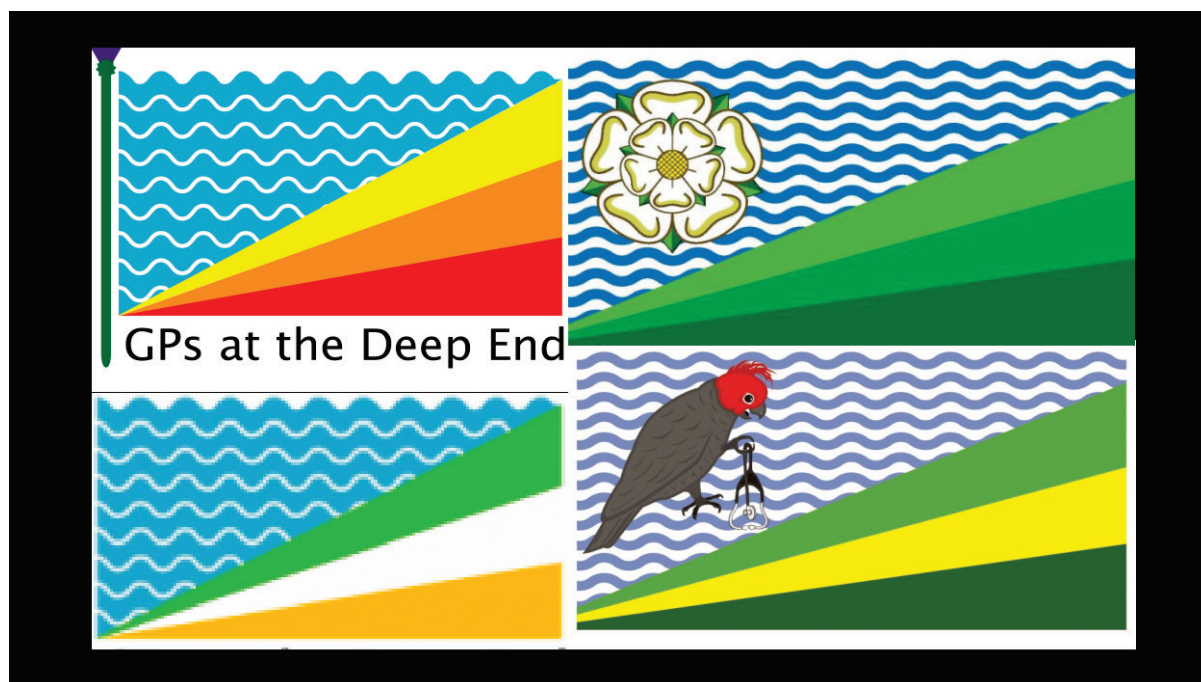


# DEEP END ZOOM MEETING NO 1



A basic tenet of the Scottish Deep End Project has been that when a group of GPs has gathered to share their experience and views, no matter how interesting the exchange has been, the event will have little lasting value to the participants, and none to those who were not there, unless at least the summary points are recorded and shared.

This report is a brief summary, therefore, of the first Deep End International Zoom meeting, held on 9<sup>th</sup> July 2020 and exploring the shared agenda of Deep End Projects.

Invitations were largely restricted to current and potential future organisers of Deep End Projects, as demonstrated in contributions to Deep End International Bulletin No 3. The meeting attracted 20 participants from Scotland (5), England (9), Ireland (2), Belgium (1), Australia (1) and the United States (2). A starting time of 20.00 BST made it possible for everyone to take part, although our Australian colleague had to get up for five o'clock in the morning.

The following points stood out.

## **Inspiration**

The conference in Glasgow in 2019, celebrating the life and work of Dr Julian Tudor Hart, the publication of *The Exceptional Potential of General Practice* and the achievements of Deep End Projects in Scotland, Ireland and England, had been cathartic, bringing together a large company of like-minded colleagues, without the

range of competing and distracting interests that are present in more general meetings of practitioners. At least one Deep End Project had been inspired by attendance at this conference.

## **Getting started**

The first step in establishing a Deep End Project is engagement with general practitioners serving socio-economically deprived communities, with vehicles for continued interest and activity. Projects have varied in their vehicles of choice, ranging from education and training to service development. Some form of organising role has been necessary to ensure communication, coordination and continuity. Organisers have often worked from an institutional base, not always with the explicit or practical support of the institution. The “Deep End” has many features of a resistance movement.

## **Common cause with other general practices**

These efforts have helped to establish and build identity and voice for otherwise poorly connected colleagues. While collegiality and solidarity have been strengthened *within* Deep End networks, a continuing challenge is obtaining understanding and support for the work of Deep End practitioners from other parts of the health system, including other general practitioners, managers, policy advisors and politicians.

An exclusive focus on Deep End practices can alienate GPs working in other practices. For this reason, the Scottish Deep End Project now also focuses on “Deep End patients”, most of whom are not registered with Deep End practices.

All general practices have in common a commitment to unconditional, personalised continuity of care. Deep End advocacy has a place, therefore, in the defence and promotion of clinical generalism, with the rider that generalism is needed most where multimorbidity and complexity are most prevalent.

## **Health inequalities**

Another challenging relationship is with experts, organisations and policies on health inequalities which often see little role for general practice.

By preventing, postponing or lessening disease complications and crises, personalised health care can improve health, reduce demands on emergency services and, by doing this for large numbers of individuals, narrow health inequalities.

Tudor Hart’s comment that *“Intellectual opposition to injustice is only the beginning of social understanding”* underscores the frustration of engaging with colleagues and organisations whose declared interest in addressing health inequalities is not matched

by practical commitment. Addressing health inequalities in a half-hearted, episodic way is certain to leave their structural causes intact.

The common cause of Deep End practitioners, as distilled at the Glasgow conference, is commitment to doing what's best for and with patients with complex problems, often lacking the knowledge, confidence and assertiveness of healthier patients. They choose not to ignore patients who are easy to ignore. Driven by values rather than evidence, evidence is needed to persuade others.

### **Media enquiries**

Colleagues shared their experience of dealing with media requests for patient contact to illustrate news items. Such contact is sometimes possible but often inappropriate, given the nature of patients' problems. GP anecdotes can help journalists writing print articles – coverage of [Deep End Report 36](#) drew heavily on quotations drawing directly on recent GP experience.

### **Patient involvement**

Colleagues discussed the desirability of closer alignment with patients and patient groups in pursuing advocacy objectives. Politically and in principle, this makes sense. The Belgian group visiting a Deep End practice in Glasgow recently commented on the positive patient and community links which had been developed. In *The Exceptional Potential of General Practice*, Professor Jan De Maeseneer described the long history of such engagement in Ghent.

It was noted, however, that one of the strengths of Deep End Projects has been the gathering of like-minded GPs, without the distraction of other interests. Increased patient involvement should be an addition, rather than an alternative, to this approach.

### **Zoom meetings**

The technology allowed colleagues to take part from across the world, at little inconvenience or cost. With organisers of Deep End Projects it was possible to share experience and views on organisational and advocacy aspects. Twenty seemed a manageable number.

Another possible use of the technology would be to convene meetings of Deep End practitioners to share experience and views of clinical and organisational issues arising within their practices.

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