I’m not sure if I’ve got a special interest as a GP. In the UK, I see that GPwSI (with a special interest) has transformed into GPwER (with an extended role). The Royal Australian College of General Practitioners has a Faculty for members with specific interests, and many of the extended roles in Australia are essential in providing secondary care in hospitals in rural areas hundreds or even thousands of kilometres away from the nearest cities. From a health system point of view, it is obvious that GPs will be required to have an extended scope of practice to fill essential workforce gaps that would normally be performed by non-GP specialists. It looks to this foreigner that this is the direction GPwER is moving toward, so extended roles are formalised in secondary care, with appropriate supervision, accreditation, and clinical governance coming from secondary care settings, and in both countries the list of interests a GP might have is similar, including dermatology, urgent care, antenatal care, and minor surgery.

This is another example of GPs being the sticky tape that holds the health system together. Where capacity, workforce, and funding limitations mean services aren’t provided, GPs end up managing people without the support of secondary care. Special interests or extended roles run the risk of being cheaper mini-specialists, reducing the GP sector’s ability to provide the primary care that we know keeps people well — comprehensive, patient-centred, generalist care.

It’s not that GPs shouldn’t have extended roles, it’s that the health system should support the generalist care provided in general practice. Special interests don’t always need to be replacements for secondary care. A GP with a special interest in diabetes can take a generalist approach that is different from — and complementary to — an endocrinologist. The same goes for GPs with special interests in antenatal care or mental health — patients and health systems benefit from the relationship-based care that GPs are expert in, but less so if we are just mini-obstetricians or mini-psychiatrists.

Established special interests in medical education or research have escaped this, for obvious reasons. Being roles that build on clinical general practice, they aren’t replacements for other roles, but ways of enhancing general practice that can only be done from within our own discipline.

Some newer special interests, such as climate change or health inequalities, are perhaps more linked to public health as a specialty, but have become cross-disciplinary, connecting the population health aspects with generalist clinical care.

Perhaps most interesting is the uptake of lifestyle medicine or social prescribing as a special interest. These could be thought of as core components of general practice, that any of us should be able to give effective tailored advice on nutrition or physical activity, and that the infrastructure for patients to access is available regardless of the interests of the patient’s GP. Highlighting the expertise in GPs doing this regularly is valuable, but perhaps it comes at the risk of denigrating GPs doing this regularly without claiming it as a special skill.

Ultimately, special interests and extended roles are very much part of being a GP. Our pragmatism means we tend to spot the unmet needs of our patients and, where possible, develop the skills to meet these needs.

It’s worth examining the reasons in the health system for supporting special interests, though. Are we playing Jenga with the health system, continually removing building blocks to replace obvious deficiencies in a rickety structure? Or are we enhancing the generalist, patient-centred care that actually improves people’s health?

Tim Senior
GP, Tharawal Aboriginal Corporation, Airds, Tharawal Aboriginal Corporation, PO Box 290, 187 Riverside Drive, Airds, NSW 2560, Australia.

Email: drtimsenior@gmail.com
@timsenior

This article was first posted on BJGP Life on 23 Jan 2024; https://bjgplife.com/extendedroles

DOI: https://doi.org/10.3399/bjgp24X736341