**Gatekeepers, wizards, and** **a mutual appreciation of each other’s kingdoms**

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Collaborative working is crucial to providing joint up, high quality care, yet medicine continues to be a divided profession of gatekeepers (GPs) and wizards (specialists).1 2 The covid-19 pandemic has in many ways only exacerbated this sense of estrangement, with ever increasing workloads and gaps in the multidisciplinary workforce not exactly conducive to goodwill across healthcare teams.

More than ever, we need to create a shared understanding of each other’s roles and ignite opportunities for interprofessional education and communication. We both participated in a GP-consultant exchange scheme3 before the pandemic and share how it’s shaped our perception of each other’s work and our practice:

**Insights into a wizard’s kingdom from a gatekeeper**

The last time I had stepped inside a hospital department was when I was training, a good 15 years before the exchange experience. I was shocked by how bustling this environment was. Everyone from porters, cleaners, catering staff, therapists, other allied health professionals, nurses, and clinical teams were vying for space on the ward.

I was impressed by the stamina my hospital colleagues needed to sustain a three to four hour ward round while leading, teaching, instructing junior teams, and interacting with numerous members of the multidisciplinary team (MDT) to make complex decisions about patient care. Their momentum, enthusiasm, and professionalism was inspiring to see. By the end of the day in practice, I’m often tired from decision making, but this was a whole new level of fatigue.

Invariably, my colleagues then switched to a new activity after the ward round that ranged from outpatient clinics, rehabilitation rounds, theatre sessions, teaching, training or developing their own specialist skills. I gained a newfound admiration for how many plates my specialist colleagues spin simultaneously.

I learnt that the referral pathway was highly complex, with over 21 steps from my referral to a procedure. Observing the multiple IT systems at work in the hospital that did not always link with each other nor with primary care gave me an appreciation of how lucky I am to have one comprehensive IT system in my GP surgery. Observing this and knowing that I have access to a patient’s whole medical record, I now write more detailed referral letters to support my secondary care colleagues. This has become even more important during the pandemic as many of our patients’ journeys are far more fragmented, with multiple agency contacts all under the umbrella of the NHS—for example, 111, the NHS Test and Trace, emergency department, out of hours, hot clinics etc.

I witnessed friendships and camaraderie among the MDT, a contrast to primary care where the MDT is more virtual. More than anything though, I saw highly skilled and compassionate colleagues spending a significant amount of time with patients—an experience that boosted my morale and has continued to sustain me through difficult times in primary care. I now better appreciate our differing specialist skills. I am a true generalist, recognising the boundaries of my skill, but I am fortunate to have a vast secondary care resource at my doorstep, supporting me to take care of my patients should the need arise.

**Insights into a gatekeeper’s kingdom from a wizard**

I was struck by the wealth of knowledge GPs have and how they use all their faculties to diagnose, address patient satisfaction, manage, and safety net for a range of conditions of varying complexity. As someone who can take an hour or more to complete a geriatric assessment, I found seeing these principles followed in a 10 minute consultation a sight to behold.

I was slightly taken aback at how isolated the clinicians were in practice: desk, screen, and couch—their second home! I was amazed at the camaraderie they shared in spite of this but am still grateful for the constant interactive environment I have in hospital.

It’s easy for narratives of blame and of work being “dumped” on each other to arise between primary and secondary care, but all I saw was a genuine respect for, and efforts to support, secondary care, with GPs keen to avoid hospitalisation and outpatient referrals. I was humbled by how much clinical uncertainty GPs live with as a consequence of their limited access to investigations and the absence or delay in communication they have from secondary care in the form of outpatient letters or discharge summaries.

As experts in chronic disease, lifestyle, and change management, GPs are ideally placed to have an impact on a person’s disease trajectory before a disabling process is established, but opportunities to make use of GPs as key and equal partners in personalised care support planning are often missed. I was amazed by how much information about a patient’s baseline function and social circumstances GPs know or have in their electronic health records, but this is often not sought in secondary care.

Equally, I’ve come to see how the information we give about the patient from secondary care through many of our discharge summaries is not always conducive to effective patient management. I’ll often bat out comments on a ward round before discharging a patient such as “get GP to check U&E in one week” without giving much thought to the reasons for my ask. These offhand requests now seem ridiculous, knowing that my discharge summary is among hundreds of correspondence letters to hit the practice that day, each specifying delegated tasks that together contribute to an unmanageable GP workload. Seeing primary care colleagues at work made me rethink my overall responsibility for organising suitable follow-up of these types of investigations. I don’t hesitate now to pick up the phone to contact my GP colleagues to facilitate seamless transfer of care. Getting to hear a voice across the line, and knowing there's a person at the end of it has been even more important during this pandemic.

**Creating a single kingdom**

Wizards and gatekeepers need each other, but this shared recognition of our mutual dependence can easily become lost, especially amid the stresses and demands of the past two years**.** We were able to use a local GP-consultant exchange scheme to gain an insight into each other’s working day, but embedding this kind of learning into the curricula of all trainees, as well as within the core values of individual trusts and integrated care systems, would help to ensure that workload does not become a barrier to other doctors gaining these experiences.4 5

Collaboration also starts with us all recognising the arbitrary primary-secondary care divide for what it is. If we want to recover from this pandemic and deliver an NHS fit for the 21st century, then neither side can do it alone: we’ll need to work together as a single kingdom.6 7

Competing interests: PA is a “gatekeeper” married to a “wizard.” HPP is a “wizard” married to a “gatekeeper.”

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