This statement is part of the curriculum produced by the Royal College of General Practitioners (RCGP) which defines the learning outcomes for the discipline of general practice and describes the skills you require to practise medicine as a general practitioner in the National Health Service (NHS) of the United Kingdom. Although primarily aimed at the start of independent work as a general practitioner, it must also prepare the doctor beyond the training period and provide support for a professional life of development and change.
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### KEY MESSAGES

- Around 24% of the population consult their general practitioner (GP) regarding a skin problem in any 12-month period\(^1\)
- Most skin disease can and should be appropriately and efficiently managed in primary care
- About 14% of consultations with a GP are for the management of diseases of the skin. Maintaining competence in this area of medicine, is therefore essential for any GP\(^2\)
- There is variable \(\text{(and generally limited)}\) training in dermatology at undergraduate level which means that GP trainees should review their current knowledge and skills\(^3\)
- Currently about 90% of diseases of the skin are managed exclusively in Primary Care\(^4\). Most skin disease can and should still be appropriately and efficiently managed in primary care
- Skin disease can impact significantly on quality of life for patients and their families. As we GPs are in the ideal position to recognise this and help
- Skin cancer rates are increasing and outcomes depend on early diagnosis. GPs have a critical role in early diagnosis
- Skin disease can impact significantly on quality of life for patients and their families

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1. RCGP Birmingham Research Unit. *Weekly Returns Service Annual Report 2006*
2. Kerr OC, Benton EC, Walker JJ *et al* Dermatological workload: primary versus secondary care. *British Journal of Dermatology* 2007; 157 (suppl. 1). Looked at burden of dermatological disease presenting across 13 general medical practices in Scotland, serving a population of 100,000, over a two week period. Skin complaints accounted for 14% of all consultations in this study
   - Davies E, Burg S, *Audit of dermatological content of U.K. undergraduate curricula* *British Journal of Dermatology* 2009; 160, 999-1005
   - Chiange Y *et al* (including C Griffiths & S Burge) Undergraduate dermatology education: a survey of UK medical students *British Journal of Dermatology* 2008; 159 (Suppl.1)
4. Information from Hospital Episode Stats (2008) (www.statswales.wales.gov.uk) and data extrapolated from Birmingham RCGP Research Unit prevalence data 2006 in fact gave a figure of 6.1% of consultations for a skin problem resulting in a referral to secondary care
Mrs Jane Smith is 36 years old. She is a teacher and married to a computer engineer. They have two daughters, aged ten and eight. Apart from psoriasis she says she enjoys good health, apart from borderline hypertension (not currently on treatment) and a high BMI.

She has had psoriasis since her early teens. Initially this presented with guttate psoriasis after a sore throat, but that soon evolved into chronic stable plaques of psoriasis on the back of her elbows, front of her knees and scattered plaques on her torso – some quite small, others up to the size of the palm of her hand. From time to time she has less scaly, almost shiny, sore areas under her breasts and in her groin and umbilicus. In her scalp she has areas of very thickened scale, and she has a few plaques of psoriasis on the nape of her neck and behind her ears. She keeps her hair long to hide these. Her face, hands and feet are clear. Her nails are ‘quite brittle’ with a few areas of heaped-up scale under a few of them (especially her right index and middle fingers). She denies any joint pain or stiffness.

In the past she has noticed a significant deterioration in her psoriasis after a sore throat, and she continues to have a bad sore throat at least four or five times a year. Both Mrs Smith and her husband smoke up to 20 cigarettes a day. She rarely has any alcohol. She is on no medication other than the mini pill (her BMI is 31), which she continues, largely as it has stopped her periods.

She previously had about five courses of light therapy (as a teenager PUVA, but subsequently UV-B). The last course was at least five years ago.

She has tried steroids creams (up to Betnovate® strength), which have helped. More recently she has been using a vitamin D analogue ointment, but she says she finds this quite ‘irritant’ and so has abandoned it. She tells you that a further course of light therapy would be very inconvenient as she works all week. During the holidays she needs to be with the children.

As her GP you are aware that their marriage has been unhappy from time to time. Mrs Smith recently told you they were now sleeping in different bedrooms. They have not had a family holiday for some years.

You ask her how having psoriasis makes her feel and she bursts into tears. ‘No one has ever asked me that before,’ she says. She goes on to say it makes her feel dirty, uncomfortable and she is desperately embarrassed about it. It looks awful and she is aware she leaves a trail of skin scales wherever she goes. She refuses to take her daughters swimming and the idea of a beach holiday (which her daughters have been begging for) appals her. She is so unhappy about exposing her body that she cannot even get undressed in front of her husband. They have not made love for years. Recently she struggled to hide her tears when her daughter said, ‘Why do you never wear pretty skirts like my friend Kirsty’s mum?’
To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

| Primary care management | What tools could I use to measure severity (DLQI / PDI)?
| | What topical treatments might you prescribe for the various affected areas?
| | What do you know about ‘complete emollient therapy’ and its place in the management of psoriasis?
| | What advice would you give regarding the use of topical steroids in psoriasis (refer to NICE / SIGN guidelines 2012)?
| | Should you consider referring her for consideration of oral second-line therapies (e.g. methotrexate / ciclosporin) and if so, what advice would you give (note she is a smoker and has borderline hypertension)?

| Person-centred care | As Mrs Smith’s GP, how am I going to help her deal with her feelings?
| | How will I enquire about the impact of the condition on Mrs Smith?
| | What are Mrs Smith’s treatment priorities?
| | Should she be given advice about a pre-payment prescription?

| Specific problem-solving skills | If her treatment is going to be topical, how is she going to treat her back?
| | How will you manage the complexity in this case?

| A comprehensive approach | What is the additional risk of chronic, moderate or severe psoriasis accelerating atherosclerosis?
| | Mrs Smith is a smoker. Should I, as her GP, use this opportunity to discuss this with her?
| | What are the chances that Mrs Smith’s daughters might also have psoriasis and undergo a similar experience? They are now approaching the age when her psoriasis presented.
| | Psoriatic arthritis is often unrecognised, but it is essential to manage this actively, as it is common and destructive (NICE / SIGN guidelines). How would you evaluate the presence of this in Mrs Smith’s case?

| Community orientation | What community resources are available to support Mrs Smith?
| | What advice would I give if she asked about going to a local sunbed outlet?

| A holistic approach | What is the additional risk of chronic, moderate or severe psoriasis accelerating atherosclerosis? Mrs Smith is a smoker. Should I, as her GP, address this?
| | As Mrs Smith’s GP, how am I going to help her deal with the psychological and social impact of her skin disorder?

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5 The best access to the Dermatology Life Quality Index (DLQI) and Psoriasis Disability Index (PDI) is via [www.dermatology.org.uk/quality/quality-life.html](http://www.dermatology.org.uk/quality/quality-life.html)
| Contextual features | What do I feel about her asking for time off work because of her feelings around her psoriasis and the need for treatment?  
How will I support her if access to local dermatology services is limited? |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Attitudinal features | What do I feel about her asking for time off work because of her feelings around her psoriasis and the need for treatment?  
How hard should I work to help her if she seems unmotivated? |
| Scientific features | What is the evidence for the link between ischaemic heart disease and chronic inflammatory disorders such as psoriasis? |
LEARNING OUTCOMES

The following learning outcomes or objectives relate specifically to the management of skin problems. These learning outcomes are in addition to those detailed in the core statement, *Being a General Practitioner*. The core statement and this statement should be used in conjunction with the other curriculum statements. In order to demonstrate the core competences in the area of skin problems you will require knowledge, skills and attitudes in the following areas:

The RCGP areas of competence

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1 Primary care management

This area of competence is about how you manage your contact with patients, dealing competently with any and all problems that are presented to you. (This area of competence is not limited to dealing with the management of the practice.)

This means that as a GP you should:

1.1 Demonstrate appropriate history-taking for patients with skin problems, including *past personal history*, family history, chemical contacts, occupation and drug usage

1.2 Recognise the importance of skin-specific symptoms, e.g. itching and rash distribution

1.3 Understand how to recognise common skin conditions in primary care, e.g. eczemas, psoriasis and infections, and instigate appropriate treatment

1.4 Be able to distinguish benign from malignant skin conditions and make appropriate referrals

1.5 Recognise rarer but potentially important conditions and know when to refer to secondary care, e.g. bullous disorders and vasculitis

1.6 Recognise emergency skin conditions, e.g. erythroderma, anaphylaxis and herpetic eczema, and act appropriately

1.7 Be aware of local, alternative referral resources such as GPs with a Special Interest (GPwSIs) or specialist nurse practitioners

1.8 Know about shared care protocols with secondary care for the follow up of patients with skin cancer/lichen sclerosis et atrophicus and, where negotiated with the secondary care provider, those on isotretinoin

1.9 Consider reviewing all referrals to establish whether the input of secondary care is ‘value added’ and to establish any learning points for similar cases (i.e. meeting doctors’ educational needs (DENS))
2 Person-centred care

This area of competence is about understanding and relating to the context of your patients as individuals, and developing the ability to work in partnership with them.

This means that as a GP you should:

2.1 Identify symptoms that are within the range of normal and require no medical intervention, e.g. age-related changes such as dry skin/hair loss and innocent moles
2.2 Appreciate the feelings engendered by skin disease, which include fears about contagion (the ‘modern-day leper’) and concerns about malignancy
2.3 Empower patients to adopt self-treatment and coping strategies, where possible, in such conditions as mild eczema and mild acne
2.4 Appreciate the quantities of cream/ointment/lotion that should be prescribed to enable patients to treat their skin condition appropriately, and when to use each vehicle
2.5 Give advice on maintaining ‘healthy skin’, e.g. avoiding unnecessary chemicals and overexposure to sun

3 Specific problem-solving skills

This area of competence is about the context-specific aspects of general practice, dealing with early and undifferentiated illness and the skills you need to tolerate uncertainty, and marginalise danger, without medicalising normality.

This means that as a GP you should:

3.1 Be prepared to carry out appropriate examination of the skin, including:
   3.1.1 Addressing the need to undress the patient sufficiently but with sensitivity to dignity
   3.1.2 ‘Difficult areas’ such as the flexures, genitalia and mucous membranes
3.2 Recognise the spectrum of patterns and distributions of rashes of different skin disorders
3.3 Describe a skin lesion or rash using dermatologically accurate terms
3.4 Understand how to carry out more detailed tests where indicated, including skin scrapings and the use of Wood’s light
3.5 Understand the different indications for patch and prick testing, and when these are appropriate
3.6 Understand the role of histopathology and when to recommend incision or excision biopsy

6 See www.changingfaces.org.uk/home
3.6 Describe a skin lesion or rash using dermatologically accurate terms
3.7 Know the indications for curettage, cautery and cryosurgery
3.8 Understand the ‘alarm symptoms and signs’ for skin cancers that necessitate fast-track referral
3.9 Be aware of likely scenarios for contact dermatitis, where patch testing may be needed
3.10 Be aware of primary care resources and when to refer to secondary care so that patients receive appropriate treatment (such as light therapy, biological therapies or immunosuppressant therapy)

### 4 A comprehensive approach

This area of competence is about how you as a general practitioner must be able to manage co-morbidity, co-ordinating care of acute illness, chronic illness, health promotion and disease prevention in the general practice setting.

This means that as a GP you should:

- **4.1** Appreciate that pathology in other systems may lead to skin changes, e.g. skin manifestations of internal disease
- **4.2** Know the association between psoriasis and arteriosclerosis
- **4.3** Be able to advise regarding risk of long-term exposure to ultraviolet and sunburn, especially in children
- **4.4** Be aware of inheritance of common skin diseases, such as eczema or psoriasis

### 5 Community orientation

This area of competence is about the physical environment of your practice population, and the need to understand the interrelationship between health and social care, and the tensions that may exist between individual wants and needs and the needs of the wider community.

This means that as a GP you should:

- **5.1** Understand the effect of a patient’s environment/occupation on skin conditions
- **5.2** Know how to refer to rapid access clinics in secondary care where appropriate
- **5.3** Provide patients with information on referral options, if appropriate (GPwSI clinic/Expert Patients Programme (EPP)/specialist nurse/secondary care)
- **5.4** Understand that services other than the traditional secondary care, consultant-led service may be available, such as the British Red Cross Camouflage Service and other patient support groups, and refer appropriately
- **5.5** Recognise the evolving trends in disease demographics, e.g. the increasing incidence of skin cancers, an aging population and the increase in ethnic minorities
6 A holistic approach

This area of competence is about your ability to understand and respect the values, culture, family structure and beliefs of your patients, and understand the ways in which these will affect the experience and management of illness and health.

This means that as a GP you should:

6.1 Recognise how disfigurement (including problems like acne which can be seen by doctors as apparently clinically ‘trivial’) and cosmetic skin changes fundamentally affect patients’ confidence, mood, interpersonal relationships and even employment opportunities.

6.2 Appreciate the importance of the social and psychological impact of skin problems on the patients’ quality of life (sleep, disfigurement, messy treatment regimens etc.)

6.3 Appreciate the impact of skin disease on family, friends and dependants, and on employers and employment (i.e. career choices)

6.4 Empower patients to self-manage their skin condition as far as practicable

6.5 Understand the significant quality-of-life issues regarding common skin complaints, which can also impact on the entire family. You should also be aware of:

   6.5.1 Sleep disturbance from itching, especially for children with eczema (which can also cause disturbed, restless nights for parents and interfere with education)

   6.5.2 Isolation and loss of confidence, especially in young people with acne or disfigurement (e.g. vitiligo)

The essential features of you as a doctor

The three essential features (EFs) below are concerned with the features of you as a doctor which may influence your ability to apply the core competences to real life in the work setting.

EF1 Contextual features

This essential feature is about understanding your own context as a doctor and how it may influence the quality of your care. Important factors are the environment in which you work, including your working conditions, community, culture, financial and regulatory frameworks.

Examples of this are:

   EF1.1 Recognising how the cultural differences of your patient population might affect not only the spectrum of skin conditions but also their management

   EF1.2 Recognising the huge prevalence of skin disease in the community and its impact on patient’s lives and healthcare resources
EF1.3 Being aware of locally determined health service priorities, e.g. restrictions on prescribing oral terbinafine/Vaniqa®/topical immunomodulators

### EF2 Attitudinal features

This essential feature is about your professional capabilities, values, feelings and ethics and the impact these may have on your patient care.

Examples of this are:

- **EF2.1** Ensuring that skin problems are not inappropriately dismissed as trivial or unimportant by healthcare professionals
- **EF2.2** Whilst respecting dignity and observing appropriate hygiene measures, demonstrate that examining the skin and touching affected areas is acceptable
- **EF2.3** Empowering patients with chronic skin problems, including managing the effects of disfigurement
- **EF2.4** Considering the help of ‘expert patients’ for conditions like severe childhood atopic eczema or psoriasis
- **EF2.5** Valuing the role of other members of the primary healthcare team (e.g. specialist health visitors for eczema and wet wrapping, district nurses/nurse practitioners for leg ulcers and wound management)

### EF3 Scientific features

This essential feature is about the need to adopt a critical and evidence-based approach to your work, maintaining this through lifelong learning and a commitment to quality improvement.

Examples of this are:

- **EF3.1** Being aware of the major advances in therapy, including biological treatments such as TNFalpha blockers and monoclonal antibodies, for severe disease that has failed to respond to standard second-line therapies
- **EF3.2** Understanding and implementing the key national guidelines that influence healthcare provision for skin problems
LEARNING STRATEGIES

Work-based learning – in primary care

Skin diseases are common and many are chronic. They will therefore necessarily form a large part of your work as a GP. The patient is very likely to be an expert on their own skin and can often tell you a lot about their condition. One of the advantages of working in primary care is the ability to develop a ‘longitudinal consultation’ by inviting the patient to come back to discuss their skin problem. That provides a great opportunity to look up their condition in the meantime.

It is very easy to fall into the trap of dismissing many skin diseases as trivial (acne, for example), but patients tell us that although they have difficulty raising the issue of their skin problem or discussing it, even with a health professional, the truth is that it can have a considerable impact on their lives. Recognising this and treating the condition well makes an enormous difference.

Be prepared to ask difficult questions (e.g. ‘Does your skin condition cause you any problems or embarrassment in your relationships or at work?’) and always try to examine and feel skin rashes or lesions (usual hygiene measures of course). For a patient, the ‘laying on of hands’ by a healthcare professional dispels concerns of contagion and being ‘untouchable’, as well as helping them to believe you understand what they are experiencing.

Consider discussing with practice members all referrals that are made to dermatology specialists by yourself and your partners to establish what exactly you and your patients are hoping to achieve from the referral – in what way will it be value added? Review your referral again after the patient has been seen to decide whether the same benefit might have been achieved from resources available in primary care.

Consider arranging a Patient Satisfaction Questionnaire (PSQ) for patients with eczema or psoriasis in order to review your delivery of care. An annual Dermatology Life Quality Index (DLQI) assessment takes less than a minute to complete and would demonstrate to your patient that you are interested in the possible detrimental effect of their disease on their quality of life.

Also consider regularly auditing your patients who are on repeat prescriptions for psoriasis treatments. Have you considered whether they might have psoriatic arthritis, that they have previously dismissed as ‘wear and tear’?

Work-based learning – in secondary care

Attending community-based and GPwSI clinics both give you valuable learning opportunities for general practice. You can also reflect on each case and ask yourself: ‘Why was referral deemed necessary and what value-added input has the specialist provided?’
Non-work-based learning

Dermatology is high on the learning needs of most professionals working in primary care. As a result, you will find that talks on the subject are regularly included in many continuing education programmes. The Primary Care Dermatology Society (PCDS) mission is to educate and disseminate high standards of dermatology in the community. They run a regular series of ‘Essential Dermatology’ days up and down the country, as well as education events on minor surgery and dermoscopy (i.e. skin surface microscopy for increasing the accuracy in diagnosing both pigmented and non-pigmented lesions).

The British Association of Dermatologists, together with CRUK have recently produced a web-based resource for lesion recognition in Primary Care (www.doctors.net.uk/client/cruk/cruk_skin_toolkit_b09/)

On a personal level, your friends and relations will also experience skin problems and talking to them about their experience can be very enlightening.

Learning with other healthcare professionals

Experienced GPs will have seen a lot of skin disease, so ask them for their thoughts on it. Our nursing colleagues too are a remarkable reservoir of knowledge, approaching patients with skin disease differently from GPs. Specialist health visitors or district nurses are also worth talking to, as of course is the specialist dermatology nurse practitioner.

Remember that your annual appraisal provides an opportunity to reflect on your particular learning needs and plans.

Formal learning

The Cardiff Diploma in Practical Dermatology (DPD) (www.dermatology.org.uk) and the Barts Diploma in London (www.londondermatology.org/index.html) are each largely distance, internet-based learning courses (three terms over a year) with a summative exam and qualification at the end.
LEARNING RESOURCES

Examples of relevant texts and resources

A key resource is:


Other useful texts and resources include:


Web resources

British Association of Dermatologists

More designed for secondary care, but this is an excellent resource for patient information leaflets (e.g. on phototherapy or isotretinoin).

www.bad.org.uk
British Red Cross Camouflage Service
Patients who need ‘skin camouflage’ for scarring or disfiguring skin conditions can be referred to this service. Trained volunteers of the British Red Cross teach patients to cover and lessen disfigurements using specialist creams and powders.
http://redcross.org.uk

Cardiff University Dermatology Department
Good patient information resource. Also gives details of the Diploma in Practical Dermatology (DPD).
www.dermatology.org.uk

Changing Faces
Patients who may benefit from ‘skin camouflage’ for scarring or disfiguring skin conditions can be referred to this service. Trained volunteers teach patients to cover and lessen disfigurements using specialist creams and powders.
www.changingfaces.org.uk/Home

DermIS
Includes a photo library with a search function.
www.dermis.net

Dermnet NZ
Good search engine. Excellent library of pictures and descriptions of diseases (including the uncommon), which can also be used for creating patient information leaflets.
www.dermnetnz.org

DermQuest
This is an excellent picture library with news on clinical and research updates available for all. Other parts of the website can only be accessed by DermQuest members.
www.dermquest.com

eGuidelines
Gives UK guidelines for dermatology in primary care.
www.eguidelines.co.uk/hub/index.php?topicID=401
e-Learning for Healthcare
The e-LfH e-dermatology resource provides an excellent series of over 100 tutorials. You will need your GMC number and an NHS email address in order to be allowed access.
www.e-lfh.org.uk/projects/dermatology/register.html

Medscape
Medscape has easy-to-navigate, short dermatology articles.
http://emedicine.medscape.com/dermatology

National Psoriasis Foundation
This site includes photos and short descriptions on psoriasis.
www.psoriasis.org

National Rosacea Association
Includes patient education materials and information for physicians.
www.rosacea.org

Primary Care Dermatology Society
This is the best web-based resource out there. It gives really good practical advice on managing the common skin problems seen in primary care (see clinical guidance section) and has excellent pictures.
www.pcds.org.uk

Royal College of General Practitioners
RCGP resources include minor surgery information.
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