

The Saltire Society celebrates the Scottish imagination. In accepting its 2018 Fletcher of Saltoun Award for Science, Professor Graham Watt replied, quoting and explaining Andrew Fletcher's dictum, 'if a man were permitted to make all the ballads, he need not care who should make the laws of a nation', which features at the start of the book he has compiled: *The Exceptional Potential of General Practice*.¹ He began by quoting Henry Sigerist:

*The ... practitioners of a distressed area are the natural advocates of the people. They well know the factors that paralyse all their efforts. They are not only scientists but also responsible citizens, and if they did not raise their voice, who else should?*²

Science is important, finding out what it is possible to know by observation and experiment, making the occasional breakthrough, chiselling away at doubt, and protecting us from fads and fancies. But science is not the source of all knowledge.

Sir Walter Scott, as President of the Royal Society of Edinburgh, was asked his view on whether the anatomist Robert Knox should be invited to lecture to the Society. Knox was notorious as the procurer of the bodies of the victims of Burke and Hare. Scott ruled against the lecture, saying:

*I think hearing it before Mr Knox has made any defence would be an intimation of our preference of the cause of Science to those of Morality and Common Humanity.*³

Modern science, especially health research, is perversely exclusive, naturally in relation to issues that cannot be resolved by scientific method, but systematically, in terms of people with complex problems and places where it is difficult to carry out research:

'Until the methods of science are made satisfactory for all the important distinctions of human phenomena, our best approach to many problems in therapy will be to rely on the judgements of thoughtful people who

*are familiar with the total realities of human ailments.*⁴

Such people include the best GPs who deal every day with whatever problems their patients bring.

When General Practitioners at the Deep End, working in Scotland's 100 most deprived communities, first met in 2009, it was the first time in the history of the NHS that they had ever been convened or consulted. Their experience and views were evidence to be tapped. A decade later, the group has identity, voice, a manifesto, shared activity, camaraderie, and impact.⁵ But inequalities in health in Scotland remain the worst in Western Europe. The poorest 10% die 10 years earlier than the richest 10% and spend twice as long in poor health before they die. TC Smout wrote:

*'The true grimness of the Scottish town was concealed from the tourist round of monuments and shopping centres, and was only revealed in the patient statistics of the Registrar General.'*⁶

We understand the theory but fail the practical. In the words of William Blake, 'He who would do good to another must do it in Minute Particulars; the General Good is the plea of the scoundrel, hypocrite and flatterer.'

The Deep End has focused on minute particulars: longer consultations for patients with complex problems; serial consultations to build knowledge, confidence, and agency in the unworried unwell; adding capacity by linking practices to resources in the community; placing financial advisors in general practices, often raising patients' incomes by thousands of pounds; attaching young GPs to practices, releasing the time of experienced GPs so they can use their experience and knowledge; sharing experience between practices, so that the best anywhere becomes the standard everywhere. The Inverse Care Law is not the difference between good medical care in affluent areas and bad care in poor areas, but rather as the difference between what

Deep End practitioners can do and could do, if they were better resourced and better organised as a group. We have learned that advocacy based on rhetoric has limited impact. When the music stops, power and resource tend to sit where they always have. The challenge is to win the argument on the ground, providing better solutions to health service problems such as multimorbidity, fragmented care, pressures on emergency departments, resource constraints, and widening health inequality. This is advocacy based on example.

The Deep End Project is an affirmation and expression of generalism, of local leadership and collective endeavour — a pre-institutional network fuelled by passion and common cause. There is no grand plan, only a direction of travel and a commitment to shared learning. The Scottish project has struck a chord. There are similar projects now in Ireland, Yorkshire, and Greater Manchester, and stirrings in Canberra and Pittsburgh. The story is being told in different ways in different places, in the best balladic tradition — something, I think, that Andrew Fletcher would have recognised, and of which I hope he would have approved.

Graham Watt,

Emeritus Professor, General Practice and Primary Care, University of Glasgow, Glasgow.

Email: graham.watt@glasgow.ac.uk
[@grahamwatt4](https://twitter.com/grahamwatt4)

DOI: <https://doi.org/10.3399/bjgp19X701093>

RCGP Scotland and the Scottish Deep End Project are holding a conference on 'The Exceptional Potential of General Practice' in Glasgow on 14–15 February 2019: <https://bit.ly/2PvOWNU>

REFERENCES

1. Watt GCM, ed. *The exceptional potential of general practice: making a difference in primary care*. Boca Raton: CRC Press, 2018.
2. Sigerist HE. *Medicine and human welfare*. New Haven: Yale University Press, 1941.
3. Anderson WEK, ed. *The journal of Sir Walter Scott*. Oxford: Clarendon Press, 1972.
4. Feinstein AR. The need for humanised science in evaluating medication. *Lancet* 1972; **2(7774)**: 421–423.
5. GPs at the Deep End. *Deep End summary 32. 8 years of the Deep End Project*. 2017.
6. Smout TC. *A century of the Scottish people 1830–1950*. London: Collins, 1986.

"When the music stops, power and resource tend to sit where they always have."