

Provision of secondary care for dermatology within general practice

GUIDELINES FROM THE ROYAL COLLEGE OF PHYSICIANS
DERMATOLOGY ADVISORY COMMITTEE

1 Background

1.1 A national framework for the provision of secondary care within general practice was published in Health Service Guideline HSG/96/31. Since this Guideline was issued, several schemes related to dermatology have been established in the UK. The key principles of HSG/96/31 require that the GP should be 'appropriately qualified and experienced'. However, there is no system of training or accrediting GPs to provide a specialist service in dermatology, so guidance is needed in this area. Second, the guideline requires the establishment by the local Health Authority of an Expert Advisory Panel, which will consider each application individually, and ensure that the person applying is qualified to undertake the relevant procedures. The document states that: 'the term "procedure" does not refer exclusively to surgical procedures, but should be interpreted more widely to include other activities, normally performed in a secondary care setting'.

1.2 However, the document also states: 'The advisory group should in general advise on individual procedures and not complete service areas'. Again, guidance is needed in relation to dermatology and the type of procedure which might be undertaken by an appropriately trained GP.

1.3 HSG/96/31 requires the Expert Advisory Panel to take account of 'relevant guidance from the medical Royal Colleges'. The present guidelines have been drawn up therefore to assist Expert Advisory Panels in this particular area.

2 General principles

2.1 The Dermatology Advisory Committee (the Committee) does not support schemes where GPs seek to provide a secondary diagnostic service for dermatology patients. In the UK the only doctors who are qualified to practise as specialists and to offer a complete service in the diagnostic aspects of dermatology, are those on a specialist registry. Throughout the European Community, dermatology training requires a statutory minimum of four years, before the trainee can apply for a CCST, and no GP in the UK holds a CCST in dermatology. The Committee recommends that secondary referral clinics within general practice should limit their activities to specific procedures (such as cryotherapy) and to specific areas of management, for example, the management of venous ulcers, or the treatment of patients with chronic inflammatory skin diseases, such as psoriasis, or eczema. This satisfies the broader defi-

nition of a procedure contained in HSG/96/31, as well as the stipulation that expert advisory panels should not advise on 'complete service areas'.

2.2 Each procedure and each aspect of dermatological management should be considered separately. It is necessary for the GP to demonstrate clinical expertise in each area and to stipulate how this expertise has been obtained. It is not satisfactory to state that this experience has been obtained in primary care, since the purpose of a secondary referral clinic is to provide expertise over and above that which is normally provided within a primary care setting.

2.3 GPs who undertake such clinics need to be aware that they are providing an aspect of service normally provided by a certified specialist, and that patients are being referred to them by other GPs, and from other practices for specialist advice. The standing of the GP should be stated clearly, so that the patient is aware that he/she is not seeing a Consultant Dermatologist. The Expert Advisory Panel needs to be aware that in the event of any medico-legal action, the GP will be judged by the standards expected from a group of his peers, and in this context, the Medical Protection Society has confirmed that the relevant group is other specialists, ie consultant dermatologists, and not other GPs.

3 Training scheme for GPs

3.1 Only 20% of GP vocational training schemes contain a dermatological component, and since the undergraduate curricula contains, on average, only six days of dermatology, some doctors entering general practice are poorly equipped to deal with dermatological disorders. According to the latest OPCS statistics, these account for 15% of GP consultations. In response to this situation, many GPs have obtained the Cardiff Diploma in Dermatology. This is a one year distance-learning course, designed to improve GPs' knowledge of dermatology, to a level where they can deal competently with dermatology patients that are seen within their own practice. However, it is made clear to all course participants that the Cardiff Diploma does not represent a certificate to function as a specialist. Further clinical expertise is needed in specific areas before a GP can be considered 'suitably qualified and experienced' as required by HSG/96/31.

3.2 This experience is best obtained in a department of dermatology, where a consultant is available to train and assist the GP in specific procedures. The committee would therefore anticipate that any GP applying to provide

secondary care for dermatology patients, would have spent a minimum period of time in a department of dermatology, under the supervision of an accredited specialist.

3.3 Many GPs will have been employed as a Clinical Assistant in a hospital department. However, this experience needs to be evaluated in relation to the specific application. The routine work of a clinical assistant might well equip them to undertake a procedure such as cryotherapy, whereas the management of patients with psoriasis is a more complex area of clinical dermatology, which requires experience of the various treatment options available. For example, patients with psoriasis commonly receive daily outpatient treatment in a hospital department using treatment protocols based on Dithranol, or crude coal tar. Such treatments might be undertaken in a specialised clinic within the primary care setting, but the treatment is usually undertaken by skilled nurses, so clinical assistants would not necessarily have any direct exposure to these procedures, and would not be qualified to supervise this treatment in general practice. A period of training specifically designed to provide such experience is therefore required before an applicant can be considered 'suitably qualified and experienced'.

3.4 In addition, GPs providing a secondary care service will need to be familiar with other treatment options used in patients whose psoriasis is resistant to topical therapy. This would include phototherapy with UVB or PUVA, drug regimes such as Acitretin, and cytotoxic or immunosuppressive therapy with Methotrexate or Cyclosporin. Again, a clinical assistant may have had only limited exposure to these treatment options and a period of specific training is required.

3.5 From a practical point of view, it may be impossible to actually provide these treatments in a primary care setting. Phototherapy machines are expensive and require the services of a trained operator. Acitretin is only available from hospital pharmacies, and monitoring of patients on Methotrexate or Cyclosporin A is a specialised area of medicine, which may require procedures such as liver biopsy or chromium-labelled EDTA clearances, which can be undertaken only within a hospital. Even so, a GP will need to be familiar with these treatment options and demonstrate knowledge of the clinical guidelines issued by the relevant specialist bodies.

3.6 Similar considerations apply to the management of patients with chronic eczema. Whilst daily treatment with topical therapy and occlusive bandaging, the use of wet wraps and advice to the patient or to parents all can be delivered within a specialist clinic within a primary care setting, other approaches, such as testing for contact allergy, or immunosuppressive treatment with cyclosporin, may need management in a hospital setting.

4 Nurse specialists

4.1 A dermatology service in the community providing specialist care would normally require the services of an

appropriately trained nurse. Guideline HSG/96/31 requires the Expert Advisory Panel to comment on the 'details of appropriately skilled and qualified support staff, including nursing support, giving details of relevance and experience'.

4.2 In the context of a secondary dermatology service, one would anticipate that the nurse attached to the clinic had experience of treating dermatology patients within a hospital-based dermatology department, and/or had undergone a period of Level 2 training in one of the dermatology modules available in the UK. In addition, they should be in contact with the British Dermatology Nursing Group (BDNG) who co-ordinate educational opportunities and training for nurses specialising in dermatology care, both in hospital and in the community. Liaison Dermatology Nurses have been established in several areas of the UK and provide an excellent model for co-ordinating the treatment of dermatology patients between hospital and the community. In any event, close liaison between the practice nurse and dermatology dedicated nurses in the local hospital would seem desirable, if only to ensure continuity of patient care.

5 Links with the local hospital

5.1 It is clear from the foregoing that the provision of Secondary Care can only be delivered effectively in a primary care setting if close liaison exists with the local dermatology department. The applicant must be trained so that the required level of expertise is attained. The applicant should continue to work under the supervision of the local consultant so that expertise is maintained. Protocols for the management of common skin diseases should be agreed with the local consultant. Clinical practice in the community clinic should be monitored by regular audit. In addition, close liaison needs to be established, so that the treatment of patients who require hospital-based facilities can be co-ordinated. Although guideline HSG/96/31 allows the GPs to function independently of the local hospital, it is apparent that this would be impractical for most dermatology patients requiring secondary care.

RECOMMENDATIONS

5.2 Involvement of the local hospital is therefore an important element in the success of any scheme delivering secondary care for dermatology patients in the community. The Committee recommends the following:

- 1 A statement by the applicant, accompanied by appropriate documentation, that he/she has the necessary qualifications and experience to provide the clinical service under consideration.
- 2 A statement by the local consultant dermatologist or other consultant responsible for training that the applicant's qualifications and experience are satisfactory.
- 3 A detailed plan for the delivery of secondary care, jointly agreed with the local consultant dermatologist.

- 4 The level of support provided for the service by the local hospital department should be discussed and an agreement with the Trust for whom the consultant works should be drawn up. This may require change to the normal contractual arrangements.
- 5 If nursing services are required, then the above plan should include details of how this is to be provided and how it is to be co-ordinated with the local hospital.
- 6 Arrangements for CME should be in place so that dermatological skills are maintained. Ideally the applicant should work with the local consultant in at least one outpatient clinic each week

5.3 The above proposal should go forward for consideration by the Expert Advisory Panel. The Expert Advisory Panel is there to consider whether the proposal seems likely to offer a clinically effective, locally appropriate, and cost effective service of good quality. At least one member of the Expert Advisory Panel should be the local consultant dermatologist. In addition, the Panel should invite the regional advisor to the Royal College of Physicians, in order to ensure that the above guidance has been adhered to. The RCP Advisor may well delegate this function to the Specialist Dermatology Advisor to the Royal College, who in most regions is the regional representative for the British Association of Dermatologists.

Special considerations

5.4 The Panel should pay particular attention to the following:

- 1 The likely cost of the service; the level of resourcing that the proposed service will require; and the demands on other practice staff and support staff.
- 2 The panel should also ensure that the GP has appropriate professional indemnity to cover the service proposed.
- 3 They should ensure that patients have a choice in being referred to a GP specialist clinic, or the local hospital and that the patients are clearly aware of the standing of the GP.
- 4 Plans for clinical audit of the service should be drawn up and an agreement to report the results of the audit to the Health Authority's Clinical Audit Group.
- 5 Plans for CME in dermatology should be stated.
- 6 Finally, the panel should ensure that the service being offered is not a diagnostic service. The clinical remit should be limited to specific procedures and specific areas of treatment.

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APPETITE AND OBESITY: Disorders of over- and under-eating

Edited by Peter Kopelman

Why do some people eat more than they need, and others less, even though enough food is readily available? And why are some more susceptible to suffer consequently from the ill effects of over- or under- weight?

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