General practitioners with special clinical interests

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Clin Med JRCPL 2001;**1**:346–7

The NHS Plan for England has proposed the creation of one thousand 'specialist general practitioners (GPs)', and has set ambitious targets for the numbers of patients to be seen in ambulatory care settings outside acute hospital trusts[1]. Subsequently the Royal Colleges of General Practitioners and Physicians produced a document entitled *General practitioners with special interests*, quietly dropping the inappropriate term 'specialist GPs'[2]. The document pointed out that special clinical interests are only one of a range of other 'outside' interests that general practitioners might have, including 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. The paper usefully explores the opportunities and threats presented by the existence of GPs with special clinical interests – there are plenty of them already – and proposes a framework for development, which may have significant policy implications. How valuable is the contribution made by GPs with special clinical interests? How feasible and appropriate is it to propose a programme of development; and to what extent is it right to think of them substituting for consultants to free up their time to do more complicated work, as suggested in the NHS Plan? Or might these GPs take an emerging role in patient care that cannot easily be compared to existing structures?

General practitioners have always had outside interests despite, and also perhaps because of, the fact that their NHS contract has, until recently, only recognised face-to-face clinical contact and patient numbers as the basis for remuneration. Now a mixed portfolio of professional activities is becoming the norm and 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 general practitioners and contributes to the prevention of professional burnout[3,4]. Diversification should be welcomed, and currently around 4,500 general practitioners in England provide clinical sessions outside their practice surgery commitments (Department of Health, personal communication). These sessions may be held in GPs' practices or health centres, acute hospital trust outpatients, community trust premises or in outpatient clinics associated with general practitioner and community hospitals. At present GPs with special clinical interests are mostly involved in providing outpatient opinions on patients referred to them by other general practitioners in clinical areas such as dermatology, family planning and surgery and in undertaking procedures such as gastrointestinal endoscopy and minor surgery. They work under a variety of contractual arrangements, from informal within-practice arrangements to clinical assistant and hospital practitioner contracts with acute and community trusts. Importantly, only the second of these carries with it a degree of security and the entitlement to study leave for continuing professional development.

The RCGP/RCP document identifies five key features of a scheme for GPs with clinical specialist interests, namely 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 interests in exercising their skills within the local service provision. The last of these is perhaps the most important: rather than simply doing a job that somebody else could do equally well, GPs with clinical special interests could play a crucially important role in the development of joint working between primary and secondary care in the context of primary care trusts and the implementation of the National Service Frameworks (NSFs).

The last five years have seen the burgeoning of a number of GP specialist societies, including those related to gastroenterology, cardiology, dermatology, diabetes, asthma and rheumatology. These interests do not map directly onto the supercharged priorities of the NHS, but provide an important starting point and a pool of expertise for a formal scheme to involve skilled general practitioners in integrated patient care in the future. Professional sensitivities are bound to emerge – generalist and specialist may feel equally threatened – and comparable systems of accreditation for those working in primary and secondary care settings will require imaginative joint working[5]. Re-validation will pose further challenges, but the pay-off in terms of the effective use of NHS resources and improved standards of patient care achieved by supporting enthusiastic, skilled GPs is likely to be well worth the effort.

References

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