and disadvantages of care closer to home. What patients want may not be what they need, nor what the nation can afford. Peripatetic specialists are inefficient and re-inventing the cottage hospital network (now termed polyclinics) is unaffordable – have we forgotten that many cottage hospitals disappeared in the 1980s because they were too expensive to run? Clinicians should only support systems that are financially sound. It is illogical to argue that emergency care must be centralised on fewer sites to improve results while potentially disseminating all other care.

Services may be provided more cheaply 'in the community' but they may not be better. There is nothing wrong with hospitals as specialist bases – to maintain clinical research; high-quality training; and good clinical governance. Professional isolation is avoided and multidisciplinary teamwork facilitated. In my own area the primary care trust (PCT) has (without discussion with its local specialists) commissioned a rheumatology service within general practice run by a retired consultant. It is one-third to one-half the cost of the current Payment by Results (PbR)-based secondary care alternatives. The reduction in hospital workload if patients are diverted to such cheaper alternatives threatens the viability of existing services.

The Royal Colleges of Physicians, Paediatrics and Child Health, and GPs agree that positive incentives are required in the NHS. The barriers between primary and secondary care must be removed and we must talk of general and specialist care, between which patients can move seamlessly, unhindered by financial issues. This is the principle behind Teams without Walls and requires vertical integration of provider services.[1] All competing services will then be on a level playing field. Conflict between GPs and specialists disappears. PbR, which forces PCTs to pay prices they cannot afford to hospitals that cannot reduce their prices without going bust, collapses. There are positive models already. In Stoke-on-Trent the musculoskeletal service is now managed by primary care (with substantial cost savings) but the current pattern of delivery has been maintained.

Do we need practice-based commissioning? The integration of general and specialist care removes its raison d'être. It allows local accountability but adds a huge layer of financial management to a bankrupt system and hinders the process of specialist referral.

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References

1 Royal College of Physicians, Royal College of General Practitioners, Royal College of Paediatrics and Child Health. *Teams without Walls: the value of medical innovation and leadership*. London: RCP, 2008.

Conflict of interest

At the time of writing, the author was President of the British Society for Rheumatology and a member of Council of the Royal College of Physicians, London.

In response

Many thanks for your reply to my article. I share your concerns and one of the great difficulties of practice-based commissioning (PBC) is that it is politically driven and the 'goal posts' are continually moving. The article I wrote was to summarise my current understanding of PBC, but not my opinion of the process.

In the article I cited two major concerns. Firstly, with the future possible role of private providers and so a plurality of providers, would PBC lead to improved efficiency or a path to further privatisation and de-unification of the NHS? Secondly, general practitioners (GPs) and consultants are becoming opponents in a bidding war, rather than colleagues with different areas of competence who currently cooperate in the management of patients.

It is therefore of particular concern to all of us who work as traditional NHS providers to observe this process which has no obvious evidence base and could potentially fragment and destabilise the NHS.

Bamji has made a very important observation and will perhaps be quoted for years to come on the concept of moving from the terms; primary and secondary care, to generalist and specialist care and therefore working as a 'team without walls'. It is imperative that we use these skills appropriately for the benefits of patients in the environment of the patient's choice and not those based on political visions. Competition between potential service providers should be avoided, but rather ensuring that the most appropriate practitioner is made available to treat a patient with a particular illness. A service provider based on cost rather than identified health need and the practitioner most appropriately skilled to meet that need, will compromise patient care.

There is a myth that care in the community is cheaper and equivalent and that it should be run by GPs with a specialist interest (GPwSIs). This has yet to be researched fully and like many recent changes in the NHS it should be piloted before it is implemented. Bamji is right, we should avoid 'reinventing the wheel' and concentrate in the areas of generalism and specialism where we endeavour to excel and the associated environments where that care is provided. We are currently losing the concept of shared care which is being undermined by locally enhanced PBC services which can actively discourage primary care from involving secondary specialist services, eg, in diabetes care.

Phrases often quoted that I find difficult are, 'we live in interesting times' and 'shaping the future'. In relation to the NHS it would be more true to say that as GPs and consultants we live in worrying times, particularly for our patients. I do share your concerns and thank you for writing.

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Lesson of the month (1)

Editor – I read Chirwa *et al's* lesson of the month (*Clin Med* February 2008 pp 107–8) with interest but would like to raise a few points. Modern computed tomography-based radiotherapy planning systems allow accurate calculation of the dose to specified areas of the brain making the phrase 'it was possible that radiation spread to the brain' imprecise and unnecessary. Most radiotherapy treatments for tonsillar carcinoma are carefully planned to avoid significantly irradiating the brain unless tumour location makes this necessary. No staging details are given to suggest why any volume of the central nervous system (CNS) should have