

# Evolution of health professional roles: GPs with a special interest in diabetes

Jo-Anne Manski-Nankervis

**Citation:** Manski-Nankervis JA (2016) Evolution of health professional roles: GPs with a special interest in diabetes. *Diabetes & Primary Care Australia* 1: 52–4

## Article points

1. In the UK, a GP who has received additional training and experience in a particular area can become an accredited GP with a specialist interest (GPwSI). No such framework currently exists in Australia.
2. There are many potential advantages to the role, including improved access to specialist care and reduced costs, but there are also potential disadvantages, such as fragmentation of primary care.
3. There are programs in Australia that are trialling whether specialist GPs are an effective way to improve access to care.

## Key words

- Advanced skills
- Education
- GPwSI

## Author

Jo-Anne Manski-Nankervis is a GP in Essendon, Melbourne, Vic, and Lecturer at the Department of General Practice at the University of Melbourne, Vic.

**The prevalence of diabetes is increasing in Australia, necessitating health professionals to work together effectively and consider new ways to ensure that optimal care can be provided to all. One way in which this may take shape is in the evolution of health professional roles. A GP with a special interest (GPwSI) can provide a level of care and knowledge above what is provided in routine general practice. The author explains the GPwSI framework currently in use in the UK and considers whether it would be beneficial to develop something similar in Australia.**

In the UK, a GP with a special interest (GPwSI) has received additional training and experience in a specific clinical area and takes referrals for patients who may previously have been referred directly to a consultant. It is possible to be accredited in a range of health specialities, such as cardiology, mental health, older people and diabetes.

## GPwSI in diabetes

In the case of diabetes care, there has been a long history of GPs in the United Kingdom working in diabetes clinics with shared care arrangements with specialists and running diabetes clinics within general practice. The increasing burden on specialist diabetes clinics, together with a government move to shift chronic care management from secondary to primary care, led to the development of the GPwSI in diabetes (Association of British Clinical Diabetologists, 2002). Whilst the role of the GPwSI in diabetes varies according to local requirements in the UK, there are three common features:

- Clinical service (i.e. provide assessment, advice, information and treatment to primary care colleagues for patients whose care *does not* require a specialist diabetes service).
- Education and liaison.
- Leadership.

The development of the GPwSI role in the UK has standardised guidance that should be adhered to (Goenka et al, 2011; Royal College of

General Practitioners and Department of Health, 2003). In order to be able to attain recognition as a GPwSI, GPs in the UK need to have generalist qualifications as well as experience working under direct supervision with a consultant physician who has a special interest in diabetes in a hospital or community setting, or a personal development portfolio. This is in addition to demonstrating ongoing professional development. It is a basic requirement that a GPwSI must have clinical and governance support from consultant specialist colleagues, and it is recommended that a GPwSI should spend a minimum of one session a week in general practice in addition to time spent in the area of special interest.

A GPwSI may form part of multidisciplinary care, working alongside specialist physicians, diabetes educators, dietitians, podiatrists and psychologists. There are also guidelines on the patient groups where it would be appropriate for primary care to refer directly to secondary care specialists rather than GPwSIs (see *Box 1* for a quick guide):

- Children and adolescents with diabetes.
- Pregnant women with diabetes.
- Individuals with very unstable type 1 diabetes or those requiring admission for severe hypoglycaemia and hyperglycaemia leading to diabetic ketoacidosis.
- People requiring new or complex treatments, such as insulin pumps.
- People with complications (e.g. retinopathy, nephropathy and foot problems requiring

**Table 1. Potential advantages and disadvantages of the GP with a special interest (GPwSI) role.**

Advantages	Disadvantages
Provides an alternate avenue for referral and access to specialist investigations	Fragmentation of care
Increased job satisfaction and reduced burnout for GPs	De-skilling of the GP workforce
Can link in-depth knowledge of primary care to specialist knowledge, allowing psychological and social issues to be accounted for	GPs may not refer to GPwSI
Reduced waiting time and improved access compared to specialist services	Relies on good communication between GPs and GPwSI
Present in the local community, which is more convenient to the patient	Framework for GPwSI accreditation does not currently exist in Australia
May be associated with reduced costs	

multi-specialist management and intensive control of risk factors in keeping with any national or local guidelines and protocols).

- Individuals requiring specialist psychological support for complications of diabetes (e.g. depression or erectile dysfunction).
- Individuals with rare or unusual types of diabetes (e.g. associated with cystic fibrosis).

### Current literature

The potential advantages and disadvantages associated with the GPwSI role are manifold ([see *Table 1*] Gerada et al, 2002; Wilkinson et al, 2005; Jiwa et al, 2012). Some specialists have voiced concerns about the potential for destabilisation of secondary care services, while others do not acknowledge a place for GPwSIs participating across primary and secondary care (Karet, 2007). However, the current shortage of specialists has been amongst the drivers for development of the GPwSI role.

A mixed-methods study evaluating GPwSI-led primary care diabetes clinics in Bradford, UK was carried out in 2004. Sixteen of the 19 clinics were led by GPs, and the researchers found that the primary care clinics were valued because of geographical accessibility, short waiting times, continuity of staff and availability of specialists in the community setting (Nocon et al, 2004). Whilst the costs of these clinics were similar to hospital clinics, the study did not compare the primary care clinics to clinics that had diabetologist input.

In the Netherlands, GPs with an interest in diabetes can undertake additional training to become a “Diabetes Executive”. This role extends past consultation and care of individual patients and includes outreach work to practices within diabetes care groups. Diabetes care groups are legal entities that sign contracts with health insurance companies to ensure the delivery of diabetes care in different geographical areas (Struijs et al, 2010).

In Australia, a number of GPs work within areas of special interest. Examples include skin cancer, women’s health and travel, cosmetic and sports medicine. Some practitioners working in these fields have additional qualifications; however, a framework like that existing in the UK does not exist here (Wilkinson et al, 2005).

The Brisbane South Complex Diabetes Service (BSCDS) operating at Inala Primary Care, Brisbane, Qld, provides one example of how something akin to a GPwSI role can work within a multidisciplinary team to provide positive outcomes for people with diabetes (Jackson et al, 2010). The BSCDS was developed in partnership with Princess Alexandra Hospital, Brisbane, a tertiary level hospital, to address the current waiting time of 12 months for individuals to access diabetes outpatient services. Advanced skills GPs called “clinical fellows”, who have completed postgraduate training in advanced diabetes care as part of a Master of Medicine program at the University of Queensland, Brisbane, work with an endocrinologist and

### Box 1. Quick guide to patient groups with diabetes best referred straight to secondary care.

- Children and adolescents.
- Pregnant women.
- People with unstable type 1 diabetes.
- People on new or complex treatments (e.g. pumps).
- People with extensive complications.
- People requiring psychological support.
- People with rare types of diabetes.

**“The Brisbane South Complex Diabetes Service has demonstrated some positive results on reducing waiting time and improving clinical outcome for people with diabetes when advanced skills GPs are employed to provide care.”**

allied health professionals to provide care to individuals with diabetes who have been referred to the hospital in a community setting. The model contains an element of specialist outreach as the endocrinologist attends the clinic in the community and both the endocrinologist and GPs co-consult with the patient. This service includes insulin initiation and titration.

Compared to the hospital clinic, the BSCDS has a waiting time of 4 weeks, their patients have significantly lower HbA<sub>1c</sub> at 12 months, there is a reduced number of non-attendees at 12 months compared to that at the hospital, a significantly higher percentage of patients are discharged back to general practice, and care per visit cost is approximately one fifth of that occurring at the hospital outpatient department. This allows for a greater number of follow-up visits whilst still delivering a clinic at a lower cost (Russell et al, 2013).

Another initiative exploring the potential for the GPwSI in diabetes role to develop in Australia is the National Faculty of Specific Interests of the Royal Australian College of General Practitioners, which commenced in 2011.

### Conclusion

GPs have been working within areas of special interest for many years in Australia, but in countries such as the UK and Netherlands the role has been formalised. No such GPwSI framework exists in Australia; however, the BSCDS has demonstrated some positive results on reducing waiting time and improving clinical outcome for people with diabetes. ■

Association of British Clinical Diabetologists (2002) *General Practitioners with a Special Interest in Diabetes – a discussion paper*. ABCD, Malmesbury, UK. Available at: <http://bit.ly/1VgJMNX> (accessed 12.02.16)

Gerada C, Wright N, Keen J (2002) The general practitioner with a special interest: new opportunities or the end of the generalist practitioner? *Br J Gen Pract* **52**: 796–8

Goenka N, Turner B, Vora J (2011) Commissioning specialist diabetes services for adults with diabetes: Summary of a Diabetes UK Task and Finish Group report. *Diabet Med* **28**: 1494–500

Jackson C, Tsai J, Brown C et al (2010) GPs with special interests impacting on complex diabetes care. *Aust Fam Physician* **39**: 972–4

Jiwa M, Meng X, Sriram D et al (2012) The management of Type 2 diabetes: A survey of Australian general practitioners. *Diabetes Res Clin Pract* **95**: 326–32

Karet B (2007) Intermediate care in diabetes: a rose between two thorns? *Practical Diabetes International* **24**: 389–91

Nocon A, Rhodes P, Wright P et al (2004) Specialist general practitioners and diabetes clinics in primary care: a qualitative and descriptive evaluation. *Diabet Med* **21**: 32–8

Royal College of General Practitioners, Department of Health (2003) *Guidelines for the appointment of General Practitioners with Special Interests in the Delivery of Clinical Services – Diabetes*. DoH, London, UK

Russell A, Baxter KA, Askew DA et al (2013) Model of care for the management of complex type 2 diabetes managed in the community by primary care physicians with specialist support: an open controlled trial. *Diabet Med* **30**: 1112–21

Struijs JN, van Til JT, Baan CA (2010) *Experimenting with a bundled payment system for diabetes care in the Netherlands*. Centre for Prevention and Health Services Research, Public Health and Health Services Division, The Netherlands

Wilkinson D, Dick MLB, Askew DA (2005) General practitioners with special interests: risk of a good thing becoming bad. *Med J Aust* **183**: 84–6

### Join the discussion!

**Q** Do you think there is a place for the GPwSI in Australia?

**Q** Are you a GP with a special interest in diabetes or a health professional working with one? What are your experiences of the role? Should it be formally recognised?

**Q** Could the formalised GPwSI role assist in the provision of intermediate care in areas of medical workforce shortage (e.g. rural areas in which access to endocrinologists may be limited)?

**Q** Are you a nurse, pharmacist or allied health professional extending beyond the “traditional” role in assisting with the management of diabetes?

Tweet @PCDSAus or comment on our LinkedIn page: [www.linkedin.com/primary-care-diabetes-society-of-australia](http://www.linkedin.com/primary-care-diabetes-society-of-australia)