# James Mackenzie Lecture 2010

## Beyond the numbers game — the call of leadership

### INTRODUCTION

Sir James Mackenzie was born in 1853 into a farming community near Scone, Perthshire.[1] He rose to become a visionary leader and greatly revered GP, attaining international acclaim for original research into heart rhythm abnormalities. His achievements were based on fundamental and unerring beliefs about the research value of the clinical observation of patients in general practice and by their meticulous application.

I was brought up and still live in the fishing community of Fraserburgh, near to where I have practised for 30 years in the sister port of Peterhead. As a young boy, I vividly remember hearing the ominous doubly volley of loud rockets that were fired over the town, summoning volunteers to join the lifeboat. The lifeboat usually returned home safely, having successfully accomplished its mission. On three occasions, the lifeboat did not return to safety, capsizing in mountainous seas, with the loss of many crew members' lives. The values of altruism, compassion, and courage shine forth. Many years have passed — time, tide, and technology have moved on. The maroons are now silent but the values of the lifeboat crews live on — the abiding recognition of the continuing humanitarian call to duty. The metaphor of the mission of the lifeboat and the safe navigation of stormy seas is a powerful one. It speaks of the fundamental importance of our own values and the need for strong leadership in challenging times.

### THE LEADERSHIP IMPERATIVE

In the 85 years since the death of Sir James Mackenzie, general practice has undergone remarkable and relentless change as part of the increased prominence of primary care services. The patient consultation remains at the hub of clinical practice, but is now being delivered in different ways, in new settings, and by a growing team of health professionals. The exceptional potential of general practice[2] continues to unfold, including anticipatory care[3] and health promotion, in addition to our traditional role of alleviating suffering, pain, and distress.[4,5] Patients rightly have increased expectations of involvement, accountability, and transparency but also have responsibilities as well as rights.[6,7] The growing evidence base supporting the value of primary care is indisputable: primary care prevents more illness and death and is associated with a more equitable distribution of health, than specialist driven care.[5]

Change cannot be wished away[8] and the practice of medicine is now distinguished by the need for judgement in the face of uncertainty.[9] This uncertainty and perceived loss of control may have impacted on our morale and altruism.[10]

The NHS is now engulfed in further far-reaching reforms. GPs find themselves at the commissioning helm of the NHS in England with the publication of the White Paper, *Equity and Excellence*.[11] These reforms may be seen by some as a threat to the professional cohesion of general practice, and there are many justifiable concerns about the scope and timescales involved, but they also constitute an obligation for general practice to rise to the occasion.

Current models of care will no longer be sustainable in future years. As hospital emergency admissions and referrals continue to mount, the balance of care must now shift away from hospital services towards general practice, innovative models of extended primary care, and self-care. These are times, not of incremental change but rather of transformational change, when our existing beliefs and ways of working are no longer adequate to meet mighty and unprecedented challenges. Such times call for resolute leadership.

The importance of leadership in general practice has been consistently signalled by the Royal College of General Practitioners (RCGP), particularly in the past few years,[12–14] but it has also been said that clinical leadership has faltered, allowing management to flourish.[7,15] Is leadership in general practice on the back foot? I believe this criticism is unfair; our College in particular has been at the forefront of promoting standards and quality, and instrumental in influencing government policy. However, I have a sense that the frequent rhetoric about the need for firm leadership, has not always been matched by our individual and collective resolve to do

***Fraserburgh Lifeboat RNLB Duchess of Kent, heads into the stormy North Sea on a rescue mission. It later capsized on service in January 1970, with the loss of life of five out of six crew members.***

*"The call of leadership is a powerful one ... General practice expects it, our professionalism demands it, and our patients deserve it."*

more about it. Mostly working in non-hierarchical practice settings, we have perhaps been too diffident about promoting general practice leadership. Leadership in general practice now needs to move from the shadows to centre stage, at all levels.

## THE VALUES OF LEADERSHIP

While there is general consensus that strong medical leadership is essential,[7,12–17] less attention has been paid to what sort of leadership — what is 'the right stuff?' For that, we need to look back to the Greek philosopher Plato, who first defined the ideal leader as someone who commits to, and is trained for, a life of service and devotion to their fellow citizens.[18] This has immediate resonance for us as GPs — the link between commitment, continuous learning (or self-renewal), and the needs of our patients. Irrespective of scientific, societal, or political change, our leadership credentials should be founded on the enduring rock of our moral values and obligations to patients and society. These values and obligations amount to our 'professionalism' as GPs.[7,9,16,19]

### A new professionalism

In his recent John Hunt Lecture, *The epitaph of professionalism*, Don Berwick encouraged us to reconsider and to 'find joy and pride ... in different places' — in a new form of professionalism.[20] This new professionalism emphasises the authority and autonomy of patients and families in a radically new distribution of power and knowledge.

Effective leadership in general practice must pivot on trust.[21] Trust lies at the core of our relationship with our patients, colleagues, and with society — and the purpose of professionalism is to secure that trust. Medical professionalism has been described as: 'A set of values, behaviours, and relationships that underpin the trust the public has in doctors'.[9] For GPs, we must include our own core professional values, that Marshall has redefined as:[22]

- medical generalism;
- holism; and
- advocacy on behalf of patients.

All of these form the basis of a moral covenant between GPs, patients, and society and, in turn, provide the foundation for effective leadership in general practice. While maintenance of professional values was once seen as the responsibility of individual doctors alone, I would argue that successful professionalism also vitally depends on the moral culture of the organisations in which we work.

## LEADERSHIP: A QUEST FOR EXCELLENCE

The main currency of leadership is the ability to influence and motivate people — leaders cope with change, they set vision and direction, and stimulate team members to follow that vision. Today's general practice leaders must focus not on what they are, but what they do. They must inspire and communicate a shared purpose — the visionary leader; promote accountability and excellence — the vigilant leader; help others to deliver — the enabling leader; protect morale and motivate others — the encouraging leader; stand up, speak out, and do what is right — the courageous leader.

### A leadership compass

Distilling this down, I suggest that the values and purpose of general practice leadership could be combined into a set of guiding principles (Box 1).[23–25]

These principles might help to serve as a leadership compass for these turbulent times.

### A commitment to renewal

The commitment to self-renewal and development is a requirement for all GPs. GPs committed to professionalism must be self-driven to provide a high-quality service, improve patient care, and to maintain continuous professional development. GP leaders must exemplify this in their own professional lives but must also be fully supportive of renewal in colleagues. Annual appraisal is a key opportunity for all clinical and non-clinical staff working in general practice, not only to ensure competent practice, but also to promote excellence.

### Sharing a vision

Over the years the RCGP has been instrumental in promoting a vision for general practice.[12,13] Declaring a vision and realising it are not the same thing. Crucially, this is not just about winning the hearts and minds of GPs and the other health professionals working in general practice, but also about engaging our patients and communities in a common cause. It will also be about more effective and close working with colleagues in secondary care and with local and national government, in order to shape a better tomorrow.

### Growing our leaders

The previous implicit recognition of the requirement for strong leadership now needs to be replaced by explicit endorsement and planned provision — not ongoing reliance on leadership by 'happenstance' or the arrival of 'accidental leaders'.

Although some indeed may be 'born leaders', adequate training and replenishment of specific leadership skills will be required to create and sustain a sufficient cohort of future GP leaders. We need to discern how best to capture, value, and promote the ethos of leadership in our undergraduate and postgraduate GP training programmes, on a more systematic basis. The leadership roles and responsibilities of medical schools and particularly of academic general practice also need to be reappraised. Early clinical academic training could also confer some of the essential skills and attributes that will be required of our GP leaders of tomorrow. Equally, there are clear opportunities for educational research into leadership and optimal multi-professional team working in general practice.

### Progressing academic leadership

**Box 1. Values and purpose of general practice leadership**

- Core professional and disciplinary values as the foundation of effective leadership
- A personal commitment to self-renewal and development
- Clear communication of a sense of purpose and a shared vision to inspire and motivate the commitment of colleagues
- Nurturing an ethos within general practice where leadership is both valued and developed
- Promoting a culture of quality, accountability, and excellence throughout the whole of general practice

Many good things have happened over recent years in academic general practice. Greatly increased exposure to general practice training has taken place in both undergraduate and postgraduate domains, with encouraging increases in staff numbers and research outputs. In the last 10 years, clinical academic GPs have increased in numbers throughout the UK by about a third compared to an overall decline of 12% in the total clinical academic workforce.[26] However, recent research found that in Scotland about 8.5% of hospital consultants held senior academic posts compared to only 0.5% of GP principals — an unhappy ratio of 17 to 1, which we must improve.[27]

### A culture of quality, accountability, and excellence

While the tasks of leadership are many, the ultimate goal of leadership is the pursuit of excellence. Key to this will be a continuing drive on quality and accountability — across the whole spectrum of general practice. Excellent care is effective, safe, assured, and fair.

### Effective care

We know our patients value timely access to care, quality of clinical care, quality of interpersonal care, and good organisation of care (including continuity and coordination).[28] When the Quality and Outcomes Framework (QOF) was introduced, there was disquiet that measurable differences in QOF measures would not necessarily translate into meaningful differences in patients' lives. A mechanistic approach may be a threat to care that should be tailored to the needs of individual patients and therefore also a threat to our core professional values and the inclusion of more elusive patient outcomes. However, QOF incentives have contributed to high levels of attainment of quality targets and a reduction over time in the variation in care quality and narrowing of the achievement gap between the least and most deprived areas.[29] This suggests that QOF may have had a positive impact on equity and health inequalities. Preliminary findings on cost-effectiveness for the QOF are also encouraging.[30] However, qualitative research has shown that the patient's agenda may be under threat due to the requirements to meet QOF targets and that there may be a divergence of opinion in relation to the worth of some aspects of care between general practice health professionals and patients.[31]

We must strike a balance between the present chronic disease-focused elements of the QOF and the quality of patient-centred, humanitarian care that are more difficult to assess, but no less important.[32,33] Rather than further polarised debate on the merits of the QOF, we need to focus our energies on improving it and finding the right equilibrium between traditional reactive, holistic care, and proactive, anticipatory care.

### Safe care

Another aspect of quality is ensuring safe care. To take one example: preventable adverse drug events account for around one in 25 hospital admissions. Recent research found a fourfold variation between practices in rates of high-risk prescribing, suggesting significant room for improvement.[34] The support and quality assurance of safe care in general practice, is therefore, another critical leadership priority for the future.

### Assured care

Our accountability record is also improving, helped by the wider publication and greater transparency of practice-based data, including QOF figures. As more general practice data become publicly available, this information must itself be quality assured to minimise misinterpretation and avoid erroneous judgements. Our accountability will also be enhanced by greater attention to governance and risk-assessment mechanisms for the assurance of safe practice and best use of public resources. In all of this, it will be crucial to enlist the assistance of our patients, as this journey unfolds.

But there are darker notes. The aspiration for excellence is across the whole of the spectrum of general practice — not just the top end. In particular, we have singularly failed to address the rump of unacceptable performance at the bottom end, inhabited by a small number of practices and practitioners. This has been identified and lamented before[22] and cannot persist. This will require concerted and resolute leadership action.

### Fair care

Lastly, our leaders should play a major role in tackling the continuing tyranny of health inequalities and the maldistribution of GP resources, which like many aspects of health care, are inversely correlated with patient need and deprivation.[3,13,14] While general practice does not hold all of the cards here, we can and should be a significant force for good.

### Beyond the numbers game

My remaining task is to explain the title of my lecture, drawn from my Inaugural Lecture almost 20 years ago.[35] Then, in the early fundholding era, I spoke of turbulent times but also times of great opportunity for general practice, of the centrality of patients, and the need for new partnerships with them. Computing and information technology, still in its infancy, had great potential. I concluded that we were becoming more numerate as a discipline. Measurement and counting — 'the numbers game' — was essential for progress but not in itself sufficient; we had to do what counted, rather than what could be counted. Ultimately, with increasing complexity, there was a danger that we would lose sight of our core values such as trust and compassion, which resist measurement.

Moving forward almost 20 years, many of these concerns have materialised, and remain relevant now. The numbers game is even more apparent in our daily practice, but we must move beyond it.

In these stormy times, the call of leadership is clear and compelling. I have suggested that general practice leadership should be founded primarily on our core professional values as GPs and on our moral obligations to patients and to society. I have also offered some guiding principles — a compass for general practice leadership — as we press onward, in a quest for excellence.

James Mackenzie was a visionary, humane, and courageous leader who prevailed in difficult times, advancing medical science for the benefit of patients and the cause of our discipline. Looking forward, it is important that we too take courage and remain steadfast on behalf of general practice and our patients. It is time once again to follow his example and step up to the leadership plate — to do what counts. That is true for us all, but it is particularly true for young GPs — our leaders of tomorrow.

The call of leadership is a powerful one. We would do well to heed it. General practice expects it, our professionalism demands it, and our patients deserve it.

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This text is based on the James Mackenzie Lecture delivered at the Royal College of General

Practitioners Annual General Meeting, London, on 19 November 2010.

**Acknowledgements**

I am particularly grateful to my patients at Peterhead for the privilege of sharing their lives and putting their trust in me since I started practising there in 1980, and for the inspiration of Jennifer Myles (1986–2010), James Morgan, and Sheena Gordon in connection with this lecture. The support and commitment of all my colleagues who work in Peterhead Health Centre and Community Hospital has been much appreciated and has made possible my work within and beyond the community of Peterhead. I wish to thank Ann Christie and my colleagues at the Centre of Academic Primary Care, University of Aberdeen; Prof Bruce Guthrie, Centre for Primary Care and Population Research, University of Dundee; Prof Stuart Murray and Dr Diane Kelly, Postgraduate General Practice Education Department, West of Scotland Deanery; Dr Ken Lawton, Dr John Gillies, and colleagues at RCGP Scotland; Prof Frank Sullivan and colleagues at the Scottish School of Primary Care; and Prof Ruth McDonald, Nottingham University Business School. Finally, I am particularly grateful to Albert Sutherland MBE (former Coxwain, Fraserburgh Lifeboat and RNLI Bronze Medal recipient), Charles Duthie (former launch secretary, Fraserburgh Lifeboat), and Albert Ogston, for historical information about the distinguished record of the Fraserburgh Lifeboat Station and its crews.*

*See also: Morris J. *The Story of the Fraserburgh Lifeboats*. Coventry: Lifeboat Enthusiasts' Society, 2003.

**Competing interests**

The author is presently a member of the National Institute for Health and Clinical Excellence (NICE) Primary Care QOF Indicator Advisory Committee.

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**Provenance**

Commissioned; peer reviewed.



## REFERENCES

1. Mair A. *Sir James Mackenzie MD 1853–1925 general practitioner.* Edinburgh and London: Churchill Livingstone, 1973.
2. Stott N, Davis R. The exceptional potential in each primary care consultation. *J R Coll Gen Pract* 1979; **29(201):** 201–205.
3. Hart JT. James Mackenzie lecture 1989. Reactive and proactive care: a crisis. *Br J Gen Pract* 1990; **40(330):** 4–9.
4. Heath I. *The mystery of general practice. Third John Fry Trust monograph.* London: Nuffield Provincial Hospitals Trust, 1995.
5. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; **83(3):** 457–502.
6. Ritchie LD. Developing primary care in Scotland. In: Woods K, Carter D (eds.). *Scotland's health and health services.* London: TSO for the Nuffield Trust, 2003.
7. Royal College of Physicians. *Future physician: changing doctors in changing times.* London: Royal College of Physicians, 2010. http://bookshop.rcplondon.ac.uk/details.aspx?e=314 (accessed 15 Nov 2011).
8. Haines A. The science of perpetual change. *Br J Gen Pract* 1996; **46(403):** 115–119.
9. Royal College of Physicians. *Doctors in society: medical professionalism in a changing world.* London: Royal College of Physicians, 2005. http://bookshop.rcplondon.ac.uk/contents/pub75-241bae2f-4b63-4ea9-8f63-99d67c573ca9.pdf (accessed 29 Nov 2011).
10. Jones R. Declining altruism in medicine. *BMJ* 2002; **324(7338):** 624–625.
11. Department of Health. *Equity and excellence: liberating the NHS.* Cm7881. Department of Health, London, 2010. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 (accessed 15 Nov 2011).
12. RCGP. *The future direction of general practice: a roadmap.* London: Royal College of General Practitioners, 2007. http://www.rcgp.org.uk/PDF/Roadmap_embargoed%2011am%2013%20Sept.pdf (accessed 15 Nov 2011).
13. RCGP, Scotland. *The future of general practice in Scotland: a vision.* Edinburgh: Royal College of General Practitioners Scotland, 2011. http://www.rcgp.org.uk/college_locations/rcgp_scotland/news__views/press_statements.aspx (accessed 15 Nov 2011).
14. Gillies J, Mercer S, Lyon A, *et al.* Distilling the essence of general practice: a learning journey in progress. *Br J Gen Pract* 2009; **59(562):** 167–176.
15. Ham C. Improving the performance of health services: the role of clinical leadership. *Lancet* 2003; **361(9373):** 1978–1980.
16. Scottish Medical and Scientific Advisory Committee. Promoting professionalism and excellence in Scottish medicine. *Scot Med J* 2009: **54(Suppl 2):** 1–24.
17. Lakhani M. The über-GP: an exploration of clinical excellence, leadership, and patient-centred care in general practice. *Br J Gen Pract* 2011; **61(584):** 218–220.
18. Plato. *The republic.* Translated by Waterfield R. Oxford: Oxford World's Classics, 2008.
19. Hilton S. Education and the changing face of medical professionalism: from priest to mountain guide? *Br J Gen Pract* 2008; **58(550):** 353–361.
20. Berwick D. The epitaph of profession. *Br J Gen Pract* 2009; **59(559):** 128–131.
21. Fugelli P. Trust — in general practice. James Mackenzie Lecture 2000. *Br J Gen Pract* 2001; **51(468):** 575–579.
22. Marshall M. Practice, politics, and possibilities. *Br J Gen Pract* 2009. [Epub ahead of print].
23. Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement. *Medical Leadership Competency Framework.* 3rd edn. Coventry: NHS Institute for Innovation and Improvement, 2010. http://www.institute.nhs.uk/assessment_tool/general/medical_leadership_competency_framework_-_homepage.html (accessed 15 Nov 2011).
24. Pendleton D, King J. Values and leadership. *BMJ* 2002; **325(7376):** 1352–1355.
25. Souba W. Building our future: a plea for leadership. *World J Surgery* 2004; **28(5):** 445–450.
26. Fitzpatrick S. *A survey of staffing levels of medical clinical academics in UK medical schools.* London: Medical Schools Council, 2010. http://www.medschools.ac.uk/Publications/Pages/Staffing-survey-2009.aspx (accessed 15 Nov 2011).
27. RCGP, Scotland. *Academic general practice in Scotland: securing the future.* Edinburgh: Royal College of General Practitioners, 2009. http://www.sspc.ac.uk/enewsletter/sec_the_fut_full.pdf (accessed 29 Nov 2011).
28. Roland M. James MacKenzie lecture 1998. Quality and efficiency: enemies or partners? *Br J Gen Pract* 1999; **49(493):** 140–143.
29. Ashworth M, Medina J, Morgan M. Effect of social deprivation on blood pressure monitoring and control in England: a survey of data from the quality and outcomes framework. *BMJ* 2008; **337:** a2030.
30. Walker S, Mason A, Claxton K, *et al.* Value for money and the Quality and Outcomes Framework in primary care in the UK NHS. *Br J Gen Pract* 2010; **60(574):** 213–220.
31. Dowrick C, Leydon G, McBride A, *et al.* Patients' and doctors' views on depression severity questionnaires incentivised in UK quality and outcomes framework. *BMJ* 2009; **338:** b663.
32. Howie J, Heaney D, Maxwell M. Quality, core values and the general practice consultation: issues of definition, measurement and delivery. *Fam Pract* 2004; **21(4):** 458–468.
33. Mercer S, Maxwell M, Heaney D, Watt G. The consultation and relational empathy (CARE) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Fam Pract* 2004; **21(6):** 699–675.
34. Guthrie B, McCowan C, Davey P, *et al.* High-risk prescribing in primary medical care: cross-sectional population database analysis in Scottish general practice. *BMJ* 2011; **342:** d3514.
35. Ritchie LD. *General practice: beyond the numbers game.* Aberdeen University Review. Aberdeen: Aberdeen University Press, 1994: 243–249.