General practitioners with a special interest

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Despite many attempts at reform, there has been a persistent shortfall in the number of consultant cardiologists.[1] As long ago as 1985, the conservative recommendation was made that each general hospital should have at least one physician, practising general medicine but having a special expertise and training in cardiology. The workload of the cardiologist was defined in terms of undertaking echocardiography, stress testing, ambulatory monitoring, emergency pacing, rehabilitation and cardiac intensive care, with the necessary facilities and staff.[2]

Meanwhile, as far as the expectations and requirements of primary care were concerned, the most important in-patient service requirement was that cardiologists should be responsible for the management of patients with acute myocardial infarction and other acute cardiac conditions.[3] The expertise and reputation of the consultant cardiologist and the waiting time for an appointment were seen as the two most important out-patient service requirements. The least important aspect was the time that patients waited in clinic to see a doctor. Interestingly, at the time of fund-holding the price of outpatient consultations was deemed to be unimportant. Waiting times for cardiac catheterisation and non-invasive cardiac investigations, together with the quality of the investigation equipment and the technical staff, were all considered to be important requirements.

Most general practitioners wanted protocols for managing common cardiac conditions. The majority wanted an open access investigation service to reduce out-patient waiting times. Those who did not want an open access service explained that they would not be confident in interpreting the results or deciding subsequent management.[3]

Despite the obvious need and the fact that heart disease is always a government priority, progress has not been substantial. Few of the larger districts have two cardiologists to meet the recommendation for populations of over 250,000.[4] Similarly, it was noted that the 1991 NHS reforms had had no observable impact on the availability and use of coronary revascularisation by 1995.[5] It was further recommended that 150 extra consultant posts (in both district and regional centres), together with adequate supporting staff and facilities, were urgently needed to provide modest cover for existing requirements.[4]

The latest figures suggest that there is still a need to double the consultant numbers from 630 to at least 1,200 (or from 1 per 80,000 to 1 per 50,000 of the population). The need for skill mix, with general practitioners, nurses and technicians all having a role to play, is also recognised.[1]

The latest attempt to improve access to specialist opinion is the development of community specialist clinics with the introduction of 1,000 'specialist general practitioners' (also known as GPs with a special interest or GPSIs).[6] This paper looks at the possible role within cardiology for GPSIs, at training implications and at possible financial implications.

GPSIs for cardiology

The role of GPSIs is essentially to deal with straightforward cases in an attempt to allow faster access to hospital specialists, who would manage more complex clinical problems. This is not altogether a new idea: existing models of chronic disease management for conditions such as asthma and diabetes are well established. Similarly, it is not unusual for primary care centres to have 'in-house' referrals to a lead clinician with an interest in cardiology. This may be as simple as providing an ECG interpretation service. There has been a parallel development and expansion of the role of nurses and other healthcare professionals within a primary care setting.

It has been suggested that evidence for the clinical and cost effectiveness of these services is 'almost non-existent'.[7]

There are data, however, which demonstrate that oral anticoagulation services can be delivered at least as well within a primary care setting as within a specialist out-patient setting.[8] These data have led to the development of an alternative model of care which is now recognised as a credible alternative to the traditional out-patient model. Unfortunately for policy makers, this is not achieved without cost as both training and capital investment are required to achieve high-quality care.[9] How might lessons learned from this model apply to the broader area of cardiology?

Service requirements

Within the field of anticoagulation, demand for services has been driven by evidence of the effectiveness of warfarin as a thromboprophylactic agent in atrial fibrillation.[10] The increased demand for cardiology services has essentially been driven by the national service framework (NSF) for coronary heart disease (CHD).[11] Whilst it must be recognised that there are other important areas of cardiology, CHD is an area where GPSIs could conceivably help to maintain the impact of the NSF in England, and implement something similar in Wales, Scotland and Northern Ireland.

Training

The development of primary care anticoagulation clinics has only been achieved with investment in training. More than 200 healthcare professionals (GPs, nurses, pharmacists and biomedical scientists) have been trained through the University of Birmingham anticoagulation course, which is credited with 10 credits at MSc level. Training requirements for cardiology GPSIs will need to be carefully evaluated. Perhaps core skills might be supplemented with practical training in techniques such as echocardiography. It is not clear whether this process is meant to start during training or only after formal qualification as a GP. Specialist training could be incorporated into the GP registrar training, or could possibly be included as part of an extended training scheme.

Whilst competency criteria are being established, it is clear that this process will not be without staffing implications in the short term and financial implications throughout.[12] Concern has already been raised with regard to ensuring quality in terms of accreditation, training and revalidation, while also ensuring diversity in service provision.[7] Thus, a cardiology GPSI may be expected to run a hypertension clinic or, alternatively, to provide a heart failure service which includes echocardiography. Are these services comparable, and are the training requirements the same for both? I think it is clear that the answer to both these questions is no.

Resource implications

It is generally assumed that provision of healthcare services is cheaper when delivered through primary care. Our experience with oral anticoagulation clinics, however, demonstrates that this is not always true: primary care clinics can cost about twice as much as hospital clinics.[9] This is essentially due to the economies of scale provided in secondary care, with high volume, high throughput clinics in comparison to the low volume, low throughput primary care clinics. Similarly, there are capital costs in terms of equipment and training, and these are relatively large in primary care. The same is likely to be true of primary care cardiology clinics using GPSIs. For example, an echocardiography service within a hospital is always going to be more efficient than providing echocardiography within a single practice only. An alternative is the hub and spoke method, with a local practice providing services for the locality. This may be more cost-efficient but it essentially re-introduces the problems of hospital-based clinics into the community.

These financial implications are severe enough, but there is also the problem of where these GPSIs are going to come from. There is already a recruitment crisis in primary care. The idea of becoming a GPSI may increase the appeal of general practice, but it is unlikely to have a quick impact. It is estimated that around 4,000 GPs already undertake tasks which could classify them as a GPSI.[7] It is not clear that there remains a reservoir of expertise and enthusiasm which can be tapped.

Summary

The shortage of cardiology specialists may be reduced by the development of GPs with a special interest for cardiology. If this is to happen, it will require a substantial capital investment in equipment and training, with the parallel development of competency criteria. Even with this investment, it is unclear where the new personnel are to be recruited from. GPSIs may provide part of the solution to improving access but there remains a need to increase both the number of consultant cardiologists and the number of support staff.

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Br J Cardiol 2004;**11**:175–8