General practitioners with special interests: risk of a good thing becoming bad?

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ABSTRACT

- There is a long tradition of some general practitioners developing areas of special interest within their mainstream generalist practice.
- General practice is now becoming increasingly fragmented, with core components being delivered as separate and standalone services (eg, travel medicine, skin cancer, women's health).
- Although this fragmentation seems to meet a need for some patients and doctors, potential problems need careful consideration and response. These include loss of generalist skills among GPs, fewer practitioners working in less well-remunerated areas, such as nursing home visits, and issues related to standards of care and training.

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General practice is, by definition and by tradition, non-specialised medicine. The expectation of patients and practitioners is, essentially, that general practitioners will be knowledgeable and skilled in a broad range of aspects of medicine and be able to integrate their knowledge and expertise to provide holistic comprehensive care to their patients. The Royal Australian College of General Practitioners (RACGP) defines general practice as:

> providing universal unreferred access to whole person medical care for individuals, families and communities. General practice care means comprehensive, coordinated and continuing medical care drawing on biomedical, psychological, social and environmental understandings of health.[1]

In contemporary Australian society, patients are increasingly expecting the very highest level of expertise to be applied to their health problems. Subspecialisation within specialist medical practice is increasing, and in recent years, general practice in Australia has seen the development of "specialisation of GPs" or "GPs with special interest areas". We need to ask: is this diversity within general practice healthy, or is the discipline facing potentially destructive fragmentation?

Diversity or fragmentation?

"Special interest" is a vague term for a spectrum ranging from finding one area of practice particularly interesting, through to having postgraduate qualifications and expertise in a defined component of practice, and plenty in between.

It is difficult to determine the prevalence of special interest, and, although RACGP members used to be able to self-declare special interests through their membership, this is no longer the case (RACGP membership department, personal communication, 27 May 2005). A review of advertisements for general practices in the Brisbane and Sydney 2005 Yellow Pages telephone directories demonstrates this diversity. Of 513 listings that clearly refer to general or family practices, 143 advertise special services, most commonly travel medicine and vaccinations, child health and immunisation, women's health, WorkCover, and skin checks (Box).

The term "diversity" of general practice as used in this article refers to situations in which GPs with special interests apply their skills and expertise within their mainstream general practice. They may formally (eg, via advertising) or informally (by word of mouth) promote their special interest areas within or beyond their own general practice.

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Fragmentation is different. Here we define "fragmentation" as the separation — in terms of organisation and delivery and as a business — of components of what is traditionally core general practice, with the emergence of standalone services. Examples of fragmentation include travel medicine clinics, women's health clinics, and skin cancer clinics — services that seem to take clearly defined components of general practice with high demand and viable funding mechanisms, from the rest of comprehensive primary medical care. In these examples, services are provided mainly (but not exclusively) by GPs, the clinics are typically physically separate from comprehensive general practices, and they are often run as a separate business and may have a strong corporate background.

Why are specialised GP-based clinics becoming more common?

There is very little empirical research about these "fragmented" services, although it is of note that, in the United Kingdom, the National Health Service Plan devised in 2000 called for the introduction of up to 1000 specialist GPs who would take referrals from fellow GPs for conditions involving specialties such as ophthalmology, orthopaedics, and dermatology.[2] A key aim was to reduce waiting times for patients to access specialist services, as patients with more straightforward problems would attend such clinics, freeing access to hospital consultants for those with more complex problems.[3] This may also be a major factor in the development of these clinics in Australia. Our informal discussions with colleagues and patients suggest several other possible contributing factors.

Practitioner factors

Like most people, many GPs seek variation in their work, and career evolution is inevitable. A doctor may develop a special interest in women's health, undertake further training, develop in-depth knowledge and give over a significant part of his or her time to this aspect of care.

Other benefits include the intellectual stimulation that comes from developing a special interest, the acquisition of new expertise, and increased job satisfaction. Gerada et al suggested that advantages of extending roles include provision of an intermediate tier of expertise and advice to primary care colleagues, alternative avenues for referral and access to specialist services, improved retention of GPs in the workforce, reduced GP burnout, the potential for "specialist" GPs to bring their unique in-depth knowledge of primary care to the respective specialist clinical area and to work across physical, psychological and social paradigms, and the potential to add value but not replace specialist services.[4] Developing special skills adds to the quantum of expertise within general practice.

General practice is a business and, compared with specialist medical practice, not a very lucrative one. In 2001–02, the average annual financial compensation received by GPs was $101 100, compared with $183 300 received by specialists.[5] However, relatively lucrative parts of general practice can be segmented off. Skin cancer clinics provide a comprehensive skin check, which can be done consistently within 10–15 minutes, with the subsequent excision of lesions where indicated. The mixture of a predictable and high consultation throughput with subsequent large numbers of excisions attracting reasonable Medicare rebates can make a viable business. Furthermore, if a group or chain of practices is established, economies of scale and advanced business practices can come into play, making the business even more attractive.

Patient factors

There is almost no empirical research about how and why patients use these "fragmented" services. Informal discussions with patients and consumer groups suggest some reasons. First there is often an assumption of expertise or specialised care: "If that is all they do, then they must be really good at it". Although not an unreasonable assumption, and one that may be held by some mainstream GPs who refer patients to these clinics, it may not always be backed up by specialised training or certification.

Interestingly, many patients we talk to indicate that they see no conflict at all with using, for example, a skin cancer clinic for an annual skin check, a travel medicine clinic for travel vaccination, and having a regular GP for other care. Perhaps this is an example of patients being at the centre of the health system, making informed choices about where to seek the health care that suits them?

What are the disadvantages of GP diversification and fragmentation?

Possible risks of fragmentation to GPs include losing some of their generalist skills and expertise, and becoming bored after several years of working in a narrow field.

Potential disadvantages to patients include lack of communication between practitioners, a reduced pool of expert GPs in the community and, if standards of quality care are not maintained, the possibility of suboptimal care. It is worth noting that general practices providing only specialised services are not able to gain accreditation, because they are not delivering general practice as defined by the RACGP. Furthermore, if more doctors move into these fragmented services, there might be fewer GPs available to provide the less attractive and less well-remunerated services, such as nursing home visits, and fewer working in socially deprived areas.

Number and type of special services advertised by general practices in the Sydney and Brisbane 2005 Yellow Pages telephone directories*

	Brisbane ($n = 49$)	Sydney ($n = 94$)
Special service advertised	Number (%)	Number (%)
Family medicine/general practice	40 (82%)	81 (86%)
Travel vaccinations/medicine	24 (49%)	19 (20%)
Child health/paediatrics/ immunisation	23 (47%)	18 (19%)
Women's health	20 (41%)	28 (30%)
WorkCover/workers' compensation	20 (41%)	10 (11%)
Skin cancer detection/mole scan/ total skin check	17 (35%)	6 (6%)
Men's health	11 (22%)	6 (6%)
Acupuncture	8 (16%)	33 (35%)
Medicals (work, diving, aviation, insurance)	8 (16%)	10 (11%)
Nutrition/weight management	8 (16%)	3 (3%)
Sports medicine	6 (12%)	22 (23%)
Surgery clinic/minor surgery	5 (10%)	4 (4%)
Antenatal care	4 (8%)	2 (2%)
Aged care	4 (8%)	2 (2%)
Counselling	3 (6%)	8 (9%)
Check ups	2 (4%)	0
Musculoskeletal medicine	2 (4%)	2 (2%)
Alternative/complementary medicine	2 (4%)	15 (16%)
Ingrown toenails	2 (4%)	0
Audiometry/ear microscope	2 (4%)	4 (4%)
Obstetric medicine	1 (2%)	0
Preventive health care	1 (2%)	5 (5%)
Sexual health	1 (2%)	2 (2%)
Occupational health	0	6 (6%)
Family planning/birth control	0	12 (13%)

*In Sydney, 32% (94/298) of general practices' advertisements in the Yellow Pages promoted special services. In Brisbane, 23% (49/215) of advertisements promoted special services.

Future issues

Inevitably, and correctly, patient choice will drive service provision. However, the market can be irrational, and the profession and government have responsibilities. Foremost is patient safety and quality of care. Determining training and certification criteria and the accreditation of medical services are crucial. Perhaps the RACGP and the Australian Government together need to determine when a medical service provided by a GP is not really general practice, and consider what additional or differential training and accreditation might be needed in these circumstances.

Access to some Medicare Benefits Schedule item numbers might be restricted to doctors with appropriate training (as is already the

case, for example, for particular aspects of mental health care, acupuncture, and prescribing of HIV/AIDS therapies within general practice), or additional item numbers at a higher rebate (commensurate with specialist services) might be available for particular services provided by accredited providers. GPs who devote significant practice time to areas of special interest should carefully consider their obligations in terms of clinical competence and performance, and professional obligations as defined by the Medical Boards.[6]

Special interest societies should be encouraged and supported financially by government, and careful consideration needs to be given to which College will support the practitioners providing these services, if it is not to be the RACGP.

More research is needed so that we better understand why these services are developing, why patients use them, why doctors choose to work in them, how their clinical outcomes compare with services delivered to patients via mainstream general practice and specialists, and whether they are cost effective.

Competing interests

DW works part-time in a skin cancer clinic in primary care. MLD works part-time in a mainstream general practice.

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