Special Interest Groups in the College

Ian St George, Censor in Chief

For several years the College struggled with its relationships with doctors, often its own members, who developed a special interest, subspecialised, and even restricted their practice to a new subspecialty. They were no longer generalists; they might accept referrals so they were no longer primary care doctors, yet they were colleagues who had educated themselves to a higher level of expertise in one aspect of our discipline, and we, educators ourselves, admired that. They formed groups to exchange ideas and continue their education.

The Medical Practitioners Act 1995 provided the stimulus for these doctors to formalise their standing. Palliative care was a good example. Many of the prime movers in that new specialty came from General Practice (many too came from internal medicine, as well as a range of other specialties), yet for several reasons outlined above, General Practice felt unable to accommodate them. Eventually they became a Chapter of the RACP. Family planning looked elsewhere too, and sports medicine did it alone.

So we eventually agreed to a set of criteria for the recognition of Special Interest Groups (SIGs) in primary care.

1. The subspecialty should be a primary medical care discipline.
2. A substantial proportion of the contents of the subspecialist's practice should be in that subspecialty.
3. The subspecialty should demonstrate a significant level of active, ongoing scientific enquiry.
4. The group should be working towards meeting the criteria for vocational registration.
5. Notwithstanding the above, the College reserves the right to determine what it accepts as subspecialty.

You can see where we were driving: we didn't want those groups who had become secondary care specialties; we didn't want GPs who were doing a little sports medicine but mostly continued as GPs to feel they had to leave the mainstream College and join a special interest group; we didn't want fringe crazies or quack exploiters; we did feel an obligation to help the groups evolve into vocational branches in their own right, though we had difficulty in perceiving exactly how this would happen; and we were still anxious enough to have a let-out clause that gave us the right to refuse any group we didn't like the look of.

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The College Council delegated to its Board of Studies the responsibility for considering requests for recognition. Recognised Special Interest Groups would be offered Affiliate membership of the College. Individual members of affiliated groups would be able to hold Associate membership of the College and would be entitled to all Associate members' rights and responsibilities.

We asked applicant groups a lot of questions:

- How many members does the group have?
- How many members are currently Fellows of the RNZCGP?
- How many members are currently Associate members of the RNZCGP?
- How many members of the group have trained as general practitioners?
- What are the specialist origins of other doctors in the group?
- What modalities are undertaken by doctors in this subspecialty?
- Why is there a need for a separate vocational branch for the subspecialty?
- Why is the RNZCGP considered to be an appropriate 'umbrella organisation' for the group?
- Does the group have an existing training programme leading to some form of recognised qualification, e.g. a diploma, Fellowship of the group?
- Does the group have an existing programme, such as a Maintenance of Professional Standards programme, for the recertification of its members?

We approved Acupuncture Medicine, Breast Medicine and Appearance Medicine as SIGs. These were very different in their approaches and needs.

Breast Medicine had already been approved as a vocational branch by the Medical Council, on the basis of its excellent vocational education and recertification programmes. The Medical Council was anxious, however, that there were so few mem-

bers, and required the group to affiliate with a larger organisation: they chose the College, even though many of their members had come from other disciplines.

Acupuncture Medicine was at the other end of the scale: they were mostly general practitioners, mostly FRNZCGP, mostly part-time acupuncturists, and they needed vocational branch recognition to advance their field academically and in terms of outside recognition. They would use College GPEP Stage 1 and Primex, would provide Stage 2 Vocational Education, and would use College processes for their MOPS, emphasising acupuncture in their members' CME and audits.

All three groups, naturally enough, wondered what letters their members would put after their names. So did we.

Clearly FRNZCGP is meant to signify to people that this is a vocationally educated generalist, who has kept up his/her expertise and can provide a high standard of general medical practice. It would be inappropriate and potentially misleading to allow members of approved SIGs to use FRNZCGP.

Then, on 24 March this year, the College Council made an historically important decision:

"That breast medicine, medical acupuncture and appearance medicine, having already met the College criteria and been approved by Council as special interest groups of the College, should be given Faculty status, so their members will become

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Fellows of the Faculty of Breast Medicine of the RNZCGP (FFBM RNZCGP), Fellows of the Faculty of Medical Acupuncture of the RNZCGP (FFMA RNZCGP), Fellows of the Faculty of Appearance Medicine of the RNZCGP (FFAM RNZCGP), or other suitable mutually agreed names, subject to the following conditions:

- there is agreement to abide by the Rules and Regulations of the College;
- a satisfactory fiscal relationship is negotiated;
- the new group continues to demonstrate clinical and educational standards acceptable to the College; and
- new entrants to the group are required to sit Primex or equivalent acceptable to the Board of Studies."

The Council further agreed to support Medical Acupuncture and Appearance Medicine actively, in their applications to the Medical Council for recognition as vocational branches.

We have yet to complete negotiations on the relationships – fiscal, representation, membership of College committees, etc. – that the new Faculties will develop with the College, and you may be sure they will not be static: these are rapidly advancing areas of practice and our relationships must be fluid enough to allow unfettered evolution.

Already there have been applications from other new groups, including phlebology.

This is an exciting phase of development for the College. In accepting these new colleagues we have shown a preparedness to celebrate diversity, to accept differences, to make room for innovation, to consider evidence and accommodate change rather than react with doctrinal rigidity. In doing so we have affirmed the confidence we have in our processes, and the comfort we have in modifying them when necessary. We will be the richer for it.