## **Gear-Wheel, Gearwheel, Gear, Cogs, Cogwheel, Cog, GearsThe 13 Professional Capabilities**

Hundreds of GPs were asked what activities they did as a GP and what they thought made a *good* GP. An analysis of the vast number of replies, revealed that they could all be grouped into 13 areas. These 13 areas define what makes a good GP. So, by logical deduction, if by the end of your GP training programme you can show that you are competent in all of these, then sure you must be good enough to qualify as a GP.

These 13 things are called the 13 RCPG Professional Capabilities. They are central to all your assessments. The whole ePortfolio and your training is geared towards collecting evidence for these 13 areas upon which you are ultimately judged towards the end of your training.

How does this list compare with yours?

1. Highlight the attributes you didn’t have on your list.
2. Have you any things on your list not covered by these 13 domains?
3. **Communication and Consultation Skills.**

A good GP is one who can used recognised consultation techniques to communicate with patients and understand the problem properly. The aim isn’t just to gather clinical data to make a diagnosis but to extract or help the patient ‘release’ other information that helps put the problem into context (such as a psycho-social-occupational enquiry). For example, emotional awareness is complementary to the science of taking a history, examination and making a diagnosis (the intellectual appreciation). Neither is privileged; both are necessary. However, an excess of emotional response can obviously interfere with a proper understanding of a clinical encounter as much as a deficiency. In other words, the right amount of emotional response is required, neither too little nor too much. Judgements engage our feelings as well as our intellect (McWhinney)

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A GP and his patient will (usually) have a long lasting relationship compared to a doctor in the A&E department. Emotional appreciation helps strengthen that bond. The good GP empathises where it is appropriate and natural to do so (empathy has moral, cognitive, emotive and behavioural components). He monitors emotions in the consultation and uses them as ‘modes of vision or recognition’ (Nussbaum) to guide his responses to a particular situation to achieve the best outcome for the patient.

1. **Practising Holistically**

A good GP is able to recognise, give sufficient time to and operate in physical, psychological, socio-economic and cultural dimensions. She listens to the stories that patients tell, the accounts of their lives and their illness (the patient’s narrative). She tries to imagine what the patient is experiencing. She takes into account feelings as well as thoughts (both his and his patient’s) – things like inner hurt, despair, hope, grief and moral pain. She attempts to understand how the patient views the situation and what they wish to be done. She is able to synthesise all the various dimensions of the problem ‘released’ in the consultation to formulate a plan that is likely to have greater impact than a purely clinical perspective one.

The relative weight attached to the clinical elements and the narrative is clearly a matter of judgement in each particular situation; the right response is the one that fits the situation. Neither is to be generally privileged over the other, nor do they exhaust the considerations that may be involved. To think otherwise is to make an ethical and a clinical mistake.

In practising holistically, a good GP sees his patient an individual with worries and concerns about illness, and not merely as an example of a disease state; the latter happens in a lot of A&E departments (for instance). At this point, we’d like to pay respect to our A&E colleagues and make it clear that we are not denigrating their roles and abilities. We understand that A&E provides something of a triage role between hospital and General Practice as well as dealing with on the spot emergencies – and that it does this mostly well. The point is that the some of the skills/attitudes required for A&E are different from those required for General Practice and therefore they must not be too deeply embedded in *GP* trainees.

1. **Data Gathering and Interpretation**

A good GP gathers the right amount of data for clinical judgement. This means that he is considers carefully things like the choice of examination and investigations. He doesn’t under or over-investigate. In the course of any clinical encounter, the GP acquires a large amount of undifferentiated information about the situation — physical findings, perhaps laboratory results, as well as the patient's experience often expressed as something like a narrative. All of this information requires interpretation.

1. **Making a Diagnosis/Making Decisions**

A good GP has a conscious and structured approach to decision making. The central problem of decision making in general practice is the need ‘to sort the unsorted’. GPs deal with a huge range of conditions: the management of ingrowing toenails, the assessment of suicide risk in a depressed patient, the immediate care of meningococcal meningitis are examples of the extremes. A good GP develops and fosters a refined ‘perceptual capacity’, which enables her to judge properly in each clinical situation. This is derived from Aristotle's idea of *phronesis* or practical wisdom (it’s a bit like intuition), and requires not only an intellectual grasp of the situation, but also imagination and an appropriate degree of emotional engagement.

Some of you might think that decision making is easy – for example, if someone’s BP, glucose or cholesterol is high, you just follow the guidelines don’t you? Yes, clinical measurements like BP are likely to be of considerable significance in decision making – but they only tell you what you need to do if you want to improve health outcomes for populations (good control of BP in a population is likely to result in 30% less mortality). The measurements don’t tell you what to do for individuals (you don’t know for sure whether a patient, whose BP you’ve controlled nicely, is going to fall into the 30% who benefit or the 70% who do not). Therefore only going on the evidence to determine what is best for an individual patient is naïve, unrealistic and unethical.

Many hospital doctors ‘tell and prescribe’ what a patient must do – how autocratic they are doesn’t vary much from patient to patient. On the other hand, a good GP knows when (and how much) to be autocratic and when to step back and involve the patient more in the management of *their* illness. The evidence needs to be appropriately used, and the facts emphatically do not always tell you what to do.

1. **Clinical Management**

A good GP is able to recognise and manage common medical conditions appropriately in accordance with good practice. You need to know a heck of a lot about a heck of a lot! And the good GP doesn’t just blindly treat all symptoms; the relative weight placed on the clinical and the narrative is clearly a matter of judgement in each particular situation and he is good at doing that. Failure to pay attention to this results in a *clinical* or *ethical* error.

1. **Managing Medical Complexity**

A good GP is able to manage aspects of care beyond the straightforward. For example, the management of co-morbidity, uncertainty and risk, and the approach to health rather than just illness. She is able to understand complex, multifaceted, ill-defined situations that occur every day in general practice. She knows how much weight to place on the clinical and how much on the narrative (sometimes the latter plays a more central part). She is able to look beyond the obvious – she has ‘imaginative flexibility’ (Nussbaum) – where she considers a variety of ways of looking at the case (e.g. taking into account what is currently happening, previous similar consultations, what the patient might be experiencing and so on – to help yield a range of possibilities (diagnostic and therapeutic) and outcomes. In other words, imaginative flexibility stops us from pre-interpreting what’s right for the patient (unlike rigid frameworks).

1. **Organisation, Management & Leadership**

A good GP makes appropriate use of primary care administration systems, effective record keeping and information technology for the benefit of patient care. For example, he makes good contemporaneous notes in good enough detail, he makes referrals in a timely way and he engages with practice/primary care systems and pathways. The good GP has good personal systems in place to ensure they are on top of their workload, action letter, blood results and other things in a timely way. The good GP takes on a leadership role to gently direct the practice to a better position as and when the need arises.

1. **Working with Colleagues and in Teams**

A good GP is a good team player. She respects those that she works with and treats them as equals (i.e. just because she’s a doctor, doesn’t mean she is more important than anyone else). She understands that every person in the practice is important to its effective functioning – just like every cog in a machine is no matter what its size. A good GP also communicates effectively with colleagues, sharing information in order to promote patient care through collaborative working.

1. **Community Orientation**

A good GP doesn’t just think about the individual patient on a 1-1 level. He also considers the health and social care of his practice population/community as a whole. For example, he might set up a new Sexual Health Clinic if he notices a high chlamydia rate amongst his practice population.

1. **Maintaining Performance, Learning and Teaching**

We said earlier that a good GP should have good levels of clinical knowledge and skills (item 5). In addition to that, a good GP needs to make sure she keeps up to date and maintains these skills. However, it doesn’t stop there – she should also aspire to engage and help in the continuing professional development of others.

1. **Maintaining an Ethical Approach to Practise**

A good GP is a **virtuous** person. Virtuous people automatically know what the right thing to do is in a given situation because of the fact they are good people (virtuous) in the first place. This branch of ethics is often called virtue ethics. In virtue ethics, the virtues are understood to be particularly valuable and worthwhile character-traits of people and are often grounded in an account of what it is to flourish as a human being (like being honest, kind, caring, compassionate).

* He has good **attitudes** – he practises with integrity, shows empathy, concern for his patient, sincerity and compassion. He is humble and generally has an open attitude.
* A virtuous and ethically-minded GP shows respect for **diversity**.
* He is **person-centred** and treats patients as individuals, as fellow human beings and respects their rights and wishes. He gives weight to the concerns and values that are often caught up in the stories that patients tell, the accounts of their lives and their illnesses is an obvious way of respecting the patient's autonomy. He helps them make decisions for themselves where possible. He is fair, kind and considerate.

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| *‘A kind person can be relied on to behave kindly when that is what the situation requires. Moreover, his reliably kind behaviour is not the outcome of a blind, non-rational habit or instinct … A kind person has a reliable sensitivity to a certain sort of requirement that situations impose on behaviour. … The sensitivity is, we might say, a sort of perceptual capacity.’ It is this* ***perceptual capacity,******aided and influenced by reflection and deliberation, that enables the virtuous person to recognise and respond to the requirements of particular situations.*** *This enables such a person to recognise, read or interpret situations well, and thus to determine what ought to be done.’ (McDowell)* |

1. **Fitness to Practise**

A good GP keeps an eye on her own performance, conduct and health and will take measures to make things better if patients are put unnecessarily at risk. A good doctor will also do something similar if she notices this in her colleagues – to protect patients and to help her colleague get better.

We’ve mentioned earlier the merits of emotionally engaging with the consultation. In addition to these, emotional engagement prevents ‘burnout’. Without it, we would depersonalise patients and see them as examples of disease states (*‘not another chest infection!’, ‘I hate dealing with headaches’*) rather than as individuals with concerns and distress.

1. **Clinical Examination & Procedural Skills (CEPS)**

A good GP keeps maintains a good level of skills – not just in communication and history taking skills, but in also of clinical examination and procedural skills.