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### Getting the swagger back into general practice

Perhaps there never was a golden age of general practice but it seems to me there was an era when GPs sustained their local community by delivering babies, performing operations, and only deferring to secondary care in exceptional circumstances. In short, they were warriors on the front line of medicine.

This perception, erroneous though it may be, presents an attractive career option; variety, excitement, and respect. It is markedly different from the perception, again erroneous, that many trainees in secondary care specialties have of GPs as referral-wallahs, sifting the sick to the appropriate secondary-care specialist. In the first case a life as a GP seems full of opportunity to buckle your swash, while the second seems drab and uninspiring.

The role of GPs has been greatly eaten away over the years not least by odd contracts that financially punish GPs for offering extra services and force them instead to focus on LES, DES, and QOF, and this narrowing of the role has, in part, created the current recruitment crisis by making general practice seem far less appealing.

Another key factor in the recruitment slowdown is the restrictive nature of the career structure created by modernising medical careers. This forces people down career paths at such an early stage in their training that the options that usually seem safest are hospital medicine or surgery, to the detriment of general practice recruitment. These two bugbears could be killed with one honeypot.

Clearly a healthcare system full of maverick GPs 'having a go' at specialist interventions would be a grave danger to patients, but by making GP training more flexible and varied we could produce GPs capable of performing them. We need training programmes that produce a wide variety of GPwSIs at the end of Certificates of Completion of Training, rather than relying on GPs rededicating themselves to a specialist interest after training.

Furthermore, the Royal College of General Practitioners needs to acknowledge and validate the experience of those who transfer into GP training from other specialties. The

urology registrar who decides he can't face a life of per rectals needs to know that, should he retrain as a GP, his experience won't go to waste and he will still be allowed to cystoscope and biopsy prostates as is within his competence. Currently his previous experience would count for nothing. Rather than embracing this kind of added experience we construct petty bureaucratic obstacles to its employment. For example, former surgeons and fellows of the Royal College of Surgeons are told at their GP appraisals to complete the RCGP minor surgical course if they want to continue cutting out lumps and bumps.

Perhaps it should be standard in GP training to spend an extra year within a chosen specialty, or split between a specialty and more experience in general practice, to develop the skills for diagnosis and intervention necessary to be a GPwSI. Whereas a specialist interest is currently the exception, there should be a future where it would be the norm. This would result in partnerships in which the corporate skill base would allow for a much greater array of investigation and follow-up to be kept in-house and, with the future federation of GP surgeries, far more could be kept within primary care.

The ad hoc system of establishing specialist interests at present will only ever nibble at the edges of secondary care and will never claw back any substantial portion of patient care. We cannot rely on people who have just completed a rigorous training scheme voluntarily taking on extra training in the speculative hope that a specialist interest will be considered useful. We need to make a specialist interest both convenient and rewarded. In this way, by offering the generality of general practice as well as the ready option for specialism and intervention, the career of general practice could be made much more attractive again and the recruitment crisis solved.

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