The breast physician: an example of specialisation in general practice

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ABSTRACT

- General practitioners face the challenge of developing a career path and credentialling pathway for doctors working in special interest areas to ensure safe practice and to develop a professional profile for these groups.
- Breast physicians are one example. They care for women with benign and malignant breast disease and work in multidisciplinary teams in hospitals, clinics, private practice, and the breast screening program.
- The training and credentialling of breast physicians has recently been formalised by the Australasian Society of Breast Physicians with the introduction of a training program and fellowship in breast medicine.

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The emergence of special clinical interest areas is an exciting development in general practice. The trend towards "specialisation" in general practice is driven by a number of factors — including the increasing complexity of medicine — that make it difficult for some general practitioners to maintain a high level of expertise in the full range of disease areas as well as meeting an increasing consumer demand for "expert" advice. This may increase pressure on GPs to either refer to specialists or to develop additional expertise themselves.

Some GPs may choose to develop specialised knowledge and skills in order to offer a higher level of care to a group of patients with conditions that hold particular interest for them. These include doctors working in the areas of sports medicine, travel medicine, sexual health, addiction medicine, adolescent health, occupational health and palliative care. Here, we use the example of the breast physician to show how such specialisation can develop. We also argue that these doctors are still primarily "GPs", albeit with additional, focused skills.

Who (or what) is a breast physician?

Most breast physicians have a background in general practice, where they develop an interest in women's health and breast disease. The breast physician was described by Harman et al in 1995 as a "medical practitioner who is skilled in interpreting screening mammograms and the diagnostic work-up of women with symptomatic breast problems".[1] The role and skills of breast physicians have now evolved to work beyond the screening and diagnostic setting, making an important contribution to multidisciplinary breast teams that manage women with benign breast disease and breast cancer.

Their specialised skills come from a range of different disciplines, such as radiology, surgery and oncology, as well as general practice. They are skilled in clinical examination, interpreting breast imaging (mammograms and ultrasound images) and performing breast interventional procedures such as fine needle biopsy, core needle biopsy and preoperative wire localisation. We believe these skills complement their skills in general practice, allowing them to provide holistic care to women with breast symptoms.

The Australasian Society of Breast Physicians (ASBP) provides representation and credentialling for breast physicians in Australia and New Zealand. There are currently 44 members, with 29 holding fellowship status of the Society. Many new fellows in recent years also hold a Fellowship of the Royal Australian College of General Practitioners (FRACGP).

What do breast physicians do?

Breast physicians perform a range of clinical and non-clinical roles, including consulting in private breast clinics, private practice and public hospital clinics. They may also be involved in surgical assistance, delivery of breast screening programs, and academic roles.

Many breast physicians in Australia and New Zealand are based in private breast clinics in Sydney, Brisbane or Auckland. In these clinics they have the main responsibility for coordinating and managing care of women with breast symptoms within a multidisciplinary team comprised of surgeons, radiologists and pathologists. Some breast physicians work in private practice, independently or in consultation with breast surgeons and other specialists in breast cancer teams in the private setting.

Some public hospitals in Australia, including at least five in New South Wales and the Australian Capital Territory, have breast physicians working in outpatient clinics. Here, their roles vary and include assessing patients with likely breast cancer, conducting benign disease clinics and follow-up clinics for women who have been treated for breast cancer, and conducting screening clinics for women at high risk of breast cancer. Breast physicians reduce the number of patients in a specialist breast centre who require consultation with a breast surgeon,[2] and provide continuity and stability within the breast team in the public hospital system, where specialty oncology registrars and fellows are rotating though the breast term every few months.

In the operating theatre, working with a breast surgeon as surgical assistant, a breast physician is able to enhance continuity of care, linking preoperative, operative and postoperative phases of care. The breast physician also brings radiological skills that the breast surgeon may not possess, enabling intraoperative ultrasound localisation of non-palpable breast lesions in some cases.

Many breast screening programs are staffed by breast physicians who work with radiologists and surgeons as part of the screening and assessment team. Several of these non-specialist medical officers hold director positions in screening services. In addition to breast screening programs, several institutions have breast physicians in senior executive positions. As well as supervising the training of new breast physicians under the auspices of the ASBP, some breast physicians are embracing academic roles, contributing to the international body of litera-

ture on breast disease and writing a number of educational articles relating to breast disease.[3-6]

How are breast physicians renumerated?

There have been suggestions that some special interest GPs "skim the easy and lucrative work" to increase their income and leave the higher-needs patients to traditional family practitioners.[7] We do not think this criticism can be levelled at breast physicians. Under the current Medicare system, they are still renumerated as GPs, with the average time for a new patient consultation being 30–60 minutes, depending on the complexity of the patient's issues. Thus, we believe that, as in other areas of general practice in which most consultations are long and involved, the role is relatively poorly remunerated in private practice.

The ability to bill for some radiological procedures does enhance remuneration, but much of this income goes towards covering the costs of infrastructure, such as ultrasound equipment, and the disposables associated with performing these procedures.

Training and qualifications

At present, many relevant specialists recognise the skills and experience of the individual breast physician rather than the ASBP fellowship itself; however, this is likely to change as the ASBP promotes formalised curricula for the award of its fellowship. The ASBP has recently reviewed and formalised its training and examination process and, following comment from relevant specialist and consumer groups, has produced *Standards for training and competency of breast physicians*,[8] which have been formally endorsed by the RACGP.

According to the Standards, breast physician training must be undertaken in a specialised breast clinic under the supervision of a mentor. There are five domains of clinical practice in which breast physicians must show competence (communication skills and the patient–doctor relationship; applied professional knowledge and skills; professional and ethical role; population health; and organisation and legal dimensions) and 11 learning modules (including family history and genetics, mammography, breast ultrasound, communication skills and breast biopsy), each with its own ongoing assessment. For example, the breast ultrasound module requires that 500 ultrasound examinations be documented in a log book, and the biopsy module requires 250 biopsies to be logged. The training document also details standards for mentors and training facilities and mandates participation in a continuing medical education program for all breast physicians.

After a minimum period of training, the registrar is eligible to sit the ASBP fellowship examination, which consists of oral and written examinations covering the diagnosis and treatment of the range of benign and malignant breast disease.

Can a generalist also be a specialist?

> The good physician treats the disease; the great physician treats the patient who has the disease.
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> – Sir William Osler (Canadian physician, 1849–1919)

The RACGP defines general practice as "the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities" and states that "general practice involves the ability to take responsible action on any medical problem the patient presents".[9] Thus, general practice is more than just treating patients with primary care health problems affecting all of the body systems. It is underpinned by a core philosophy of comprehensive holistic care with an understanding of the presenting illness in the context of the patient's life. We believe it is this philosophy and perspective that defines the GP, not the patient or the condition being treated. Thus, special interest practitioners are still GPs, and it is this holistic perspective that sets these practitioners apart from specialists practising in the same area. Furthermore, the ASBP considers the general practice background of most breast physicians central to their valuable skills and perception of patient needs.

Specialisation within a generalist field is not a new concept. General physicians and general surgeons have struggled through the same issues as subspecialty areas have developed in recent decades. After an unsettled period of debate, with resistance from some and enthusiasm from others, subspecialties have been embraced and integrated into medical practice, and credentialling processes and benchmarks have been developed to ensure that practitioners in these areas reach a minimum level of expertise and provide a high standard of care. For example, standards for subspecialty training have been set by the Royal Australasian College of Physicians[10] and the Section of Breast Surgery of the Royal Australasian College of Surgeons.[11]

In these professions, it is now accepted that there is a role (and in fact a need) for subspecialties and that the existence of these specialised practitioners is an essential part of the profession being able to offer a high standard of care to patients and to improve outcomes. For example, in the case of breast surgery, it has been shown that women who have their breast cancer treated by surgeons who have a greater breast cancer caseload have better survival.[12]

In the United Kingdom, the emergence of special interest groups in general practice has been acknowledged and discussed in some detail, and these doctors are known as GPwSIs (GPs with special interests.)[13,14] A questionnaire survey of GPs in the UK found that over 70% of respondents had at least one area of special clinical interest and that 38% of respondents were undertaking separate clinical sessions in their area of interest. Extrapolating from these results, one could estimate that at least 16% of GPs in London practise at least part-time in a special interest area, although it is not known how many work exclusively in their special interest area. The most common areas identified were diabetes, dermatology, minor surgery, family planning and occupational health.[15] Support for GPwSIs comes from the National Health System (NHS), which has included the development of 1000 GP specialists by 2004 in the NHS Plan.[16]

In Australia, the issue of specialisation within general practice is being addressed by the RACGP, which has formed a series of consultative committees and joint working parties with special interest groups, including breast physicians.[17] Considerable resources have been invested in forming links with special interest groups within general practice, with the aim of discussing issues such as credentialling and strategies to incorporate special interest practitioners into the Australian health system. In 2004, the RACGP formed a joint working party with the ASBP to discuss these issues as they relate to breast physicians, with a particular focus on developing a program for quality assurance and continuing professional development. Subsequently, the document setting out standards for training[8] was endorsed by the RACGP as an

Potential advantages and disadvantages of specialisation in general practice to various stakeholders

	Advantages	Disadvantages
Patient	• Holistic approach to specialist care — "general practice" philosophy • Easy access to special interest practitioners • Enhanced access pathway to specialist when traditional specialist care is needed	• Fragmentation of care • Confusion about role and qualifications of the doctor • Perception of not seeing a "real" specialist
Referring GP	• Collegiate familiarity, enabling rapid referral and access • Second opinion on non-surgical issues	• Confusion as to role of special interest practitioners • Additional barrier between referring GP and specialist
Special interest GP	• Option to explore areas that hold particular interest • Opportunity for professional development • Opportunity to vary practice with a combination of general and specialty sessions in the same week • Potential increase in job satisfaction and self-esteem • Being in a good position to take advantage of evolving opportunities in a complex medical system that is under-resourced in many areas	• Additional training and study required • No structured career path for most special interest areas • Poor remuneration relative to specialists providing similar care • Potential erosion of self-esteem by resistant specialist colleagues • Concern about alienating GP colleagues • Feeling of "not belonging" professionally
Specialist	• Potential for parallel/multidisciplinary consulting to enhance specialist practice • Potential for links with GP referral base to increase referrals to specialist • Opportunity to share workload • Exchange of ideas, varied perspectives on patient needs • Increased collegiality	• Blurring of lines between general practice and specialist practice; "turf" disputes • Uncertainty about skills and qualifications to practise in the area • Possibility of offending referring GPs if patients seen by "another (specialist) GP" instead of a specialist
Health care system	• Large potential workforce • Reduced cost of providing specialist care • "Bridging the gap" between primary and secondary care	• Difficulty defining place for practitioners in the health system • Need to explore issues of credentialling, referral, billing

GP = general practitioner. ◆

appropriate pathway for gaining experience in breast medicine after completing a fellowship of the College.

Advantages and disadvantages

The development of special interest areas is an exciting extension to family medicine, bringing potential benefits for patients, general and specialist doctors working in the area, and the health system as a whole. However, there may be potential disadvantages as well (Box).

Some observers have expressed concern that the development of special interest areas may lead to fragmentation of patient care and lack of communication between practitioners.[7] However, we hold the converse view — that the breast physician model has the potential to enhance continuity of care and communication between doctors. We believe the breast physician in the multidisciplinary breast cancer team is in a unique position to offer holistic care and support and to act as a care coordinator for patients being treated by a number of different specialists over a period of many months. The breast physician can facilitate communication between specialists and between the treatment team and the family practitioner.

The breast physician can also see the patient through the follow-up phase of care, offering continuity in managing the long-term effects of treatment, such as menopausal symptoms and issues related to life after breast cancer. While this could also be done by the patient's oncologist or GP, the breast physician is ideally placed to offer this.

We believe the development of special interest areas also has the potential to increase the profile and professional standing of general practice as a whole, as specialists recognise the high quality of care and the holistic perspective that a GP can add to the care provided by the specialty team.

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Competing interests

None identified.

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