

General practitioners with a special interest in dermatology – the dermatologist’s perspective

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ABSTRACT – The NHS plan promises the creation of general practitioners with a specialist interest (GPSIs) who will be able to provide an alternative referral resource for primary care. At present, only the specialties of orthopaedics, ophthalmology, ENT and dermatology, which have the longest waiting times for outpatient appointments, have been earmarked for GPSIs. The British Association of Dermatologists has examined, investigated and piloted several such schemes for dermatology provision. This paper summarises its principal conclusions.

KEY WORDS: clinical governance, dermatology, GPSI, skin surgery

The NHS Plan, published in July 2000, stated that by 2004 there would be 1,000 general practitioners with a specialist interest (GPSIs) who would be able to take referrals from fellow GPs and undertake diagnostic procedures in dermatology, ENT, ophthalmology and orthopaedics. These specialties were targeted because they have the longest waiting times for outpatient appointments. To a politician, driven by targets and working within a 4–5 year parliamentary time frame, the GPSI concept has obvious attractions. Others point to the current shortage of GPs in the UK and wonder who will continue to do the routine work. This paper focuses on how this proposal will affect dermatology, but the issues raised potentially concern all specialists.

Key Points

The British Association of Dermatologists supports the development of adequately trained and supervised general practitioners with a special interest (GPSIs) in dermatology services

Training of GPSIs should be competency based and done by the local supervising dermatologist

The GP should continue to work alongside the supervising dermatologist for an agreed proportion of their time

Secretarial, clerical and nursing support should be provided

Fully equipped minor operating facilities should be available for GPSIs doing surgical procedures

Dermatologists recognise that there is an enormous demand for dermatology services which cannot be met within the current NHS structure. They support the creation of the new GPSI scheme provided it is adequately resourced and high-quality clinical and patient safety standards are established for GPSI training, ongoing supervision and accountability. Several dermatologists are already involved in the establishment of pilot schemes, some funded by the Department of Health’s own Action On Programme, many of which have yielded promising results.

This paper summarises the British Association of Dermatologists’ (BAD) view on how GPSI services should be organised and training and supervision implemented.

Core activities

Since the inception of the NHS a significant minority of GPs have taken an active interest in dermatology, working as clinical assistants or hospital practitioners within their local department of dermatology; without them the service could not function. The proposed GPSI scheme is viewed as an extension of existing services, with the GPSI working as part of a team within an integrated dermatology service. Clinical governance issues, ie training, continuing medical education (CME), professional development and accountability, must be sorted out before the schemes are implemented. Because the local consultant dermatologist will be responsible for training, accreditation and providing CME for GPSIs in dermatology, the time and effort required must be recognised in the business case and consultant job plan.

The BAD strongly believes that future success will depend upon discussion and agreement by all interested parties, including patients, long before a local scheme is devised and an appointment is made.

Models of service

The new service could take a number of forms:

- General dermatology clinics run by GPSIs in the community receiving referrals of agreed dermatological conditions directly from GPs or

after consultant triage. These clinics could be fully supported by a dermatology-trained nurse backed up by the resources and expertise of the local dermatologist. The GPSI clinic would be part of the overall integrated dermatology service.

- Community-based chronic disease management clinics involving both GPSIs and dermatology-trained nurses for patients with psoriasis, eczema or leg ulcers.
- Skin surgery sessions, undertaken in the community by trained GPs, provided suitable, approved facilities are available. Appropriate documentation of lesions and close links to the local dermatology and histopathology departments would be essential. If skin cancers were to be treated then the service would be governed by the local cancer services plan. GPs carrying out skin surgery would be expected to have diagnostic as well as surgical skills.

Workload, facilities and personnel

The numbers of patients seen during a GPSI clinic or operating list should be subject to agreed limits. The Department of Health guidelines¹ written by the Royal College of General Practitioners in conjunction with the BAD and patient groups suggests 15 minutes per case. Similar limits should be set for review clinics held with the local consultant dermatologist. Space and time should be available to permit discussion of difficult clinical problems.

Secretarial and clerical support for the service must be provided. Facilities must also be adequate, and should include a consultation room with good lighting and another private room for patient education where nurses can demonstrate the application of treatments and bandages. If surgical procedures are to be performed then a fully equipped minor operating suite would be required. The GPSI should work with either a trained practice nurse or a specialist dermatology nurse.

Training

Numerous experienced GPs, most of whom hold clinical assistant or hospital practitioner posts, are already providing dermatology services in regular clinics or operating sessions within their local hospital department. If the local dermatologist is satisfied with their dermatological knowledge and skills, then these individuals could develop a role as GPSIs if they so wished.

GPs who wish to develop the role without previous dermatological experience will need to train alongside a local consultant dermatologist tutor. Training should be competency based. The duration of training will depend on the nature of the skills that are necessary, and the ability of the trainee to demonstrate that they have been acquired. For individuals wishing to practise across the full range of dermatology, it is likely that approximately 100 consultant supervised clinical sessions would be necessary. For those needing a more limited range of competencies, eg running a specialist eczema clinic with a specialist nurse, less time will be needed, but competency should be demonstrated. The training sessions should be appropriate for

the sort of service the GPSI intends to develop (general dermatology, chronic disease service or skin surgery). The dermatology tutor should judge competency through a combination of logbook record and in-training assessment. It should be understood that from the outset these clinical sessions are for the purposes of training and not for the provision of service.

It is anticipated that many GPs developing these specialised roles will wish to obtain a diploma in dermatology, such as the one offered by the Universities of Wales and Glasgow, or an equivalent benchmarked qualification in dermatology. The BAD is currently assessing the available courses so that the role and remit of each is clear. This will allow GPSIs in dermatology to select the diploma most suited for their particular role. Diplomas and other written qualifications should be complementary to and not a substitute for supervised practical clinical experience.

Continuing medical education

Training and educational support for the GPSI would be maintained by the GPSI working alongside the consultant dermatologist for an agreed proportion of their time, ie a minimum of one session per month. This contact would also provide access for patients seen in the community requiring more specialised investigation or care.

A CME session should also take place regularly in conjunction with the local department of dermatology.

Levels of skill

The core competencies required are described in some detail.¹ The GP with a general dermatological interest should be able to diagnose, assess and manage patients with common skin diseases to a much higher standard than that of non-specialist colleagues.

Unlike clinical assistants, GPSIs will be largely unsupervised, choosing to seek a second opinion only when they feel out of their depth. It is thus essential that GPSIs are conscious of their limitations and willing to seek help when required.

For those seeking accreditation in a more limited area, eg an eczema or psoriasis clinic, then training requirements could be modified. The length of training would be shorter but, as before, the local dermatological tutor would assess competency.

GPSIs performing skin surgery should have been trained and assessed by a local dermatological surgeon until they are deemed competent. They should gain and demonstrate diagnostic skills relating to benign and malignant skin tumours and they should have an understanding of histopathology.

Audit, clinical governance and appraisal

Regular attendance at dermatology audit sessions within the local provider department and audit of the local GPSI dermatology service are required.

Once in place, GPSI schemes must be subject to periodic review by local and/or national bodies, including the BAD,

appropriate GP representative groups and the Commission for Health Improvement (CHI). This audit process should involve other participants in the provision or development of services, including patient support groups, primary care trusts and local dermatologists.

The issue of indemnity for each GP delivering a defined specialist service should be clarified with the employing authority and relevant defence union. Appraisal is the responsibility of the employing authority but should be carried out by someone who is acceptable to both the GPSI and the secondary care department.

Impact on hospital departments and service capacity

The impact of training, assessment and CME of GPSIs will involve dermatologists to a substantial degree. Dedicated time for this work must be built into the consultant timetable and job plan. This will have an impact on service provision. It should also be recognised that improving access to a service often creates more demand for that service by lowering the threshold for referral and increasing public expectation.

Without doubt the majority of GPSIs, currently being offered sums in excess of £200 per session, will be recruited from the ranks of hospital-based clinical assistants, who earn £65 per

session. They in turn will have to be replaced and their successors trained.

Conclusions

The GPSI scheme, as envisaged by government, is intended to reduce the demand for consultant outpatient appointments. It is the role of the Royal Colleges of Physicians and General Practitioners aided by the BAD to ensure that this is not achieved at the expense of quality care and patient safety. A structured service, as outlined here, will be slow to introduce and expensive to set up and run. It has yet to be shown to be a cost effective alternative to conventional primary and secondary systems of care.

Reference

- 1 Department of Health. *Guidelines for the appointment of general practitioners with special interests – dermatology*. www.doh.gov.uk/pricare/gp-specialinterests/index.htm