Specific interests in General Practice
within the RACGP –
A discussion paper

Introduction to the paper

“...we are increasingly moving away from the old hierarchies, the traditional barriers between primary and secondary care and the unhelpful compartmentalisation of staff and their skills.”

“Instead, we are seeing a growing recognition that delivering truly patient-centred health care is a team activity. Nowhere is this shift more evident than in the growth of practitioners with a specialist interest (PwSI).”

“Developing services around PwSIs is about having the right people with the right skills in the most effective place to provide convenient care.”

From: Practitioners with special interests: Bringing services closer to patients NHS Document 2006

The Royal Australian College of General Practitioners (RACGP) is committed to setting, maintaining and promoting standards for safe, high quality, equitable general practice care for the Australian population.

Since its foundation in 1958, the RACGP has demonstrated its commitment to improving standards in general practice through the development of the College examination leading to Fellowship, the RACGP Training Program, General Practice Vocational Registration, the Quality Assurance and Continuing Professional Development (QA & CPD) Program and the RACGP Standards for General Practices.

The purpose of the paper is to support discussions about standards of care in the context of ongoing interest in the issues surrounding ‘special or specific interests in general practice’ from within the RACGP and outside it (in the profession and community).

The interest in these issues is reflected in a resolution of the Convocation of the RACGP in 2006 to consider the establishment of a Faculty of special interests in general practice within the RACGP. It is also reflected in the ongoing discussion about recognition and reward for growing wisdom in the performance of the broad scope of general practice, in contrast to the pursuit of a specific interest.

For the purposes of this paper, the term ‘specific interest’ will generally be used. The term ‘special’ is thought by general practitioners (GPs) who have been involved in early discussions, to connote greater importance, rather than specificity; and in that context is not a useful way of describing the interest areas.

The focus of the paper is on the development of advanced competence in general practice after general practice vocational training.
This paper is written in four parts. The first part outlines some concepts used in the paper. This is necessary because there are divergent views on the issues and potential outcomes, and it assists to have a common conceptual framework for the discussion.

Part 2 explores a model for understanding specific interests in general practice.

Part 3 of the paper explores a structure through which these interests could be supported within the RACGP.

Part 4 of the paper explores policy issues that would need to be addressed for this approach to be sustainable.

**Part 1: Concepts underpinning the paper**

**General practice**

The term ‘general practice’ is not consistently used in international literature. In Australia, the RACGP defines it as follows:

*General practice is the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.*

General practice is the first point of contact for the majority of people seeking health care, and often therefore the first point of referral. In the provision of primary care, much undifferentiated illness is seen; the general practitioner often deals with problem complexes rather than with established diseases. The general practitioner must be able to make a total assessment of the person's condition without subjecting a person to unnecessary investigations, procedures and other treatment.

General practice has a core set of clinical characteristics and practices, unique within medicine. These characteristics and practices are defined by the General Practice curriculum - developed and maintained by the RACGP and reflected in the standards set for clinical practice and the award of Fellowship of the College (the FRACGP).

Surrounding this well-defined set of core clinical characteristics and practices, there are significant variations relating to the demands of particular clinical contexts, and to the particular skills of individual practitioners. Context demands generally reflect both geography and particular populations. The variable demands of clinical contexts extend – for example, from remote rural contexts with high aboriginal populations to outer metropolitan areas with high levels of chronic illness and/or refugee populations, and inner-city groups with high rates of HIV, Hep C and D&A problems.

General practice training is intended to equip its graduates with both core clinical skills and the ability to assess and address the learning needs arising from differing clinical contexts over a professional lifetime.

**The ‘unit of analysis’ – clinician, not setting**

The focus of this paper is on the clinician – does the clinician pursue a specific interest and what are the implications of pursuing a specific interest (or not).

The practice setting is another 'unit of analysis', and not the focus of this paper (though, as outlined in Part 4 of this paper, the resolution of a path forward also raises important issues for practice settings).
Different mechanisms are at play for the different units of analysis. Quality assurance and improvement for doctors occurs through (ongoing) education and training, certification, registration and credentialing. Clinics (practices or settings) undertake quality assurance and improvement through different mechanisms, including accreditation.

It is possible for a doctor with a specific interest to practice in a general practice (e.g. to pursue an interest in mental health within a general practice). In contrast, a practice that was solely devoted to a specific clinical area is less likely to be seen as a general practice.

The payment mechanisms are also different. Doctors attract fee-for-service payments, and in some cases, other payments which are not volume related (e.g. rural retention payments). There are different payment mechanisms for practices (e.g. the Practice Incentives Program).

These factors require care to be taken in discussions about specific interests, as the issues are different for individual doctors than they are for the practice settings.

**Breadth or scope**

General practice is, by definition, comprehensive and holistic. It addresses the wide range of health issues of the ‘whole person’ in the context of their family/families and community/communities.

This characteristic of general practice differentiates it from other medical crafts, and introduces to the discussion the issue of ‘scope’ or ‘breadth’. The ‘scope’ of general practice – in training, competence, and performance over time, is central to the discussion of specific interests. The training in the broad scope/breadth of general practice is, for example, a hallmark of Australian general practice vocational training; and is assessed for the award of Fellowship of the RACGP.

**Depth or mastery**

The degree of skills and knowledge, and degree of understanding of the various elements of general practice varies across doctors involved in general practice, as is illustrated by differences in the competence and performance of medical students on placement in general practices, prevocational doctors, vocational trainees, Fellows of the RACGP, and GPs who are established in their craft.

This variation in general practice introduces to the discussion the issue of ‘depth’ or ‘mastery’.

**‘Core’, ‘context’, ‘patient’ and ‘clinician’**

As expressed in the RACGP’s definition of general practice, the discipline has a core set of clinical characteristics and practices, unique within medicine (the ‘core’). This ‘core’ includes a series of ‘perspectives’ and attitudes that are central to excellence in general practice. The RACGP also conceives of these clinical competencies as ‘core’ as they are those required of doctors who seek to become Fellows of the RACGP.

Surrounding this core are significant variations relating to the demands of particular clinical contexts. The ‘context’ is the environment (both geography and particular populations), which brings different demands on clinical practice (the core).

General practitioners continue to refer to their ‘consumers’ as patients. Patients, both as individuals and as groups or communities, also play a role in shaping both the
expression of general practice at the level of individual encounters, but also as it is expressed in particular communities and as it operates at the whole-of-health-system level.

The ‘clinician is a factor that shapes general practice, which is additional to the core, context and patient. Doctors share with other people the characteristic that they have preferences, and, as time progresses, they will be naturally drawn to areas which they find most interesting or have an imperative to master and spend less time on, or avoid, areas that they don’t like or do not have an imperative to maintain.

The journey/career of general practice

The ‘journey of general practice’ is a concept that has been used to describe the phases of involvement in the craft of general practice.

A number of models are used to describe this journey. Most centre on the ‘apprenticeship’ model – apprentice, journeyman and master.

Increasingly, however, there is a challenge to extend this model in order to ensure that it continues to describe general practice in the 21st Century.

At one ‘end’ of the ‘journey’, there is a growing focus on general practice in the pre-vocational period. In the re-development of the RACGP’s curriculum for general practice, for example, the early part of the journey is seen as:

- Beginning at University as a medical student
- Continuing through pre-vocational exposure and placements (e.g. through the Prevocational General Practice Placement Program), and
- Branching off, at vocational training, to be an identifiable path to status within the specialty as a general practitioner who can practice unsupervised.

There is also a growing interest in differentiating the other ‘end’ of the ‘journey’ – the levels of mastery gained through a career in general practice.

One model proposes that the journey of a GP involves the following stages:

- The new Fellow: 1-2 years after Fellowship
- The skill-building career stage- 2-10 years in practice
- The mature GP- 10-20 years in practice
- The late-career stage-the last 5 years of professional work.

In the European guild system, the term used for those above a master was a 'grandmaster'. A grandmaster is someone who is widely recognised by other masters to be an exceptionally skilled/knowledgeable master.

In Japan, some pre-eminent master craftsmen are considered 'living treasures'. This idea extends the traditional apprenticeship model in which a master is the most advanced category of craftsman. In Australian general practice there is a small group of doctors who might be seen in this light (eg. Prof John Murtagh). It also raises the important issue of how those GPs who are considered to excel as generalists are conceived of, in a model of specific interests/skills.

Although the terms are unfamiliar to general practitioners, the result of this ‘extension’ is that the concept of journey is transformed from:

- Apprentice, journeyman, master, to
- Pre-apprentice, apprentice, journeyman, grandmaster, living treasure.
**Essence and expression**

In general there appears to be agreement amongst Australian GPs that sound generalist training should precede training in clinical areas with a significantly narrowed scope. In contrast, where clinicians’ training is confined to a narrow clinical base without sound generalist training, it follows that subsequent practice must be restricted to that specific clinical area.

There must be a defined post vocational entrance point for all new specialty or subspecialty areas for practitioners with sound generalist training that appropriately recognises their skills and prior learning.

There is a view in some parts of general practice that some aspects of the core are relatively immutable once gained – including the perspectives and attitudes that underpin whole person, continuing and integrated care. This is a view that there is an essence in general practice that remains, regardless of the nature of actual practice. This means that GPs have the view that, following vocational training, a GP will always be a GP – that although one might lapse in the practice of the craft (or all aspects of the craft) a core clinical approach remains. These doctors would take the view that GP’s with specific interests maintain their core general practice approach, despite working in a specific clinical area.

An alternate view is that general practice is better seen as what one actual does – that one is not a general practitioner unless one treats the whole person, and cares for individuals, families and communities. This can be conceived of as an ‘expressive’ view of general practice – the doctor is a GP if their work is an expression of the diversity of general practice.

These differing perspectives often underpin the point of view of discussants, with discussants being spread on a continuum (like a continuum on the relative importance of ‘nature’ and ‘nurture’).

**Strengthening, rather than fragmenting general practice care is the path to take**

The individual patient and his/her care needs is the centre of health care, and the patient’s health is the reflection of the “sum” of the interconnections of his/her life. The comprehensive GP who can provide community based advanced primary care will be needed in order to deal with the increasingly complex care required for patients with chronic disease. This means that there is a requirement to enable extension of skills required for the greater complexities of care into a comprehensive service range.

The international evidence increasingly points to the benefits of generalist training and the inefficiencies, costs and risks of further fragmentation of care, and convincingly illustrates that effective, comprehensive, integrated primary care underpins cost effective health systems.

Traditionally, health systems have evolved around the concept of acute, infectious disease – not around preventive care and coordinated chronic disease management. However, general practice care has been shown to be extremely cost-effective, offering fewer tests, higher patient satisfaction, less medication use, and lower care-related costs. Adequately resourced general practice can reduce the pressure on our hospitals and emergency departments by delivering high quality preventive care, health promotion, and coordinated chronic disease management. The availability of general practitioners (GPs) has been shown to significantly reduce...
health disparities, particularly for areas with the highest income inequality.\textsuperscript{16, 17, 18} Strong general practice with multi-disciplinary teamwork and defined delegations between primary health care professionals will be a key strategy in tackling the workforce shortages affecting health care provision across Australia.

Accessible specialty care, appropriately targeted, is essential to effective health systems, but it is not a Population Health Strategy. Doctors who restrict their clinical scope have been shown to deal poorly with co-morbidity\textsuperscript{19}, and escalating co-morbidity will be an increasing feature of Australia's ageing population. Patients receiving care from specialists providing care outside their area of specialisation have been shown to have higher mortality rates.\textsuperscript{20}

Further research is required to ascertain whether this is due to specialist-specific training, understandings and models of care being applied to primary health epidemiology. This may result in assumptions of higher frequency for more complex morbidities, and inappropriately intensive investigation and treatment, with consequent increases in complications and costs.

**A common conceptual basis is important**

To this point, the paper has proposed a number of concepts. It has suggested that there is a need for a common conceptual basis to underpin the discussion; and suggested that this common basis will assist in clarifying the areas of similarity and difference amongst the stakeholders.

**Part 2: A model for understanding specific interests in general practice.**

**Core, context, patient and clinician – a way to explore specific interests**

General practices can be thought of as complex adaptive systems\textsuperscript{21,22}, whereby the potential scope of general practice (the core), the practice population (the ‘patients’), its environment (the context) and the clinician (the GP/their team and their preferences) interact to shape the response of patients, GPs (and their teams) and the practice.

The role of GPs with specific interests in health care needs to be clearly defined, to ensure that these GPs are not regarded or treated as ‘second tier’ service providers. Creating and consolidating the roles of a GP with specific interests will require a clarification of the core skills, competencies, responsibilities, service provision agreements and monitoring arrangements of that role.

Defining the conceptual framework for a specific skills framework for general practice means retaining and strengthening the conceptual framework for general practice care.

**The clinician – the early stages**

The expression of personal/clinician preferences occurs in pre-vocational placements, for example, when interns seek placements in certain sorts of general practice (eg Aboriginal health services). It also occurs in vocational training, for example, when registrars seek advanced skills posts or undertake preparation for the Fellowship in Advanced Rural General Practice.
General practice training, however, is intended to equip FRACGPs with both the core clinical skills and the ability to assess and address learning needs that arise from differing contexts through the journey of general practice (over a professional lifetime).

This is expressed in the diagram below, showing the scope/breadth of general practice, and the growing depth/mastery of the core. At FRACGP (after the early three stages of the journey of general practice), the RACGP considers that a GP has sufficient mastery over the appropriate breadth of health issues to be able to practice unsupervised in the Australian context.

This outcome contrasts with the position of consultant specialists, who train in their specialty immediately after university and internship. The difference is illustrated in the next diagram, where the pale blue area show the concept that such consultant specialists have a depth of knowledge in a very limited area/scope. In addition, they do not have a generalist base.
Thus, although a clinician might have personal preferences to pursue specific interests, and might have been exposed to, or work in, contexts which demand particular skills, at completion of general practice training, the aim is to ensure mastery of the breadth/scope of general practice at a level that allows safe and unsupervised general practice.

The clinician – the later stages

Most GPs will naturally learn more about the things they need the most and grow a little rusty with the things they do not use. This can be seen as a useful adaptation to the context/environment. It is illustrated in the diagram below.

In some cases there is an ebb and flow of interest and expertise, depending on the developmental stage in the GP’s career. As a result, one might see a degree of specialisation within general practice as inevitable and desirable. This reflects the context in which the GP works, and reflects their personal preferences (which can be shaped by personal factors and experiences). These changes can be important to the overall quality of patient care; and can be personally and professionally fulfilling, leading to higher rates of retention in general practice. If this ebb and flow is inevitable and desirable, the dynamic needs to be seen as a part of the journey of general practice.

It is often in the skill-building stage when the skills learned in training are mastered and new skills are acquired based on the needs of the community being served. These can include for example, the mastery of new clinical skills and procedures. At the mid-career stage, many GPs are preparing for positions of leadership and examples of specific interest skills that may be acquired include leadership skills, mentoring skills and teaching skills. In the case of the mature GP, examples of specific skills areas include governance skills for service on boards and committees, leadership skills, teaching skills as well as maintaining clinical excellence.

It is not uncommon for a general practitioner to acquire several specific interest skills within a lifetime career journey, with these skills being context-dependent and varying in terms of level of complexity and depth of acquisition of skills within that interest area.
As time progresses, these people will become more expert in some areas of medicine. In addition, they will slowly lose their expertise in other areas of medicine. Most will recognise this and modify their practice accordingly – creating safeguards to patient care in the areas where they are less expert. Such safeguards include cross-referral with other GPs, and shared care with consultant specialists. Many GPs will maintain their core general practice skills and knowledge through broad-based continuing professional development.

At some point, through continuing their mastery, some GPs may recognise (and/or their peers and patients may recognise) that these GPs have become relatively expert in the area. This is illustrated in the diagram below.

Some may abandon their generalist skills and concentrate solely on their interest area. Some will move from general practice to the other consultant specialty.

Some of those who do move from General Practice do so as there are no structures within the General Practice framework to cater for them. Those that remain in General Practice often find that they have to “fend for themselves” when it comes to trying to maintain their knowledge and skills in a particular specific interest area.

This gives rise to the issue of the RACGP, as an institution or network of GPs, supporting GPs with specific interests.

The ‘advanced general practitioner’
The discussion about specialised and/or advanced skills is usually associated with the development of specialised or advanced skills in a particular, or a small number of particular areas (e.g. counselling, women’s health, obstetrics). Underpinning this approach appears to be the view that there is a limit to the breadth and depth that any one GP can cover – that increasing depth/mastery inevitably means a narrowing of the breadth of practice.

Champions of general practice believe that it is important that the advanced skills of a practitioner who continues the broad scope of general practice are also recognised and valued.

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The RACGP’s position is that these skills need to be recognised and rewarded; and this paper proposes a new/different conceptual approach to the ‘advanced generalist’, based on the concept of ‘core competencies’.

The usual way of conceiving of advanced competencies is as ‘technical’ competencies – an excellence in a particular technical area.

Arguably, an ‘advanced general practitioner’ is advanced in the skill of managing undifferentiated illness, and/or integration of information (e.g. managing patients with multiple and complex morbidities), and/or coordinating care in a complex environment – skills which cross the domains of general practice, rather than reside within one of them. They are also advanced in synthesising the elements of an ethical dilemma and articulating options and issues.

This set of abilities might be better understood as using a different sort of competency – an ‘adaptive’ competency. The (enhanced) skill resides in the ability to (better) analyse and synthesise diverse elements in an environment, rather than in mastery of a particular domain (more like project management than being a master plumber).

The idea of an advanced general practitioner is illustrated in the diagram below.

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**General Practice Specific Skills Framework**

One approach that would bring together the issues raised by skills development through the journey of general practice is a general practice specific skills framework.

The emerging three-level GP Special Skills Framework works well for areas of specific interest, both within general practice or between/shared by general practice and other medical disciplines. The Special Skills Framework recognises three levels:

- **Level One**: the knowledge, skills and behaviours required by all general practitioners for safe and competent practice;
- **Level Two**: the knowledge and skills required by general practitioners who have a specific interest in a particular clinical area and wish to enhance their patient management and potentially develop their practice to incorporate a
higher proportion of patients in this area (or somewhat more advanced skills in the ‘adaptive competency’, if that model is supported), and

- **Level Three**: the advanced knowledge, skills, behaviours - and usually additional qualifications required to make the specific interest a major focus, or the only focus, of the GP’s practice. At this level, general practitioners may be accepting referrals from other GPs, and/or working part or full time in secondary sector settings. The expression of the ‘adaptive competency’ for an ‘advanced generalist’ is most difficult to describe for this level.

Demand by patients and by third party insurers, together with the impetus of some GPs for recognition create the need to consider credentialing doctors who achieve Level Two.

Complexities of definition and demarcation can emerge in Level Three, where the specific interest area may be:

- entirely within the general practice curriculum - albeit at a very advanced level (for example Aboriginal and Torres Strait Islander Health, chronic and complex care, refugee health, women’s health and many more);
- extending usual general practice skills significantly, but still regarded as entirely general practice based (for example a procedural skill areas where defining the necessary curriculum requires input by the relevant specialist college in addition to the RACGP). This applies in general practice anaesthetics, surgery, paediatrics and a number of other areas. The RACGP Graduate Diploma of Rural General Practice fits this model;
- extending general practice skills into the curriculum domains of other specialty disciplines, resulting in advanced specific skills areas where practitioners may originate from differing discipline bases (for example Advanced Counselling, Geriatrics, Pain Medicine, Palliative Care, and a number of general practice-public health combinations).

On the basis of the approach described above, a number of sub-specialities might be shared by, and accessible to, more than one discipline – for example, pain medicine and geriatric medicine ought logically be shared by both the Royal Australasian College of Physicians (RACP) and the RACGP and continue to be accessible to graduates of both college training programs. Many GPs who develop a major commitment to Aboriginal and Torres Strait Islander health will undertake public health training, and a joint course and qualification is now in development, with training able to be commenced at any point, including during vocational training for either discipline. Flexibility within and between disciplines will be more, not less important in our future health system.

This approach, for Australian general practice, is based on a view that, as a rule, soundness of training and quality of care are best served if specific interests are pursued only after broader generalist training to the point of vocational registration – (though more specialised training may commence during generalist vocational training).

Requiring generalist training as a prerequisite to subsequent practice in a narrow clinical field does not necessarily significantly lengthen training. General practice training currently facilitates specific interest training in parallel to, or integrated with usual training, and advances in competency-based assessment offer the promise of more streamlined training in all areas.

Some Level Three specific skill areas have been, or may ultimately be judged to be separate specialities or more commonly, sub specialties on the basis of the
Australian Medical Council’s (AMC’s) four basic criteria. A secondary question then is, should that specialty or subspecialty have its own vocational training program or should it continue to be accessible only after more generalist training?

**What do we know about GPs with ‘special interests’?**

The Australian context has a number of differences to that in the United Kingdom. It is also important to recognize that GPs with ‘special interests’ are used in a quite specific way in the United Kingdom. Despite that, it is useful to consider the information available.

Independent studies have evaluated the impact of GP with ‘special interest' services in England, and show:

- 30-40% patients referred to secondary care could have been seen by a GP with special interests, with the right training, equipment and support.
- GP with special interests discharged about 70 – 80 per cent of patients back to the care of their GPs
- the rates for patients not attending their appointments at the clinics of GP with special interests were very low
- Clinics using GP with special interests in the sites cost around half of the cost of usual secondary care

The RCGP/RCP have developed a document that identifies the five key features of a scheme for GPs with clinical special interests. It outlines the principles that should underpin the scheme:

- Flexibility to adapt to local circumstances and needs;
- National minimum standards for training and accreditation;
- Quality assurance to patients and other health professionals;
- The development of the competencies of these general practitioners; and
- Support for those with clinical special interest in exercising their skills within local service provision.

The concept of general practitioners with specific clinical interests is not a new concept and specific clinical interests are only a limited part of the range of ‘outside’ interests that general practitioners may have. These interests include research and academic general practice, postgraduate and undergraduate teaching and training, leadership in service development and other activities related to health services management and quality assurance. There is some evidence that providing a mixture of clinical, academic and service development work helps to deal with problems of recruitment and retention of medical practitioners and can help prevent professional burnout.

In general, GPs who pursue a specific interest fall into three groups:

- Those who give opinions (working in outpatient departments for example);
- Those who perform procedures; and
- Those who lead or develop a service, drawing on education or management rather than clinical skills.

In the UK the policy reasons for encouraging the development of GPwSIs have included:

- Reducing waiting times for treatment;
- Meeting needs in primary care rather than secondary care;
- Enhancing the quality of primary care services;
- Enabling secondary care to concentrate its efforts and resources where its skills are most needed; and

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Improving career opportunities for GPs.

GPs with specific interests can help to address problems at the interface between secondary and primary care but this must not occur at the expense of general practice being seen as a ‘second tier’ service. The clinical services provided by GPs with specific interests can include triage, diagnostic tests, procedural services and chronic disease management within a wide range of specialties but works best within a multidisciplinary team based approach.

The nature of the relationship between GPs with specific interests and other general practitioners needs to be set out, particularly in situations where the GPs with a specific interest may act as a referral service for other GPs, and GPs might undertake whole-of-person care that complements the specific care provided with GPwSIs to the patients of GPwSIs. Issues related to negotiation of responsibility for the primary care of the patient need to be addressed, i.e. who will act as the patient’s primary GP? The quality of feedback between GPs is also crucial as is the level of support that will be provided by specialists for GPs with specific interests, including the education and training in the delivery of specialized services.

The UK Department of Health and RCGP have jointly produced a guidance document for the GPwSI role and suggested three components to the role:

- Deliver a clinical service beyond the normal scope of general practice;
- Undertake advanced procedures; and
- Develop services.

New Practice Models – complement and/or alternative?

The pattern whereby larger group practices incorporate nursing and allied health staff and provide a range of additional services collocated with and collaborating with a cluster of GPs, including those with specific skills, is increasingly common. It enables the practice to continue providing essential comprehensive, continuing and coordinated care to their local communities while also expanding their service range without fragmentation of care.

In NSW, the Integrated Primary Health and Community Care Services (IPHaCCS) initiative will trial new entities combining a wide range of integrated general practice and community health services oriented to the needs of their local communities – and involving those communities in health service decision-making. This model see much secondary level care being provided in such IPHaCC services by specialists who travel between such services (outreach) – rather than within tertiary or other service specific settings.

Flexible models along these lines not only offer significant service gains to the local community, they potentially provide personal, professional and financial benefits to all involved primary care professionals. The NSW Government’s Integrated Primary Health and Community Care Initiative and other Commonwealth and state initiatives reflect a growing appreciation of the essential role for integrated care strategies and models in our future health environment.

Arguably, models which create a framework for integration complement the continuation of coordinated care; and could assist to bring together doctors with specific interests and reduce fragmentation.
Fragmentation as the alternative

A strong case has been made against the fragmentation of general practice in Australia. Wilkinson et al. have argued that compared to other specialties, general practice is not particularly financially rewarding, but certain aspects - such as skin cancer care, can be segmented off to increase its business potential.

The marketing of such services may be quite aggressive and patients may access these doctors – many of whom lack adequate generalist training, as primary care practitioners without the need for a referral, and thus tend to do so without first consulting their regular GP.

The resulting disadvantages to patients noted by Wilkinson and colleagues include:

• lack of communication between practitioners
• a reduced pool of expert GPs (as distinct from specialising GPs) in the community
• reducing quality of comprehensive primary health care standards
• reduction in number of GPs prepared to engage in more poorly remunerated primary medical care, such as in areas of low socio-economic or other demographic disadvantage.

Summary

Broadly, three stages of specialisation within general practice are proposed. Although there are a number of different models in the literature, the RACGP proposes that there is a level of mastery reached at FRACGP, and achieved through training in the specialty of general practice. Following this, some general practitioners will advance their generalist skills while others will pursue further mastery in a specific (clinical) area. In this model, both of these groups continue to provide comprehensive, whole person, continuing and coordinated care. This model suggests that some GPs will continue their pursuit of a specific interest to the exclusion of other aspects of general practice; and that their continuing engagement in general practice may include taking referrals from other GPs.

Part 3: A structure within the RACGP to support specific interests

Specific interest areas may be very narrow and specialised or very broad. There may be only a few GPs interested in them or many people may be interested. Examples include:

- Acupuncture
- Anaesthetics
- Breast Medicine
- Dermatology
- Counselling
- Mental Health
- Obstetrics
- Drug and Alcohol Medicine
- Emergency Medicine
- Integrative Medicine
- Phebology
- Medical Deputising
- Military Medicine
- Forensic Medicine
- Skin Cancer Medicine
- Sexual Health Medicine
- Sports Medicine
- Surgery
- Women’s Health
- Aboriginal and Torres Strait Islander Health
- Health

Thus, a structure for the RACGP needs to be flexible enough to cater for most interest groups.

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The terminology is important

The RACGP has existing structures for GPs who form identifiable groups within it, including:

- **Faculties** – the RACGP has geographically defined faculties (eg the Queensland, or NSW/ACT Faculty); and the National Rural Faculty (NRF) (although the common thread in the NRF extends beyond geography to other issues in common)
- **Chapters** – the RACGP has a Chapter in Military Medicine which comprises people of similar interest
- **Clinical Networks** – the RACGP has a range of mostly clinical networks of GPs with similar interests, though the networks vary in formality and often have some connection to one of the RACGP’s National Standing Committees (eg networks of GPs who have worked on the curriculum review, or networks of GPs who work on publications like the Silver Book).

The language is important, as it supports the perception that the specific interest and any qualification has within the RACGP (and within the community). Thus, it is probably important to consider the use of the term ‘Faculty’ for some specific interest structures. This might mean Faculties within a Faculty of Specific Interests.

As a result, it is important for the RACGP to decide which language it wishes to use, and whether it wishes to change the current characterisation it uses for these structures.

**Faculties – a refined model**

The model proposed involves two forms of Faculty – an overarching Faculty of Specific Interests in General Practice, and a Faculty for each specific interest (e.g. a Faculty in Breast Health, and a Faculty in Sports Medicine).

Many, though not all GPs who pursue a specific interest, also have an interest in a post-vocational qualification that recognises their expertise.

This already occurs within the RACGP for rural GPs, some of whom pursue recognition of their expertise through a post-vocational qualification conferred by the RACGP’s NRF (the Fellowship of Advanced Rural General Practice [FARGP]).

Status as a Faculty could be conferred by Council following the creation of a post-vocational educational curriculum, assessment and continuing professional development program in a specific interest area which has been endorsed by the RACGP’s Council.

The demands in developing, consulting over, writing and testing a formal curriculum leading to a post-vocational qualification are likely require a threshold number of people, leading to a threshold size of a Faculty. This capability, expressed in the post-vocational qualification would provide an alternative criterion for the establishment of a Faculty, rather than a geographic parameter (as is already used by the RACGP – State/Territory or rurality) or a numerical threshold.

Both Diploma and Fellowship endpoints could be offered both nationally and internationally. This could provide members with recognition but also provide a revenue stream to the RACGP.

The endpoints could be delivered through other providers (universities, institutes, regional training providers) accredited by the RACGP (in conjunction with a specific
interest ‘college’ where one existed) using the model developed to accredit regional training providers. A fee could attach to this accreditation.

A Faculty would also need to advise Council on suitable alternate qualifications that could be recognised for Fellowship of the Faculty – a process which already occurs within the RACGP leading to Fellowship of the RACGP ad eundum gradum.

It is proposed that there be one position on the Council of the RACGP for the Chair of the overarching Faculty. All members of Faculties for specific interests could vote for the Council member, and Chairs of the particular specific interest Faculties could form the Board of the overarching Special Interest Faculty.

As an ongoing role, these Faculties could be responsible for contributing to the educational curriculum (at medical student, intern, vocational training and post-vocational levels), and also host ongoing meetings with other relevant specialist medical colleges, thus allowing the RACGP to reconsider the role of Joint Consultative Committees. They could provide formal feedback on other issues of safety and quality, such as the standards for practice settings. Both could occur through the RACGP’s National Standing Committees as they do now. Faculties could also, within the RACGP’s media policy, be the source of authoritative comment about issues in general practice. Faculties might publish their own newsletter.

There would be an incentive to create a post-vocational award and curriculum in order to gain Faculty status. With Faculty status could come some (additional) resources that underpin the staffing needed to maintain the educational qualification, continuing professional development and other standards.

GPs could self-elect to be members of a specific interest Faculty at no cost additional to membership of the RACGP (as the RACGP currently does for both State/Territory Faculties and the NRF). GPs would become Fellows of the Faculty (specifically, rather than of the RACGP) on attainment of the post-vocational qualification. To maintain this certification ongoing professional development with the RACGP, at the standard agreed by the Faculty (and Council) would be needed. The RACGP could list the post-vocational (Council endorsed) skill certifications on the RACGP’s “Find a GP” web page. This would assist to clarify the difference between an interest in an area, and expertise in a specific area.

Historically, a number of other ‘colleges’ and societies have developed in the primary care area. Most see themselves as remaining autonomous. However, joint membership of the ‘college’ and the relevant RACGP Faculty could allow these GPs to be supported under the umbrella of the RACGP. The way in which the RACGP coordinated with these organisations would need to be refined.

An advantage of this model is that identifiable groups within the profession who have members within the RACGP could rapidly determine if their RACGP members had an interest informing a Chapter (see below), and then move to create a Faculty.

A potential disadvantage of this model is that it could result in a large and growing list of Faculties with their own certification endpoint. Each Faculty would need a Board. Specific Interest Faculty Chairs might need to form an electoral college to elect a single member for the RACGP Council, thus providing formal input into the governance of the Council.

For discussion, September 2007
Joint Faculties
A number of specific interests are shared by more than one discipline/craft and specialist medical college (e.g. care of older people). Many general practitioners who develop a major commitment to Aboriginal and Torres Strait Islander health will undertake public health training, and a joint course and qualification is now in development, with training able to be commenced at any point, including during vocational training for either discipline. Flexibility within and between disciplines will be more, not less important in our future health system.

Although the RACGP does not have any joint Faculties, such Faculties exist between other specialist medical colleges in Australia, and GPs have expressed the desire for the RACGP to explore such models.

Chapters – a refined model
While many GPs seek formal qualifications, some with a specific interest do not seek this, and for some groups, this may not be relevant.

The members of the RACGP’s Chapter of Military Medicine appear, for example, to be interested in sharing experiences and informing preparedness, without seeking a formal qualification.

The discussions about specific interests have included whether the RACGP could have a specific interest group for GPs who have the same ethnic background (e.g. Indian GPs) who wish to share ideas; or who have the same linguistic base (e.g. Chinese-speaking GPs, who may not all be Chinese), and who wish to share ideas and experiences.

These groups could be supported through a Chapter, without a necessary expectation that a Faculty would result.

The RACGP could provide assistance to establish consultation boards for these chapters and provide very limited secretarial support. It may be possible to offer web-based online forums and perhaps teleconferences. These groups could be encouraged to hold annual meetings at the RACGP’s Annual Scientific Convention, where the RACGP would fund space to meet, but members would fund their way, as occurs for the Chapter of Military Medicine.

Were there sufficient momentum in a specific clinical area to start development of a post-vocational qualification, GPs with a common interest could form a Chapter, and be supported through the process of developing a post-vocational qualification (e.g. the work being undertaken by the breast physicians with the RACGP), and become a Faculty on completion of the task.

As an ongoing role, these Chapters could support their members by providing an avenue for discussion and information sharing. Their role in contributing to the educational curriculum (at medical student, intern, vocational training and post-vocational levels) would be less formal, probably through the use of an ad hoc working group. They could provide feedback on other issues of safety and quality, such as the standards for practice settings through the RACGP’s National Standing Committees. Consideration would need to be given to the role of credentialing doctors at Level 2 of the framework outlined earlier. Members of Chapters may be on the list of doctors who have the delegation of the President to provide authoritative comment about issues within general practice within media policy.
The advantage of this approach is its relative informality, allowing members of the RACGP to cluster together with little ‘red tape’.

The issue might be a threshold size of the initial chapter.

**Clinical Networks and Joint Working Parties – a refined model**

The RACGP has had informal and formal networks of clinical interests. It would be proposed that these continue.

These networks can play an important role in promoting discussion about clinical areas and identifying the need for greater structure within the RACGP.

If a specific interest were identified, a Joint Working Group comprising members of the RACGP and members of the specific interest area outside the RACGP could be formed. Such a group would have the task of further scoping that particular interest area. They would look at:

- Numbers that are interested
- What groups currently exist to represent these people (and their charters)
- Training and post graduate diplomas/degrees on offer
- Scope the possibility of forming a Reference Group

Where the interest was within general practice, and there were no outside organisations, the working group could be within the RACGP.

Where the analysis showed that it would be appropriate, a chapter could be formed.

**Summary**

This model suggests a three-level approach to the structures within the RACGP, built on existing models within the RACGP.

Faculties would be the most advanced structure, and would have responsibilities including the maintenance of post-vocational awards. Chapters, Clinical Networks and Joint Working Parties could support GPs with specific interests where there was no post-vocational qualification.
## Summary table of proposals

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<th>Structure</th>
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</table>
| **Faculty**       | Voluntary and free       | Endorsed by RACGP Council           | Following competency assessment against curriculum | Through Specific Interest Faculty Chair | • maintaining the standards for the post-vocational qualification, including assessment (in collaboration with the RACGP’s Board of Censors)  
• contributing to the educational curriculum (at medical student, intern, vocational training and post-vocational levels)  
• hosting ongoing meetings with other relevant specialist medical colleges  
• providing formal feedback on other issues of safety and quality  
• providing authoritative comment about issues in general practice within media policy |
| **Joint Faculty** | Voluntary and free       | Endorsed by RACGP Council and Council of another specialist medical college | Following competency assessment against curriculum | Through Specific Interest Faculty Chair | • maintaining the standards for the post-vocational qualification, including assessment (in collaboration with the RACGP’s Board of Censors and the other specialist medical college)  
• contributing to the educational curriculum (at medical student, intern, vocational training and post-vocational levels)  
• providing formal feedback on other issues of safety and quality  
• providing authoritative comment about issues in general practice within media policy |
| **Chapter**       | Voluntary and free       | Possibly in development (though not essential) | No Fellowship for the Chapter | None                             | • supporting members by providing an avenue for discussion and information sharing  
• contributing (informally) to the educational curriculum (at medical student, intern, vocational training and post-vocational levels)  
• providing feedback on other issues of safety and quality  
• providing authoritative comment about issues within general practice within media policy |
| **Clinical network** | Voluntary and free | None                               | No Fellowship for the network | None                             | • promoting discussion about clinical areas  
• identifying the need for greater structure within the RACGP |
Part 4 – Outstanding policy issues

The establishment of a new Faculty of Specific Interests is likely to bring into focus a small number of policy issues in which the RACGP either has limited policy, or in which the RACGP has no documented policy. Following, are some policy issues that may need to be addressed.

Credentialing and clinical privileging

Arguably, doctors who train in narrow areas of clinical practice without sound generalist training and qualifications should have their scope of clinical practice restricted.

The more complex issue is likely to be clinical privileging and (re)credentialing of GPs who have pursued a specific clinical interest.

Assessment for Level 1 has traditionally been by examination for FRACGP. Practice Based Assessment (PBA) has been introduced, and recently, the RACGP has begun a trial of a Modular Assessment Pathway (MAP). Each, though different, is to be a valid and reliable test of achievement.

Assessment for Level 2 involves some particular challenges. The differentiation is less formal. Despite this, the differentiation might attract recognition by patients (eg. I know a doctor who is interested in mental health) or by third parties (eg. GPs with specific skills in occupational health might be treated differentially by workers compensation schemes). As a result, across the domain, it may be important to agree on a streamlined and consistent model for ‘credentialing’ at this level (especially if the RACGP is to support cross reference and any differential treatment). At this level, recognition of prior learning and experience in the area appear to be the differentiating characteristics.

Assessment for Level 3 is likely to be by achievement of an additional qualification in a specific interest area. As with Level 1, the validity and reliability of the assessment is integral to the development of the assessment, prior to RACGP Council endorsement. Amongst the remaining challenges for the RACGP would be to define the benchmark of achievement for an ‘advanced generalist’. This is likely to need to cover all five domains of general practice.

The issues surrounding privileging and (re)credentialing are dynamic; and this is likely to be an area in which the RACGP will need to do further policy work.

Recognition and reward

One of the major challenges continuing to face the RACGP is the issue of vocational recognition. Attaining the Fellowship of the RACGP is the ‘gold standard’ for new entrants into Australian general practice.

However, there is a significant ‘legacy’ problem created by the change to vocational recognition in the 1990s (now complicated by changes in 2007). The challenge revolves around the status of doctors who are not eligible for vocational recognition under the Australian Government legislation/regulation; and those who have lost (or who would lose) vocational recognition under this system.

The issue of vocational recognition has already challenged the RACGP. The complex nature of the test of spending 50% of clinical time in ‘general practice’ has proven to
be problematic to many stakeholders. Arguably, a change in the RACGP’s position about a Faculty raises the question of whether pursuit of a specific interest continues to be ‘general practice’, and thus whether doctors working in these areas would be eligible (at least from the view of the RACGP) to be eligible for (restoration of) vocational recognition. The implications of a change in position on doctors who had been denied vocational recognition may need to be explored.

Despite this, there is a desire to maintain recognition of ‘general practice’ as a distinct discipline.

Some members of the RACGP have expressed the view that there is justification for increased recognition and reward for doctors who provide high quality generalist services – particularly where service range is extended and/or services are provided in areas of need. These GPs are concerned that there would be an automatic increase in the reward for doctors who chose to restrict their scope of clinical competency, especially where the scope is aligned to the work of other consultant specialise (including procedural specialties). Balanced against this is an ‘equal work for equal pay’ view in which GPs should be funded for the service provided to patients (and especially the quality of the service). The concern by some GPs about this perspective is that it is ‘reductionist’, and views medical practice too narrowly, thus excluding aspects of the intrinsic value of general practice (eg. management of undifferentiated illness, coordination, integration and continuity).

In addition to fee-for-service payments, there are a number of non-fee-for-service payments, including the Practice Incentives Program, and Rural Retention Payments. Traditionally, the RACGP has taken the view that such payments are rewards for general practice, and should not be extended to practices or practitioners who restrict the scope of their service to specific interest areas. The practice-based payments also raise the issue of practices which have doctors with different specific interests working together to provide a comprehensive suite of services.

As a result, it is likely that the RACGP will need to re-visit its policy on recognition and reward.

**Standards for the settings**

The RACGP has been working with a number of groups on the standards for primary care settings which are not general practices. These include health services in Australian immigration detention centres, ‘after hours services’ and skin cancer clinics.

The consultation surrounding the development of the RACGP’s Standards for general practices (3rd edn) indicated a consistent view that GPs wanted one set of standards for the broad range of settings in which general practice care is provided. The detention centre work has shown that there are small alterations needed to the scope of the standards, and that the overall quality benchmark for the various facets of the standards can be met. In the skin cancer area, probably reflecting the medico-legal risk attendant on procedural services, there have been suggestions of adopting slightly more rigorous standards than expressed in the RACGP’s Standards for general practices (3rd edn).

Despite this, the RACGP is confident that, overall, its Standards for general practices could be used in most specific interest settings with minimal amendment.
A more complex issue arises in the characterisation of the practices which meet the RACGP’s Standards for general practices (in whichever form). There have been suggestions that specific interest practices be able to characterise themselves as a ‘(specific interest) practice’ (eg a women’s health, or mental health, practice). There have also been suggestions that such characterisations be restricted to such practices. This raises issues of perception (and of marketing), which might suggest superior quality care in a specific interest practice; or which might suggest that a specific interest practice was a general practice (if it was accredited against the RACGP’s Standards for general practices).

The RACGP has demonstrated its interest in continuing the development of its standards for settings in collaboration with key stakeholders, such that the wishes of the profession and public for a similar level of standards are met.

The RACGP may need to address the policy issues which surround the variation in the specifics (eg the desire for enhanced clinical auditing in surgical practice); and the issues that surround characterisation of the practice and its accreditation.

**The role of National Standing Committees**

Recently, National Standing Committees such as the National Standing Committee – Quality Care, the National Standing Committee – Education, and the National Expert Committee on Standards for General Practices have acted to formally advise the RACGP Council on a range of standards-related issues.

The advent of new Faculties will raise the issue of the role of adviser. The RACGP will need to determine the ways in which formal policy advice, or policy positions as articulated in media statements will be coordinated.

**Broader health policy issues**

Institutional “endorsement” of fragmentation might easily occur - even if unintended, via formal recognition of inappropriate specific interest or sub specialty areas as new medical specialties.

This has the potential to lead to further demoralisation within general practice, and to validate the craft’s drift towards fragmentation, and away from the more poorly remunerated, but ethically more necessary provision of comprehensive primary medical care.

Development of a framework for GPs with specific interests requires a strong emphasis on primary care in health policy. It needs to build on the work already accomplished in the UK for example which includes:

- Guidelines for the provision of secondary care within general practice
- Removal of demarcations between groups of professional staff and role redesign within primary care
- Guidelines for GP with specific interests services, including service design, skills and competencies

**The change process**

The development of a Faculty of Specific Interest Groups will involve a process of ‘transitional change’ as a new organisational structure is implemented over a controlled period of time. The ‘unfreeze-change-refreeze’ model of Lewin provides a template for understanding the change process-see Figure 1. Recognising the importance of ‘structure’, ‘process’ and ‘people’ in the change process is critical. In
the case of GPs with specific interests, the importance of ‘people’ as a source of inertia and as a leverage for change means that GPs with specific interests may be resented as a threat to traditional specialist roles (from both within primary and secondary care) or welcomed as an additional resource, perceived as undermining the specialism of general practice or embraced as an opportunity for professional development. All of these issues need to be considered within the development of a specific skills framework.

**Conclusion**

This paper suggests that it may be helpful for participants in the discussion about specific interests in general practice to share a common language and conceptual basis – thus facilitating discussion about the aspects of agreement and difference.

It suggests that it may be useful to share an understanding of the journey of general practice and of the conceptions of a career in general practice which might incorporate pursuit of specific clinical interests.

The paper suggests that it may be useful to structure a number of Joint Working Parties, Chapters and Faculties within which the support for specific interests can be undertaken; and through which the contribution of specific interests to education and training, and other forms of standards-setting can be coordinated.

Any proposed structural model and the further incorporation of specific interests into the life of the RACGP will create a further focus on a small number of policy issues. Ideally, these will be addressed as the momentum for inclusion continues.

This paper was authored by Ian Watts.

It builds on work which has been undertaken by Dr Kaye Atkinson, Dr Stephen Leow, Dr Chris Mitchell, Dr Di O’Halloran, Dr Morton Rawlin, A/Prof Achim Sturmberg and Mr Roald Versteeg.

The diagrams within the paper were provided by A/Prof Achim Sturmberg.

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1 This does not preclude doctors training in a special skills area or towards a special skills qualification during vocational training. This is already a common and successful strategy undertaken by many GP registrars during general practice vocational training.


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Barbara Starfield, MD, MPH Berlin, Germany January 27, 2005


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