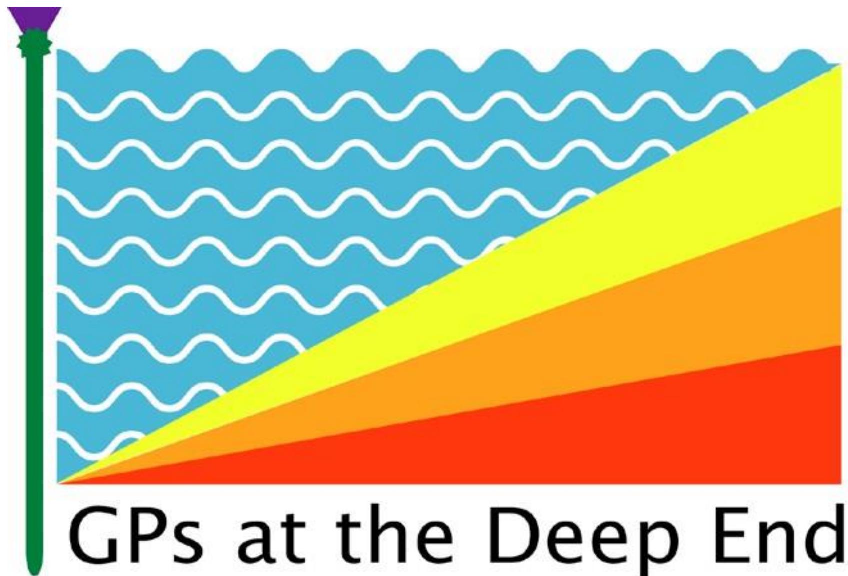

Deep End Report 33

Increasing undergraduate education in primary care in areas of socio-economic deprivation (the Deep End)

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August 2018

SUMMARY

- Across all medical schools, there is a drive to improve the quantity and quality of undergraduate (UG) teaching in general practice.
- There are particular challenges related to UG general practice teaching in areas of socio-economic deprivation (the Deep End).
- The inverse care law is the fundamental barrier to improving the volume and quality of medical education in areas of deprivation. Simply put, practices in more deprived areas struggle to meet the needs of the higher proportion of patients with complex health and social problems, resulting in limited capacity to take on teaching roles.
- The higher proportion of smaller, often singlehanded, practices in deprived areas makes it more difficult to accommodate teaching and training requirements.
- There are relatively more GPs in Deep End practices approaching retirement, meaning recruitment to these areas is all the more pressing, with knock-on effects for medical education.
- The particular nature of clinical work in deprived areas, characterised by high volumes of alcohol and drugs problems, multimorbidity, psychological distress, polypharmacy, vulnerable families and other social problems, results in particular learning needs, which are inadequately addressed by current UG medical curricula.
- Potential solutions to improve UG medical education in the Deep End should be considered as part of a comprehensive strategy across the medical education continuum, from widening access to medical school for pupils from disadvantaged backgrounds, through medical school and postgraduate training, to improving retention of more experienced GPs.
- Addressing the inverse care law requires not just a more proportionate distribution of resources, but also more critical attention to the psychological biases and power dynamics that maintain the deprivation of care for marginalised people.
- Addressing the issue of space is a key element of any plans to accommodate increased UG education in areas of socio-economic deprivation.
- Efforts to widen participation should support the process of ‘getting ready’ (considering a career in medicine and preparing to apply), as well as ‘getting in’ (the selection process itself), and financial support during studies, if required.
- Relationships of trust are key to working with marginalised people, addressing stigma and shame through support and advocacy. The knowledge, skills and attitudes required to adopt this model of care should be at the heart of a values-based approach to medical education if the NHS is to be at its best where it is needed most.

“General Practitioners at the Deep End” *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*

Full report available at www.gla.ac.uk/deepend

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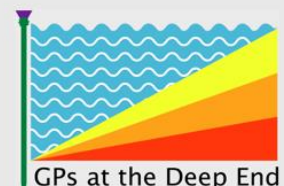

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BACKGROUND

John Gillies is chairing a group on increasing undergraduate (UG) education in primary care in Scotland. This is part of the Scottish Government's planning to increase the number of GPs in Scotland by 800 by 2028. The group will report to Scottish Government and the Board for Academic Medicine (BfAM) by Easter next year. NES have established a parallel group looking at ACT support in primary care.

General Practitioners at the Deep End work in 100 general practices serving the most severely socio-economically deprived populations in Scotland (www.gla.ac.uk/deepend).

As such, we have been invited to provide our collective thoughts and ideas on how to increase undergraduate education in primary care in this group of practices.

WIDER CONTEXT

Across all medical schools, there is a drive to improve the quantity and quality of UG teaching in general practice. This reflects a recognition of the need to improve subsequent recruitment to general practice, but also of the unique aspects of expert generalist practice, which have been historically neglected in medical education.

The report 'By choice – not by chance' identified three very significant but deeply seated issues affecting medical students' attitudes towards general practice:

- "tribalism" – leading to a perception of primary care as being of "lower status";
- "negativism" – low morale within the GP workforce discourages students;
- "finance" – lack of equity of reimbursement for UG education teaching across different health care settings is absolutely fundamental.

As well as these issues, there are a number of particular challenges related to UG general practice teaching in areas of socio-economic deprivation (the Deep End).

UG TEACHING ISSUES IN THE DEEP END

1. Inverse care law

The inverse care law today is not so much the difference between 'good' and 'bad' medical care as the difference between what GPs can do and what they could do if resourced according to the health needs of their practice populations [1]. There is a large body of evidence that demonstrates the social gradient in health needs, with a two to three-fold increase (in premature mortality, the presence of physical and mental multimorbidity, or self-reported health) between the most affluent decile of the population and the least affluent decile [2,3]. Yet the distribution of the GP workforce is more or less flat across the population [2].

Research comparing GP stress levels in practices serving deprived compared to affluent areas demonstrates increasing stress as consultation length increases in deprived areas but

not in affluent areas. If you are having a challenging consultation and starting to run late in a deprived area, there is a high chance that the waiting room is filling up with equally complex patients [4].

Time is the real currency of general practice [5]; more time is needed for all GPs, but the pressures of time are felt particularly acutely in areas of high deprivation and this affects a GP's capacity to engage with teaching and training. The inverse care law is the fundamental barrier to improving the volume and quality of medical education in areas of deprivation.

2. Space for teaching

In keeping with the inverse care law there is an 'inverse training law', whereby there are more GP training practices in more affluent areas compared to more deprived areas [6, 7]. It is not clear if this is true to the same extent for UG teaching placements in general practice, but the challenges are likely to be similar. This inverse training law is partly a consequence of the increased pressures and lack of time associated with the inverse care law, and partly explained by the higher proportion of smaller, often singlehanded, practices in deprived areas, which makes it more difficult to accommodate training requirements [8]. The potential consequence of this unequal distribution of training is that GP trainees may feel less confident about working in deprived practices if they have not had any experience of them during their training [9]. It seems reasonable to make similar assertions with regard to medical student experience.

3. Workforce issues

A third challenge facing efforts to increase UG education in primary care in severely deprived areas relates to the GP workforce in the Deep End. A 2015 analysis of GP demographics in Scotland found, in keeping with the inverse care law, that 54% of GPs serve the more affluent 50% of the population, resulting in 358 more GPs than the 46% of GPs serving the more deprived 50% [10].

In terms of the proportion of GPs approaching retirement, the most deprived decile has the oldest GPs, with 37% aged 50 and over (6% over 60) compared to 31% aged 50 and over (3% over 60) in the most affluent decile [10].

If relatively more GPs in Deep End practices are about to retire, then recruitment to these areas is all the more pressing; it may take two (or more) part-time GPs to replace a full-time GP with 30+ years of experience.

From a recruitment perspective, medical students being placed in a deprived practice where there are high levels of practitioner stress and burn out may have more negative consequences than not being placed there at all.

4. Content of medical education

The third challenge relates to the content of medical teaching. Given the particular nature of clinical work in deprived areas, characterised by high volumes of alcohol and drug use, multimorbidity, psychological distress, polypharmacy, vulnerable families and other social problems, there are particular learning needs of medical students (and GP trainees) in 'Deep End' practices. A medical student placement in Deep End general practice is arguably the ideal place to understand the importance of the social determinants of health, the impact of Adverse Childhood Experiences (ACEs), and how to support the 'unworried unwell'.

These issues have been highlighted by the 'GPs at the Deep End' group in Scotland [11], which identified three generic areas where there were learning resource gaps: how to build productive relationships with patients who are hard to engage and lack health literacy; how to promote and maintain therapeutic optimism when working in areas of high deprivation; and how to apply evidence-based medicine effectively when working with patients with high levels of multimorbidity and social complexity.

The last of these merits further consideration. How generalisable is the 'evidence' derived from studies that routinely exclude patients from very deprived areas, either due to co-morbidities or difficulties in recruiting to research? How applicable to 'Deep End' general practice are the guidelines that this evidence informs? These questions are beyond the scope of this report to address (and have been considered elsewhere [12, 13]) but are particularly relevant to medical education in, and for, areas of deprivation.

POTENTIAL SOLUTIONS TO IMPROVE UG TEACHING IN THE DEEP END

Potential solutions to improve UG teaching in primary care should be considered as part of a comprehensive strategy across the medical education continuum, from widening access to medical school for pupils from disadvantaged backgrounds, through medical school and postgraduate training, to improving retention of more experienced GPs. For the purposes of this brief report, however, recommendations will focus on widening participation and UG teaching.

In keeping with the principle of "proportionate universalism" outlined by Sir Michael Marmot, the targeted solutions outlined below should be considered complementary to more widespread efforts to address the tribalism, negativism and financing disparity highlighted by the Wass report [14], of which the latter is most pressing [15]. Furthermore, it is worth restating that none of these targeted solutions will be sustainable without addressing the inverse care law, which remains the fundamental barrier to improving the volume and quality of medical education in areas of deprivation.

1. Inverse care law

Addressing the inverse care law requires not just a more proportionate distribution of resources (including GP and other health and community resources), but also more critical attention to the (often unconscious) psychological biases and power dynamics that maintain the deprivation of care and interest towards marginalised people. The latter should be embedded throughout undergraduate medical teaching, as discussed below.

Of course, addressing the inverse care law in primary care will not only improve UG education, it is the only viable way to address health inequalities through the NHS. The work of Barbara Starfield and colleagues highlighted that, in the context of ageing populations with increasing multimorbidity, more and better person-oriented generalist primary care is required [16, 17].

2. Widening participation

The main arguments for widening access to medicine for applicants from more diverse backgrounds relate to social justice, social mobility, and improving health care provision by

establishing more diverse medical schools which are more representative (and more understanding) of the populations they serve [18]. There is some evidence from the USA that doctors from ethnic minority groups are more likely to work in underserved communities and with patients of the same ethnicity [19].

Despite a range of efforts over the past decade to widen participation in medicine, the dominance of medicine by the more affluent persists [20]. There is wide variation between medical schools in terms of the proportion of applicants from socio-economically deprived backgrounds they attract and the proportion who accept offers, suggesting that some schools may have implemented more effective strategies than others [20].

Efforts to widen participation should support the process of 'getting ready' (considering a career in medicine and preparing to apply), such as the Reach programme in Scotland [21], as well as 'getting in' (the selection process itself) [18]. For the latter, funding is required for more GPs to be on medical school interview panels.

Attention also needs paid to supporting retention of disadvantaged students, including financial support (e.g. grants, bursaries) if necessary.

3. Undergraduate teaching

In April 2016 the UK Parliament recommended that primary care and general practice be taught in UK medical schools "as a subject" that is "as professionally and intellectually rewarding as any other specialism" [22]. To date, there is no UK core curriculum in general practice, but medical schools across the UK are committed to increasing the quantity and quality of teaching in general practice. This takes many forms, from GP placements to communication skills and vocational studies courses led by GPs, to Student Selected Components (SSCs) and electives in general practice.

'Deprivation medicine'

There is undoubtedly scope for medical students to learn more about the theory and principles of general practice [22], but general practice is not a homogeneous entity. Deep End general practice is very different to general practice in non-deprived areas, and merits specific training in the same way that there are specific rural GP training pathways at undergraduate and postgraduate levels [23].

As well as addressing the higher prevalence of clinical and social issues highlighted above, Deep End practitioners are increasingly aware of emerging evidence around the importance of psychologically informed environments (PIE) for people who have experienced complex trauma or multiple disadvantage. This approach recognises the centrality of relationships and understands that all behaviour has meaning. Through reflective practice, it seeks to promote this understanding by asking the question 'what has happened to you?' rather than 'what is wrong with you?' It is inclusive, non-judgemental and non-stigmatising. Training and education in PIE is clearly of relevance to all those working in primary care, but it has particular relevance for those working in the Deep End with those who are most marginalised and excluded.

Undergraduate medical educators should consider the extent to which GP teaching currently addresses the diversity of the patient population in their area, including deprived communities and marginalised groups (see coda below [24]).

Additional support for Deep End student placements

4-5 week attachments in Deep End GP can be very intense – for students and practices – so alternative models should be considered. Suggestions include splitting this between different practices, or students having a full or half day in the same practice over several weeks (e.g. throughout their final year), to allow for development and continuity – for students and patients.

As noted above, addressing the issue of space is a key element of any plans to accommodate increased UG education in areas of socio-economic deprivation.

Interest from students

The Deep End GP group has become aware of increasing interest from students in getting experience of Deep End general practice. This has manifest both in an increasing number of requests for self-proposed electives or SSCs in Deep End practices and in the overwhelmingly positive feedback from the 1st Deep End GP student symposium, held in October 2017, which was oversubscribed within a few weeks.

Interprofessional learning

Finally, at a time of increasingly multi-disciplinary team working in general practice and primary care, particularly important for patients with multimorbidity and social complexity [12], consideration should also be given to interprofessional learning in undergraduate GP teaching.

CODA – ON THE CORRECTION OF SOCIAL IGNORANCE

"For the time being, only a small minority of medical students have personal experience of the personal and working lives of most of their future patients, and intellectual opposition to social injustice, even when present, is only the beginning of understanding. If students are to retain patient-oriented rather than disease-oriented motivation, they must learn to identify in complex, concrete, detailed terms with people they know only as crude stereotypes and of whom they are usually afraid.

Ideal humane commitment to patients in general must be transformed into effective concern for real people; the present hierarchy of specialties that relegates primary care, geriatric and psychiatric care to the bottom of the heap, shows that this transformation is hardly attempted by our present medical education, let alone achieved. Only after this phase of social re-education is it safe to make the partial and controlled detachment that is absolutely necessary to effective doctoring.

Primary care is a good level (though not the only one) at which to impart this unshared common social experience, to learn real rather than formal respect for patients, the many ways in which doctors must be subordinate to patients, and that the sick must become the subjects rather than the objects of care. This part of medicine has got to be rebuilt, and this may best be done by little doctors of slight authority, close and exposed to patients, with a minimum of technical and social armour." [24]

By Julian Tudor Hart (1927–2018).

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