FAULT LINES

The NHS got off on the wrong foot in 1948. Specialists' mouths were 'stuffed with gold' to persuade them out of lucrative private practice into public work. Their terms and conditions appropriately reflected their professional status. Poorly trained GPs were consigned to the small-business model of primary care, damningly described shortly after the foundation of the NHS in the Collings report,¹ and have never worked with a contract that recognises anything more than the provision of services to patients. Teaching, research, management, and medical leadership were firmly located in the hospitals and the Royal Colleges. The disparity of esteem between the two branches of the medical profession was encapsulated by Lord Moran, Winston Churchill's physician, who described the career path to being a consultant as a ladder off which many fell, only to become GPs. The referral system, and the gatekeeper role of GPs, formalised the split between primary and secondary care and, for as long as I can remember, the primary:secondary care interface has been a war zone.

Many of the problems, reorganisations, and costs that have befallen the NHS over the years have their roots in this professional fault line and, conversely, many real advances and innovations in patient care have involved breaking down barriers, and establishing inter-professional collaboration between specialists and generalists, often in partnership with community and third-sector services. Indeed, *The Five Year Forward View* of the NHS is clear that the over-worked word 'integration' is, indeed, integral to the clinical and fiscal survival of the service. Lessons will be learned, of course, from the Manchester experiment.² In this issue of the *BJGP* you will find a number of examples of good work and good intentions at the primary:secondary care interface, but also a warning that things need to improve considerably if we are to solve current problems of career choice, recruitment, retention, and affordability.

The important interfaces between generalists and specialists is described in editorials and articles in which day surgery, acute access for surgical emergencies, the appropriate management of dental problems in general practice, and shared

care in rheumatology all make the same point — that high-quality care depends on mutual understanding and collaborative working. We all recognise this, but why is it so difficult, and why does it so often go so wrong? Generalists and specialists train at the same medical schools, read more or less the same books, even marry each other, yet within a few years of qualification consultants and GPs more often than not become at best tribal, and at worst antagonistic and mutually disparaging.

Des Spence, in his welcome first column for the *BJGP*, puts his finger on it in identifying the early sources of trouble in medical schools, where senior figures still regard general practice as a second-best career option, and still have been heard to ask some of their best students why on earth they choose it, rather than specialist medicine. Early and consistent exposure to high-quality general practice and to GP role models during medical education must be encouraged — and there is now a real danger that, in order to make up the numbers, students may find themselves in placements with demoralised GPs, creating a downward cycle of loss of interest and under-recruitment. Amidst the gloom and meltdown it is really important to assert that general practice can be a terrific career, enormously enjoyable, deeply rewarding, and intellectually challenging.

In his Trust Deed to the Royal College of Physicians in the 16th century William Harvey quoted Sallust, the Roman historian: '*Concordia res parvae crescunt, discordia magnae dilabuntur*' — 'With harmony small things increase, with discord the greatest come to nothing.' Worth thinking about.

Roger Jones,
Editor

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