Core values: *Cum Scientia Caritas*

Benchmarks, scales and yardsticks

Introduction

The landscape in which general practice in Scotland operates is changing rapidly. The Scottish Government's *2020 Vision* demands that more care be provided 'at home or in a homely setting', which will inevitably lead to a shifting of work outwith hospitals.[i] The Integration of Health and Social Care, towards the *2020 Vision*, is now in operation but the nature and extent of new arrangements on the work of GPs and their teams will take some time to become clear. For over a decade the share of NHS Scotland funding delivered to general practice through the Scottish Government budget has been reduced consistently, from 9.8% in 2005/06 to 7.4% in 2014/15, with final figures for 2015/16 almost certain to show significant further losses. Workforce numbers and GP trainee recruitment are at a low and perhaps unsustainable level and almost a third of practitioners are considering retirement within the next five years, with a further 14% wishing to reduce their working commitment to part time. Meanwhile, patient expectation and demand continues to grow. In this context the establishment of new ways of delivering general practice care has been suggested and Scottish Government has made clear its willingness to act decisively to ensure this work progresses.

The nature of the GP team is also changing. The future role for the general practitioner is being proposed, according to a December 2015 BMA Scotland briefing, as one of supporting a wide range of other clinical professionals while working as an 'expert medical generalist'[ii] and 'senior clinical decision maker in the community, who will focus on:

- Complex care in the community
- Undifferentiated presentations
- Whole system quality improvement and clinical leadership'[iii]

In considering Out of Hours care, Professor Sir Lewis Ritchie noted in his report's Key Messages that, 'Future urgent care will be delivered by well-led and trained multidisciplinary and multi-sectoral teams. GPs will no longer be the default health care professionals to see patients for urgent care, but they must continue to be an essential part of multidisciplinary urgent care teams, providing clinical leadership and expertise, particularly for complex cases. People seeking help need to see the right professional at the right time, according to need.'[iv]

This shift has been developing over some time. In Gillies, Mercer, Lyon et al.'s 'Distilling the essence of general practice' (the *Essence*) it is remarked that,

'Although the direction of NHS policy appears to suggest that many functions of the GP can be performed by other professionals, including pharmacists and nurses, GPs are still uniquely trained, motivated, and situated, geographically, historically, and culturally to take forward this task [the consultation] in the 21st century.' [v]

The BMA has also recognised some dangers inherent in this approach to teams, although it concerned both secondary and primary care. The Role of the Doctor states explicitly that, in this instance, 'Where such role substitution is employed, there is a risk that patients do not have access to the range of knowledge and skills that characterise a doctor's holistic approach to care.'[vi]

Roles, responsibilities and lines of communication within teams must be clearly and appropriately defined.

Increasingly, with the introduction of other clinical staff in practices, GPs no longer undertake routine work such as chronic disease management, ante-natal care and the monitoring of patients on oral contraceptives. It has been proposed, within the negotiation of the new Scottish GMS contract of 2017, that further removal of the GP from aspects of healthcare presents the only viable solution to current GP workload and recruitment problems. The GP, as the 'senior clinical decision maker' in a team, 'would be less involved in the more routine tasks and require a greater reliance on other health professions in the wider community team'.[vii]

An increased emphasis on care planning is proposed together with the further development of patient health literacy and self care, particularly in those with long term conditions. The proposals suggest increasing options for patients to self refer to other areas of the primary care team, such as optometry, physiotherapy and podiatry, alongside maintaining existing routes to pharmacy, midwifery, nursing and other specialisms.

In the context of such proposed change, it is vital that the profession consider the role of the GP within these new models of care and the potential impact on patient outcomes.

Cum Scientia Caritas

In its successful manifesto for the 2016 Scottish Parliamentary election, *Promoting general practice*, RCGP Scotland made plain that,

'With the Scottish Government committing to the trial of new models of primary care in the development of the planned 2017 General Medical Services contract, it must be acknowledged that any new model can only be made fit for purpose with the full engagement of the profession.'[viii]

The College has a duty to put forward the standards that should be aspired to. So great are the changes currently proposed that the College must comment from the foundations represented through its motto, *cum scientia caritas* ('compassion with knowledge').

Science and 'compassion' or 'care' are not always clear bedfellows to those outside healthcare. Indeed, it could be argued from one perspective that the cold logic of the first has no place for the second, or from another that the emphasis on subjective need is incompatible with objective practice. Michael B Taylor, in his discussion paper 'Compassion: its neglect and importance' recognises this and confronts it.

'Talking of compassion in a scientific journal such as this is awkward and even a little embarrassing, partly because there are no units of measurement. The nearest surrogate is the soulless 'continuity of care'. We have rightly become comfortable with numbers because of the power they have brought with the advancement of scientific method, but it is folly to neglect what is important simply because it cannot be counted.'[ix]

The profession of the general practitioner expresses values that explicitly and consciously combine the two. It has done so since its beginnings and throughout its development. Dr D.L. Crombie, commenting on *caritas* as 'compassion' and 'feeling with' in his delivery of the annual James Mackenzie Lecture, remarked that,

'It is this "feeling with" which enables a doctor to bring to bear on the problems of his patients, information which cannot yet, and probably never will be, obtained by "scientific" methods. Scientific method is subsumed by the chains of reasoning which logically link identifiable and identified causes with effects.'[x]

A combination is required. Quantities of evidence make plain that such a combination is greatly to the advantage of patients, with better health outcomes resulting.

Similarly, the logic of how to respond under reduced funding and considerable challenges to workforce numbers must be tempered with those values. Balanced with science, the nature of appropriate patient care, then, must be the measuring tool within the general practitioner's mind when assessing whether any new model is fit for purpose in appropriately meeting the needs of patients. Faced with proposals of such momentous change, the profession may gratefully rely upon previously defined frameworks and standards through which to define what such care is and how it may be expressed. After months of RCGP Scottish Council's consideration of those frameworks and standards, then, the College is in a position to establish the core values that should be preserved in any new model of care. These values should also be considered as starting principles for the 'peer-led, values driven' approach of the proposed Scottish GP Quality Clusters.

The First Minister, Nicola Sturgeon MSP, then Deputy First Minister and Cabinet Secretary for Health and Wellbeing, in her Foreword to RCGP Scotland's document, *The Future of General Practice in Scotland: A Vision*, echoes Iona Heath's famous assertion that 'The consultation is the foundation of general practice'.[xi] She said,

'Patients in Scotland have told us that they need and want … continuity of care and clinical excellence. It is encouraging that the College highlights a core skill within general practice as the ability to communicate in a meaningful way with patients, relatives and carers. I share the RCGP Scotland belief that high quality GP consultations should be the main focal point for enabling patient centred local care in future and where necessary seamless access to secondary care services.'[xii]

In the First Minister's belief lies encouragement and the political authority to act.

Benchmarks, Scales and Yardsticks

The roles, advantages, tests and values outlined below have been formally considered by RCGP Scotland's Scottish Council, coming, as they do, from solid and tested previous work. Indeed, members of that Council have produced one of the papers providing them, the *Essence*. They are set, through this paper, as benchmarks, scales and yardsticks through which approaches to general practice may be measured.

The *Essence* was written from a forward thinking point of view, 'exploring the core values of general practice with an emphasis on the future'. It is very clear as to its own relevance to our purposes, advising that 'Successful adaptation to future challenges needs local GP leaders who have vision, and can see the opportunities ahead and respond in a way that does not compromise core values.'

Ten key roles

'purpose and ethos, and that, therefore, should be of principal concern in shaping its future',

the *Essence* identified seven 'Key roles for future GPs' in its section 'Essential future roles

and personal qualities'. Those seven key roles were as follows:

- Chronic disease management
- Prevention of ill-health
- Teaching colleagues/self
- Team working
- Holistic/personal care

- Continuity/coordinated care
- Generalist

Included within the role of the generalist clinician, in which managing the range of diseases and contexts presenting in general practice is implicit, it is appropriate to specify the further key role of diagnostician of undifferentiated presentations, acknowledging the challenge of uncertainty that this brings to the role of the general practitioner. Also, in the evolving context of our ageing population and the increase in multiple morbidity, we would add to these eight key roles two further key roles: that of managing the complexity of multiple conditions and that of delivering palliative and end of life care. These extended, ten key roles form the first measuring tool RCGP Scotland will use to identify appropriate descriptions of general practice.

Six key advantages

The *Essence* provides a second scale, that of the six 'Key advantages of general practice'. These six key advantages are 'central to the future development of primary care' and are described as follows:

- Trust: achieved by high-quality empathic communication with patients and past experience of good-quality care; essential for concordance with treatment, co-creation of health, effective gatekeeping, and avoidance of medicalisation. Underpinned by local perceptions of altruism, fair dealing and other personal qualities, competence, integrity, and probity, and by both rhetoric and an assumption of good intentions.
- Coordination: in dealing with patients' multiple problems and issues; between patients and relatives/partners, between GP and members of the primary healthcare team, social work, and voluntary agencies, between hospital consultant-led and primary care services.
- Continuity: generated by repeated contacts, developing and strengthening relationships with patients over months and years. Challenged by many trends, including new working patterns among GPs including daytime working and multiple providers of care. [The original 2008 *Essence* document included a challenge from the 'feminisation' of general practice and one from GP-led health centres.]
- Flexibility: to address problems in the order and at a pace that suits patients; adapting clinical evidence to the individual patient, nGMS contract requirements to local community needs; balancing individual and population approaches in day-to-day work [to which may be added the modern challenge of balancing the increasing demand of those who need quick access with those who need continuity]; dealing capably with continuing NHS change; liaising effectively with local voluntary organisations; and innovating to good effect.
- Coverage: comprising over 90% contact with list populations over a 5-year period, including many who are 'hard to reach' using one-off screening approaches, so that special measures to enhance coverage are required for very few people. This cumulative approach to population coverage is much more sustainable than screening.
- Leadership: including the ability to implement change quickly, based on multidisciplinary knowledge and experience of local circumstances, staffing, and population characteristics.

Five tests of integrated care

As part of the solutions based work around the RCGP Scotland document, *A blueprint for Scottish general practice* (the *Blueprint*), in order to ensure 'that patient centred care is hardwired into emerging new models by building on the strengths of general practice', five

tests to be applied to integrated care were developed.[xiii] This is in harmony with the Scottish Government's clear desire to see 'care that is person centred rather than condition focussed'[xiv]. The Chief Medical Officer's Annual Report 2014-15 describes how 'The person centred portfolio in Scottish Government is driving and supporting policies and quality improvements that help reshape health and care through the lens of people using services.'[xv]

The rationale behind the tests was simply expressed. 'The doctor-patient relationship must be protected. In the context of rising levels of multiple morbidity, these new models will need to move away from the traditional NHS focus on single-disease pathways and individual episodes of care. It is vital, therefore, that these emerging models build on the strengths of general practice, including the 'local' nature of GP services, their generalist scope, the continuity of care they provide to individuals and families and the population level perspective they are able to take through the registered patient list.' In this the *Blueprint* reflects Joanne Reeve in her *Protecting Generalism* assertion that,

'Yet generalist practice is more than disease-focused care delivered in a community setting. It is a different approach to understanding and addressing health and illness. Generalism describes a philosophy of practice which is person, not disease, centred; continuous, not episodic; integrates biotechnical and biographical perspectives; and views health as a resource for living and not an end in itself.'[xvi]

The five tests, then, are that proposed models of integrated care should:

- Ensure community-based services are led by community-based clinicians [GPs] with a person-centred perspective.
- Underpin safe patient care by ensuring that GPs can continue to act as independent advocates for their patients, with the emphasis on the person not the institution.
- Be person focused, responding to the needs of the individual and protecting them from overmedicalisation, with general practitioners working with specialists [and, now, with other clinicians in the community] to contribute to the holistic care of the individual.
- Develop existing structures and resources to work in an increasingly co-operative way, recognising that primary care is a network of providers and requires a network literacy in its management, with the IT to support this.
- Ensure that general practice and primary care funding is sufficient to meet their unique and vital role in delivering person centred care, with investment in robust evaluation of new models of integrated care.

The four Cs

Barbara Starfield has provided general practice with perhaps its most succinct measure, the Four Cs. They are cherished for their effective safeguarding not of general practitioners' modes of practice but of patient care. In 2015 the Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison MSP, addressed the RCGP Annual Primary Care Conference. Within her address she insisted upon their centrality to general practice, saying,

'From Cumbernauld to Cape Wrath, the services your community needs should be there for you, locally planned and locally delivered, reflecting the Four Cs of contact, comprehensiveness, continuity and co-ordination advocated by the RCGP.'[xvii]

The Four Cs may be expressed as:

- Contact: General practice is the default place, the first point of contact, for the vast majority of patients seeking access to healthcare for the first time.

- Comprehensiveness: It's not just about seeing the person and their presenting complaint. GPs see people in their holistic lived experience. GPs are uniquely placed to deal with aspects of medical, social, and psychological factors. GPs ask people about something they didn't come in for and take the time to listen, identifying major issues.
- Continuity: GPs are there from cradle to grave, with care benefitting from long term relationships with patients.
- Co-ordination: Critically, GPs are able to oversee care from multiple providers and act as a 'system failure service' for the NHS. When anything goes wrong, GPs are usually the ones to hear about it. The co-ordination of services at primary care level is an important determining element in the responsiveness of health services provision and the health system as a whole.

The Kings Fund & Nuffield Trust set down, as a 'design principle' for primary care, that 'Patients are offered continuity of relationship where this is important, and access at the right time when it is required.'[xviii] Importantly, RCGP Scotland recognises patients' right to access appropriate care at all times of need, including the ability to consult a general practitioner at any point, 24 hours of the day, seven days a week.

Patient participation

In recognition of the central value of patient centred care the Royal College of General Practitioners has consistently advocated for effective patient representation and on this basis we would not wish for such far reaching change to the delivery of patient care to be trialled without adequate representation from patients.

The *Blueprint* expresses that,

'Patient feedback and participation should be central to the development of any new model. RCGP Scotland will, for its part, continue to seek the input and guidance of its Patient Partnership in Practice (P^3) group and others.'[xix]

It is difficult to envisage any new model of care being understood or accepted by the public without such feedback and participation.

Measurement

These, then, make up the benchmarks, scales and yardsticks general practice must use to evaluate whether any proposed new ways of delivering general practice care in Scotland are models safe to be described as Scottish general practice; the ten key roles, the six key advantages, the five tests of integrated care, the Four Cs and patient feedback and participation. There is much cross pollination between them, indicative of their strength and concrete roots. For example, where the five tests speak of the need to 'contribute to the holistic care of the individual,' the Four Cs speak of how 'GPs see people in their holistic lived experience. GPs are uniquely placed to deal with aspects of medical, social, and psychological factors.' Where the *Essence* describes how 'the inherent strength and complexity of the doctor-patient relationship supports quality at a much deeper level' Starfield has it described as 'Continuity: GPs are there from cradle to grave, with care benefitting from long term relationships with patients.'

General practice is undoubtedly going to need to do things differently but as we consider these changes, whatever the demographic or geographical context in which these changes occur, RCGP Scotland believes that it is essential that we stay true to the core values in this document that we believe are at the core of how general practice has served the NHS and the population of Scotland with such distinction for the last 60 years and more[xx] and which can continue to do so into the future.

The College, therefore, asks its members to bring these tests to bear as they engage in the design, development and trial of any new models of care in Scotland through which appropriate patient care may be delivered in future.

Conclusion

This position paper is intended as a sharp and unfailing tool to be used when considering any future development of the role of the general practitioner. It is apparent, however, that the timing of its publication is borne from necessity, during a period of increased pressure on general practitioners to make decisions quickly with regard to the future of their profession. Any decisions must be made from the surety of positive, solid, values based foundations, so looking beyond the short-term horizon, beyond the mid-term, to the long-term future of general practice. The warning against divergence supplied by the participants in the *Essence* project, who represent a spread of career stages, is clear. 'A further concern shared by trainees and trainers was the erosion of the traditional value base of general practice'.

While some of these benchmarks, scales and yardsticks at once welcome and challenge certain aspects of current thinking around future Scottish general practice, that does nothing to reduce their importance nor their accuracy. As the *Essence* has it, 'contracts should be used to enable rather than limit developments in general practice.' It is for current general practitioners to define routes through which to realise and enshrine ambitions, realities and core values.

By way of example only, the question of the role and responsibilities of the wider primary care team, in the light of those of general practitioners, is one such issue. RCGP Scotland's *Blueprint* recognises that, 'the role the wider primary care workforce has to play in delivering services is vital.' The *Blueprint* calls for a widening and extension of that workforce. The *Essence* notes, though, that 'there were tensions between the need for effective teamwork and patients' wish to relate to and sometimes see their own GP, rather than another team member.' That seeming conundrum of core value and possible solution must be openly and explicitly addressed if lasting positive progress is to be made.

The College fully recognises that the pressures to change and to innovate in reaction to the current Scottish context, exemplified in Abraham Lincoln's well recognised words used at the start of the *Essence*, have only increased. 'The dogmas of the quiet past are inadequate to the stormy present.'[xxi] The quotation may be continued, 'The occasion is piled high with difficulty, and we must rise - with the occasion.' General practice undoubtedly must develop, as it always has, to appropriately meet the needs of patients in whatever context it finds itself. We believe that it is of central importance that new models of care fully reflect and maintain these values into the future.

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Author: David Webster
RCGP Scotland, 25 Queen Street, Edinburgh. EH2 1JX Tel: 020 3188 7730
www.rcgp.org.uk

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