Please mind the gap

ADDRESSING THE DIVIDE BETWEEN PRIMARY AND SECONDARY CARE

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In the UK, most people with a myocardial infarction, complex diabetes or an inguinal hernia turn to their National Health Service for help. They do not turn to primary care or to a hospital, but to a service. While the routes they may take through that service are legion, often capricious and inefficient, many will have noticed – but not voiced – the dislocation that can occur at the boundary between primary and secondary care[1]. It is this dislocation and possible ways to deal with it that are the subject of this editorial.

There are many divides in the modern caring services. While this article is mainly concerned with the divide between general practice and hospital practice, patients experience medical-social, doctor-nurse, consultant-consultant, senior-junior, political-service, management-clinical, trust-trust and many other divides. It might be argued that such dichotomies are inevitable in such a vast organisation with a million employees; if so, we have a duty to recognise and mitigate their effects.

Specialism and generalism

Our particular divide has its origins in the evolution of the medical profession and the historic deal in the Medical Act of 1858 that gave the hospitals to the physicians and surgeons, and the patients to the general practitioner[2]. This created the 'right of referral' and the roles of the general practitioner as a patient's advocate, the giver of continuity of care to individuals, families and communities, and the holder of the lifelong record. It reinforced an efficient use of hospital services, the pressure for specialisation and the consultant as the deliverer of intermittent or episodic care.

None of these features is consistent. A patient attending a general practice may see a succession of locums using poor records; in some specialties the consultant takes over responsibility for all care for some patients. Yet the philosophical chasm must be recognised, as must the endless, tiring tension between the virtues of generalism and specialism. Both generalism and specialism are key components of any efficient health care system, and preferably should co-exist, valued for their own contribution. This is not only a primary-secondary care issue. The demise and re-emergence of the 'general physician'[3] and proposals for 'specialist GPs' in the NHS Plan[4] highlight the generalist-specialist tensions within, rather than between, disciplines.

In general practice we find that the reductionist, cost-efficiency thinking of managers and politicians undervalues holistic, rounded, general skills while extolling specialisation. Our job is more than the sum of its parts – it is the embodiment of the values of the NHS. At its best it is a personal tailored service that sees the patient in physical, social and psychological terms; in which the doctor has unique understanding of that person's beliefs, hopes, fears and expectations; and is a participant and witness in their life's experience[5].

There is potential for us to come together, therefore, in the middle ground between specialism and generalism. A renaissance of the general specialist (as in the general physician) and the generalist with special interests (as in the 'specialist GP') might offer one way forward. The RCGP shares this aspiration with the RCP and we are working on proposals for training, standards and quality assurance for GPs who want to develop special interests.

Career separation

While these developments may bring existing general practitioners and consultants together, we will only attempt to mend an age-old division between our disciplines based on our separate training experiences. Young doctors, even medical students, are tempted into career choices early and once choices are made, significant changes in direction are difficult.

Even within the senior house officer grades the experience of different doctors in apparently identical posts can be determined by their career choice. A career paediatric SHO may have a substantially different educational experience from that of a career general practitioner doing a similar post at the same time. This may be justified, but early differentiation blocks interchange and institutionalises perceptions of 'two services'.

The current review of the SHO grade offers some possibilities to deal with these issues. More generic training would help to delay career choices, develop

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core medical skills and avoid the skills atrophy/hypertrophy of specialisation for a year or two longer.

One possibility is more training experience in the community for future hospital doctors. This carries both threats and opportunities. Early experience with pre-registration house officer posts that include four months in general practice is generally positive. It seems intuitively right to offer substantial training for future physicians in community (wider than general practice but including general practice) settings[6]. A doctor intending to become a diabetologist would gain from seeing and carrying out screening, early diagnosis, the management of uncomplicated diabetes and the care of people with diabetes in the community.

Such training should not detract from the essential acquisition of specialist skills, but rather supplement them with wider perspectives and generalist skills. It also offers a real opportunity for all doctors to experience general practice after registration, just as all experience hospital medicine. Two fringe benefits should be erosion of the primary-secondary chasm and acquisition of additional skills in primary care.

There are also two foreseeable difficulties. Experience in community settings must be of the highest quality, with the acquisition of knowledge and skills regarded as so valuable that it sells itself. While general practice has instituted high quality vocational training, it would be necessary to develop the educational content of such experience, and that would take time. The second problem would be capacity. General practice is stretched and teaching more young doctors must not be a second choice option, or it will fail.

Physical barriers

It may be trite to observe that general practitioners are 'out there' and consultants are 'in here', but since the demise of domiciliary visits, GPs and consultants seldom consult together and they communicate mainly by letter. The early hopes that outreach clinics, sponsored by fundholding, would remedy this situation were confounded by the realities of time and economics.

This may be inevitable. The differences between the roles of general practitioner and consultant may conspire to ensure that we meet more often socially than professionally, and that we seldom have opportunities to share together beliefs and values – the cement in teams and relationships.

However, the development of intermediate care offers one possible mechanism for change. This has not happened in isolation. It is, in part, a response to the shortage of capacity in acute Trusts[7] and the increasingly intensive nature of acute care[8]. If the hospital is to become a citadel of intensive, high technology care, then it increasingly becomes an inappropriate environment for ill people who do not need the technology.

These ill people who need lower technology care have become the lepers of the NHS. There is a jargon associated with them: 'bed blockers'; 'inappropriate admissions'; 'trolley waits'. However, patients are not the problem; the problem lies in the evolving nature of the modern acute hospital, and the perceived solution lies in intermediate care.

There is another disconcerting pressure for intermediate care. It is the perception that acute hospitals are hostile environments for people: not in terms of surgical mortality, although that contributes; nor of MRSA infections, although they too cause concern. It is more fundamental: there is an increasing perception that it is not *our* hospital but *theirs.* To an extent this is part of a trend in which people feel less loyalty to, and ownership of, the NHS as the post-war consensus is challenged. However, it is even deeper than that. The 'local' hospital used to be an integral part of its community. There used to be a clear sense of ownership and contribution. As the notion of charity has been replaced in health care by state provision and as the hospitals' size and technological wizardry has burgeoned, district general hospitals have lost contact with their communities and populations.

Intermediate care as a solution?

This is a statement, not a complaint. Intermediate care may present one solution. By aspiring to deliver care as close to the communities in which patients live as is compatible with quality, team working and efficiency, we may re-connect populations with their health services in the widest definition.

A cynic might point out that to achieve 'quality, team working and efficiency' one would need to see all people in an outpatient clinic in a district general hospital. However, consultants up and down the country can attest that this is not so. Many rural areas such as the South-West, East Anglia and Wales have fought to retain community hospitals, and other areas have kept smaller district general hospitals. These are now, or can be developed into, facilities in which integrated care between primary, secondary and social sectors can occur[9].

Although the visions for intermediate care are legion[10] and some are no more than enhanced care in the person's home or residential settings, most aim to step down a patient's need of high technology care, step up low technology care to high support care when required short term, and to provide rehabilitation. Much day surgery, outpatient and chronic care could occur in these environments.

Suggestions that whole hospital disciplines could relocate to intermediate care are unacceptable to some consultants. The idea that gerontology, diabetology, gastroenterology, psychiatry, dermatology, rheumatology and other disciplines could do most or all of their work outside the main district general hospital has met with resentment. There are some good reasons for this. The peer support and organisational depth of the large hospital are attractive. Yet there will be strong tides running in favour of the vast majority of routine 'hospital' care occurring in smaller, lower technology environments, and in delivering this care general practitioners and consultants will blur the traditional divide[11,12].

Conclusions

If the gap between the hospital and the community, the gap between our two disciplines, does not benefit patients – and

indeed often disadvantages them – then we have a responsibility to see how we can reduce it. Solutions include coming to terms with the virtues of both specialism and generalism. The advent of general practitioners with special interests (or 'specialist GPs') offers one way forward, as do potential changes in training rotations. However, intermediate care may offer the greatest potential of all – a safe environment in which we can work and learn together in a true partnership for patient care.

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