation. *Education for Primary Care*, 30(3), pp. 165-166.
(doi: 10.1080/14739879.2019.1600047)

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Deposited on: 9 April 2019

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Commentary

Supporting GP training in areas of socio-economic deprivation

The paper by Cunningham and Yeoman provides an important and timely contribution to the debate on how best to support GP training in, and for, areas of socio-economic deprivation [1]. In their qualitative study of recently-qualified GPs who trained in deprived area practices (or DAPs, as they call them), they identified a number of challenges and made suggestions for change.

The early career GPs in the study described two key differences between their training experience and those of their peers who trained in more affluent area practices. First, they perceived heavier clinical workloads, reflecting the higher concentration of health and social complexity in areas of deprivation [2]. The study participants reported that this workload had on occasion impacted on protected time for learning. Second, they felt they had less experience of patient-centred consulting as many of their patients appeared reluctant to be involved in shared-decision making. The GPs felt that this had put them at a disadvantage in the CSA component of the MRCGP exam, a view shared by GP trainers in a previous study [3].

Cunningham and Yeoman propose that making aspects of additional learning (e.g. day release programmes) more relevant to the challenges of working in DAPs would be beneficial; previous research has outlined the particular CPD needs of GPs working in areas of high socio-economic deprivation, including migrant health, safeguarding children, and supporting people with addictions and those living in poverty [4].

The idea of tailoring training to the needs of the population served is not new. In February this year, GP colleagues in Greater Manchester launched a GPST programme in partnership with Health Education England NW, which has a strong focus on "deprivation medicine" (https://www.sharedhealthfoundation.org.uk/deprivation-medicine). They are following the example of the North Dublin City GP training programme, which specifically trains GPs to work in areas of deprivation and with marginalised groups (https://www.healthequity.ie/education-ndcgp).

Practice rotations are also suggested by the authors as being mutually beneficial for GP trainees in more affluent and deprived areas. For those in DAPs it could reduce their anxiety related to the CSA exam; for those in practices in more affluent areas a rotation could "dispel the myths" of deprived area training, and perhaps encourage recruitment to such practices in the future. This was also recommended in the 'By choice – not by chance' report [5].

Finally, the early career GPs in this study described the importance of supportive practice teams and flexible working patterns, with portfolio careers suggested as helpful to sustaining work in a DAP. This is in keeping with recent research on what influences GP career choice [6], though the suggestion that larger practices are necessarily more supportive than smaller practices is open to debate. In our experience with the Deep End GP Pioneer scheme, participating practices have ranged in size from roughly 2000 to over 10,000 patients; a small amount of additional capacity and protected time (for professional and service development within and between practices) was transformational for all concerned [7].

What is beyond doubt, however, is that targeted investment is required to support GP practices in areas of socio-economic deprivation if we are to improve the quality and volume of GP training (and, indeed, undergraduate teaching). For if general practice is not at its best where it is needed most, inequalities in health will inevitably widen.

Reference List

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