From the Editor

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Health preservation: collaboration between primary and secondary care

Communications and relationships between general practitioners and hospital medical and nursing staff have steadily improved during the last two decades with great benefit to the practice of medicine and the welfare of our shared patients. Those who work in both primary and secondary care deserve great credit for this improvement, because it has developed during a period which has seen the demise of joint domiciliary consultations, yet simultaneously has led to highly innovative collaborations.

Over that same period, concepts of patient care have changed substantially with the realisation that highly distinctive approaches are needed on the one hand for treatment of illness and suffering, and on the other for the preservation of health over the longer term[1]. The idea that apparently healthy people might need medications, sometimes quite complex in nature, to preserve their health is relatively new in historical terms, and even now not always understood in developing countries where the perceived role of doctors is solely the alleviation of illness. The requirements for treating the sick clearly differ from those needed to maintain health, such that new ways of delivering care, particularly the evolving relationships between hospital physicians and general practitioners, should be examined.

At a time when many specialist physicians are struggling to remain generalists, some general practitioners aim to develop special interests[2–4]. Indeed the NHS Plan specifically encourages the concept of GPs with special interests[5]. It makes sense therefore, that at least in some specialties, delivery of *health* preservation should increasingly evolve as a collaboration between hospital physicians and GPs.

Some innovations have had limited success or even outright failure. The concept of outreach clinics in which consultants attended patients at GP surgeries seemed an obvious way forward, yet the reality failed[3,6]. Absence of consultants from their hospitals while attending clinics in the community diminished essential resources and training within their hospitals; relatively small numbers of patients were actually seen; and those with more complex problems were inevitably referred back to hospital. Few GPs apparently attended such clinics, so that even the idea that such visits would serve an educational role was not on the whole fulfilled.

Furthermore, attempts by the previous CMO to encourage specialist practice by GPs were in some ways dangerously unsuccessful. The terms of reference that they should be 'appropriately qualified and experienced' and 'vetted' in this regard by 'experts' were far too vague, with no arrangements for appropriate training or accreditation. This raised problems regarding revalidation, CPD, clinical governance, and even some medical legal issues – in the event of any medical legal action one might expect the GP to be judged by the same standards as an accredited specialist. The newly proposed training standards described in a recently published joint report from the Royal College of General Practitioners and Royal College of Physicians should go some way to addressing these issues[2] which are discussed by Professor Roger Jones in an editorial in this issue of *Clinical Medicine* on page 346[4].

The article from a consultant and a GP with a special interest in diabetes published in this issue of *Clinical Medicine* (page 374)[7] raises some further problems concerning specialist practice in the primary care setting. The GP perceived that his specialist work in diabetes was undertaken in an environment isolated from the dialogue needed to maintain an up-to-date practice. Introduction of a specialist registrar to work with the GP was valuable for registrar training, and indeed there is growing recognition of the need for hospital trainees to spend some time in general practice. But the idea that a GP should be kept up-to-date by a rotating trainee registrar cannot be right, and should not be the formal basis for GP CME in the specialties. Furthermore, the specialist registrar was quickly aware of the problems of working in a vacuum away from the team needed to deliver the entire spectrum of health care for those with diabetes, for example specialist nurses, dieticians and chiropodists. The lack of access to specialist investigations needed for more complex problems were also highlighted as a difficulty. This is unsatisfactory, especially with the knowledge that the high mortality of diabetic patients particularly notable among those suffering environmental deprivation is at least in part preventable[8].

So the idea of intermediate care is evolving, in which GPs and consultants work together to deliver the needs of a range of specialties, such as gerontology, diabetes, rheumatology, gastroenterology and psychiatry[3], and there could be others such as asthma and epilepsy. It is, however, vital to acknowledge that each of these specialties also include patients with complex problems requiring the higher technology available only in larger acute hospitals. Each of the teams needed to deliver care

would therefore require a presence on an acute hospital site, yet splitting teams geographically is at best inefficient and at worst a disaster for patient care, training and research, as many of those working in 'merged' units understand all too well. The 'alchemy of individuals'[9] on which new ideas (and team building) evolve, develops over cups of coffee taken under one roof because that 'brings together people of common interests but different scholarly backgrounds in surprising, unpredictable but above all fruitful ways'[10]. Pragmatic considerations will determine the environment for delivering joint services, but careful thought is needed to ensure that future planning does not worsen rather than improve overall patient care.

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