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GPs with special interests

Benefits to patients, GPs and the community

Some general practitioners are naturally drawn to particular patients and skill sets, and it is from this intellectual curiosity that they develop special interests. General practitioners with special interests (GPwSI) offer great potential benefit to patients, the profession and the health care system, and need to be supported. Colleges, universities and other training and accrediting bodies play an important role in supporting these GPs.

In the United Kingdom, where GPwSI have been encouraged and supported by a systemic framework, benefits to the health system have included reduced specialist waiting lists,[1] lowered costs and increased patient and physician satisfaction.[2] However, recent Australian articles have raised concerns that encouraging this approach here may exacerbate the current GP workforce shortage.[3,4]

The Royal Australian College of General Practitioners (RACGP) has taken up the challenges posed by GPwSI, releasing a discussion paper exploring the use of this model in Australia.[2] The paper starts by asking which term is better to define these practitioners' particular skills: 'special' interests or 'specific' interests. 'Special', as the Oxford dictionary defines it, can mean 'studied in particular depth',[5] which seems an apt description for GPwSI. By contrast, the dictionary defines 'specific' as 'clearly defined' or 'precise'[5] – a definition perhaps more suited to specialists than GPs with particular interests who work from a generalist base. 'Special', which is common parlance in Australia and has also gained overseas acceptance, seems the better term.

The RACGP discussion paper, while cautioning against fragmentation, supports the consolidation of special interests in general practice. This consolidation will come about, the paper states, when competencies, responsibilities and service provision agreements have been clarified. The paper goes on to look at the relationship between GPwSI and other GPs, and the role of the RACGP in facilitating faculties, chapters and clinical networks of GPwSI. The RACGP sees itself as having a role in policy development relating to credentialling, recognition and remuneration for GPwSI.[2]

Drivers

Advances in medical technology

Advances in medical technology have greatly increased the scope of diagnosis and management in primary care. General practitioners now have access to Medicare rebatable investigations in areas as diverse as congestive cardiac failure, sleep apnoea, coronary imaging and retinal photography (see *Case study*). With these technological developments now becoming more widely available, it is both desirable and feasible to arm GPs with advanced skills and knowledge in areas of growing importance to the community.[6]

Health service demand

Around the world, aging populations and an increasing prevalence of chronic disease are driving a massive increase in health service demand. Internationally, waiting lists at specialist outpatient departments continue to grow, while demand for chronic disease monitoring is stretching acute services to breaking point.[7,8] Australia faces the same problem: a recent Queensland health outpatient department report identified long waiting lists and difficulty accessing hospital outpatients as key barriers to access.[9] Some of this demand could be met by GPwSI taking on a much greater role in areas such as diabetes management and screening, management of chronic kidney disease, dermatology, musculoskeletal medicine, and dementia assessment and management.

Case study

Setting – an urban indigenous health service

Problem – poor access to diabetic retinopathy screening for indigenous patients with diabetes, resulting in significant screening nonattendance and long public hospital ophthalmology waiting time.

Intervention – retinal camera and photography in a culturally appropriate environment within the community; upskilling of GP through Masters of Medicine primary eye care short course.

Outcome – over 100 indigenous patients have had their eyes photographed in 12 months. More than 60% of these retinas were reported as normal, reducing the need for ophthalmological review.

GP strength in holistic care

The reality of an aging population is an increasing prevalence of comorbidities in the one patient. Managing diabetes, renal failure, acute coronary syndrome, depression and osteoporosis in one patient is not uncommon. Optimal management of comorbidities requires knowledge of multisystem disease as well as social and community support services. Appropriately skilled GPs can provide this care for less expense than most hospital outpatient departments.

Benefits

Patient and community access and satisfaction

Experience overseas has demonstrated a significant patient appetite for GPwSI.[10] Patients prioritise easier access within their community to care that supplements usual GP management.[7] This can mean easier access through improved time to appointment, less transport and parking dilemmas, and continuity of care with effective feedback of management plans to ongoing care providers (see *Case study*). In a UK study, patients attending GP based clinics were more satisfied with access to appointments and information received than those attending hospital orthopaedic outpatient clinics.[11]

GP job satisfaction

When asked, GPs state that special interests increase their job satisfaction,[2] and that they value the opportunity to become more skilled in specific areas while maintaining a generalist base. At medical student GP career sessions, the opportunity to pursue special interests is a recurring theme. For students who might not like the narrow focus of the specialities, but have a special interest they imagine pursuing, these opportunities are important.

Many GP special interests, such as care for the homeless, drug users and Indigenous Australians, lie outside specialist domains.[1] Where there is overlap between GPs and specialists, careful collaboration between credible practitioners can still result in successful service delivery.[12] Indeed, provided there are clear partnership guidelines, GPwSI are able to carry a greater responsibility for common complex conditions. Collaborations between GPs and specialists allow GPs the opportunity to work more productively with their specialist colleagues; the resulting educational and professional relationships have the potential to benefit all GPs in a given area.[13]

Some GPs without special interests may become concerned that GPwSI are poaching their patients. This should not be a cause for concern: the majority of GPwSI refer patients back to their regular GP once the episode of care they are dealing with is over.[2]

Networks of GPwSI have the potential to contribute quality articles to *Australian Family Physician* – which, in turn, has the potential to increase readability and relevance for GPs who might feel alienated reading articles on general practice topics written by specialists.

Health system

Health service managers report that GPwSI have benefits including decreased specialist waiting lists and increased recruitment and retention of GPs.[6] In the area of ear, nose and throat, GPwSI have been found to halve the cost of specialist clinics.[14]

The encouragement and consolidation of GPwSI in Australia has the potential to promote research ideas and networks and care management discussions that benefit the health system as a whole. These discussions could focus on areas critical to the health system, such as increasing the scope for management of complex comorbidities within the community.

Challenges

Effect on the workforce

The greatest concern in instituting the GPwSI model in Australia is the potential impact on our limited GP workforce, resulting in overall deskilling of GPs, the loss of services in low socioeconomic areas, and the fragmentation of the health care system.[3,4] However, managed well and focused on health system 'hot spots', GPwSI could increase GP workforce participation and retention, and inspire registrars to new challenges in their scope of practice.

Accreditation and recognition

The sheer number of potential special interest areas is daunting; the list in *Table 1* merely scratches the surface of the many possible areas GPs can pursue. A number of these areas have already developed clear training and accreditation processes, which provide a good framework for further advancement in other areas. Many of them, however, have no such framework. Our greatest challenge may lie in ensuring appropriate training, infrastructure and support for GPs choosing to practice within these areas.

To ensure both standards for consumers and appropriate remuneration for GPs undertaking more complex care, the skills of GPwSI need to be recognised and accredited. At the same time, care needs to be taken to make sure any accreditation of skills and knowledge is appropriate and does not become unduly onerous or bureaucratic. To get accreditation processes right for such a broad array of special interest groups will be a complex task.

Online training has become popular with GPs – it suits their hectic and often unpredictable working environment. To accommodate a

Table 1. Potential GP special interest areas

- Academic general practice
- Aged care and nursing homes
- Chronic disease (eg. diabetes)
- Complementary and alternative medicine
- Counselling
- Diabetes
- Drug and alcohol
- Emergency medicine
- Ear, nose and throat
- Family planning
- Geriatric medicine
- Hyperbaric medicine
- Indigenous health
- Minor surgery
- Musculoskeletal medicine
- Non-English speaking background
- Obstetrics
- Orthopaedics
- Paediatrics
- Pain management
- Palliative care
- Refugee health
- Sexual health
- Sports medicine
- Surgical assisting
- Women's health

greater range of skills training, existing online education resources may need to be expanded. To this end, governments have recently demonstrated their preparedness to fund GP training in areas that will improve care in their local population.[15] In time, growing recognition of the role GPwSI play could lead to remuneration through specific Medicare Benefits Schedule (MBS) item numbers.

The future

General practitioners with a special interest are on the agenda for the National Health and Hospitals Reform Commission, the MBS review, and for ongoing discussion with the RACGP. They offer the potential to increase job challenges and remuneration for those GPs opting to take on advanced training and accreditation, but require careful thought regarding workforce recruitment and retention. It may be that GPwSI are best utilised in a traditional general practice setting, where community need can guide provision of specific services such as diabetes care, dermatology and urology.

Partnerships between training bodies are essential to facilitate training in advanced skill areas. As well as knowledge, GPs will require clinical attachments, which may be public or private sector. To get the process started, dialogue between colleges and universities relative to how to make advanced skilling for GPs a reality, needs to begin soon.

Given the diversity of special interest group needs, the RACGP needs to be flexible in its approach to the issues posed by GPwSI. A number of special interests are already well supported by the college – indigenous health, for example, is served by a range of resources and research grants. This support could readily be extended to other areas. For example, the college could support GPs with a special language interest by collating relevant resources on its website and facilitating a network that might occasionally meet. For other areas of expertise, university departments of general practice may take the lead, based on their historical strengths.

Conclusion

If the 1940s and '50s were about medical generalism, and the 1970s, '80s and '90s were about specialisation, then surely the 21st century, with its aging population and increasing prevalence of chronic disease and multiple comorbidities, demands a careful mix of both these approaches. General practitioners with a special interest will be an essential element in facilitating this combined approach, and if carefully nurtured and supported, will bring a diversity to general practice that will reward both Australian communities and the GPs themselves.

Conflict of interest: none declared.

References

1. Torjesen I, Smith P. Taking an interest. Australian Doctor 2008:25–7.
2. The Royal Australian College of General Practitioners. Specific interests in General Practice within the RACGP – A discussion paper. 2007. South Melbourne: The RACGP, 2007.
3. Jiwa M, Ee HC, Beilby JJ. Will promoting general practitioners with special interests threaten access to primary care? Med J Aust 2007;187:71–2.
4. Wilkinson D, Dick ML, Askew DA. General practitioners with special interests: risk of a good thing becoming bad? Med J Aust 2005;183:84–6.
5. Oxford English Dictionary Online. Oxford: Oxford University Press, 2008.
6. Boggis AR, Cornford CS. General practitioners with special clinical interests: a qualitative study of the views of doctors, health managers and patients. Health Policy 2007;80:172–8.
7. Sabit R, Griffiths TL, Watkins AJ, et al. Predictors of poor attendance at an outpatient pulmonary rehabilitation programme. Respir Med 2008;102:819–24.
8. Davies HT, Crombie IK, Macrae WA. Waiting in pain. Delays between referral and consultation in outpatient pain clinics. Anaesthesia 1994;49:661–5.
9. Queensland Health. Specialist outpatient services in Queensland public hospitals. Brisbane: Queensland Government, 2007.
10. Ridsdale L, Doherty J, McCrone P, Seed P. A new GP with special interest headache service: observational study. Br J Gen Pract 2008;58:478–83.
11. Baker R, Sanderson-Mann J, Longworth S, Cox R, Gillies C. Randomised controlled trial to compare GP-run orthopaedic clinics based in hospital outpatient departments and general practices. Br J Gen Pract 2005;55:912–7.
12. Moffat MA, Sheikh A, Price D, et al. Can a GP be a generalist and a specialist? Stakeholders views on a respiratory general practitioner with a special interest service in the UK. BMC Health Serv Res 2006;6:62.
13. Jackson C, Askew D. Is there a polyclinic alternative acceptable to general practice? The 'beacon' practice model. Br J Gen Pract 2008;58:733.
14. Sanderson D. Evaluation of the GPs with Special Interest (GPwSIs) Pilot Projects with the Action on ENT Programme. York: York Health Economics Consortium, 2002.
15. Australian Department of Health and Ageing. Better Outcomes in Mental Health Care. Canberra: Australian Government, 2001.

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