The Review
The tortoise and the hare

Everyone is familiar with Aesop's fable of the tortoise and the hare. Although the hare was faster over short distances, it was the plodding tortoise which won the race.

The recent history of policies and initiatives to address inequalities in health is littered with harebrained schemes, exchanging long-term effect for short-term display. Many of these schemes are conceived in mad March, when there is end of year money to spend. Like genetically-programmed crops, they disappear when the year is out.

Deep End GPs describe the life cycle of many community initiatives which, by the time they get established and become useful, are already starting to wind down. In maintaining a list of local community resources, the continuing challenge is to keep up to date.

Health check programmes are also in vogue and can process large numbers of people through the initial stages of risk assessment, but when most of the resource goes into the beginning of the process, is it a wonder that such programmes fizzle out?

A frequent notion of initiatives to address health inequalities is the 'transformative encounter', in which patient behaviour is changed by a single professional intervention. But such examples, however celebrated, are notable for their rarity, and unlike the reality of working with the large numbers of patients with multiple morbidity and complicated social problems.

Patients with long-term problems have few consultations in which diagnoses are made, but dozens and sometimes hundreds, in which the business of the consultation is living better with risks and conditions, and avoiding or delaying their complications. Yet the focus of most medical education, evidence, guidelines and NHS policies to address inequalities is on the start of this journey.

In the film *Brief Encounter*, Trevor Howard plays a GP who has a series of short and intense emotional encounters with Celia Johnson in Carnforth railway station. Young people watching this film today are prone to say, 'Not a great deal happened'. The same is often true of brief encounters in primary care.

Serial encounters in general practice are a fact, and individual patients attend all of them. The encounters may or may not feature continuity, in terms of practitioner contact or information sharing. They may or may not involve cumulative learning, co-production (with the patient taking an increasingly active role) or the building of social capital, by which patients acquire increasing knowledge, contacts, experience and confidence. But in the absence of adequate time to get to the bottom of problems, sustained effort, and effective links with other professions and services, few of these things are likely to happen. Instead of serial progress, there are cycles of repetitive, non-productive behaviour.

Such trajectories are seldom simple. They stop and start, with reverses, delays, diversions and the intrusion of events. There is no 'logic plan'. But within this Brownian motion there can be constant purpose and steady progress — the tortoise rather than the hare.

In his book *A New Kind of Doctor*, Julian Tudor Hart described 25 years of care of a big muscular man, who had been invalided out of the steel industry following an industrial accident.[1]

'For the staff at our health centre it was a steady unglamorous slog through a total of 310 consultations. For me it was about 41 hours of work with the patient, initially face to face, gradually shifting to side by side. Professionally, the most satisfying and exciting things have been the events that have not happened: no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care.'

In a spat with Tudor Hart, Professor David Sackett, a pioneer of clinical epidemiology and evidence-based medicine, remarked that it was the first time he had been likened to a snail. Ironically, it was by snail-like progress that Tudor Hart improved the health of his practice population.[2]

The future challenge is not to re-create this pioneering example of anticipatory care, but to deliver its essential elements via local health systems with general practice at the hub. Key ingredients are flexibility, constancy and an always open door. Perseverance is more important than pace. Nor is perseverance one long journey; it is many short journeys, one after another

The disappearance of personal doctors is greatly exaggerated. At a recent meeting of three Deep End GPs with a journalist, there were over 60 years of local experience in the room, and an enormous amount of knowledge, commitment, and compassion on display. Such knowledge is no longer the preserve of GPs, and is frequently acquired by other members of the health team. Exchanging such knowledge is an important team function.

All that GPs can do to reduce inequalities in health is via the sum of care they provide for all their patients. To realise this contribution, the NHS needs not only to address the inverse care law, increasing the volume and quality of care where needs are greatest, but also to understand, value, and support serial encounters in primary care.

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On behalf of the Deep End Steering Group. This is the 10th in a series of articles from General Practitioners at the Deep End.

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