

Osteoarthritis in primary care

Policies advocating self management need re-evaluating

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Osteoarthritis is the most common cause of disability in elderly people in the developed world, and pain and restricted activity are the most common symptoms.¹ Disabling chronic knee pain alone is thought to affect a quarter of all elderly people in the United Kingdom.² Traditional approaches to treatment such as joint replacement are successful for people who have advanced or severe disease, but they are not useful for most patients, who present with milder symptoms or at earlier stages of disease progression. Targets for preventing osteoarthritis of the hip and knee are similar to those for many chronic diseases—for example, controlling weight, increasing physical activity, improving education and psychological health, and avoiding injury. However, optimal management of symptoms and of restricted activity in people who already have hip and knee pain is a priority for general practitioners, as this can reduce the prevalence of disability among elderly people in the community. A trial in this week's *BMJ* assesses one of the ways this may be achieved, by teaching patients to manage their arthritis in the community.³

Simple strategies of effective self care that deal with all aspects of pain management—from physical activity and analgesia to psychological health—are needed. Such strategies will only affect chronic pain and disability at a population level if they involve most elderly people with osteoarthritis of the hip and knee. So who should initiate and maintain self care for osteoarthritis? Government policy has encouraged lay led initiatives such as the expert patient programme, despite the lack of evidence showing benefit on health outcomes.

The randomised trial reported by Buszewicz and colleagues in this week's issue is a major achievement for research in this field with its large sample, complex design, and collaboration between a voluntary organisation delivering a self management programme (Arthritis Care) and an academic group.³ The trial found no significant improvement in pain or physical function in patients allocated to the self management "challenging arthritis" programme compared with the control group after one year. The authors conclude that widespread referral to such a programme from primary care would not result in substantial health gains for patients with osteoarthritis of the hip or knee.

This conclusion does not mean that such programmes should not be undertaken. Several earlier trials, mostly based in the United States, have shown

that volunteers can cope better with their arthritis after these programmes, and many of the components of the UK programme (such as good information about the condition) should be made available for patients, simply because this is good practice. Furthermore the potential therapeutic benefits of providing choice, or of matching interventions to the expectations and preferences of patients, are a priority for research in this field, though the trial reported this week was not designed to deal with such issues.

The finding that the programme did not greatly improve pain and physical health status contrasts with consistent evidence from other trials where health professionals introduced self management strategies. Advice from physiotherapists or nurses about specific or generalised exercise regimens has improved pain and reduced disability in daily life, at least in the short term.^{4 5} The interventions in these trials were no more intensive than those in the challenging arthritis programme. However, the evidence published in this week's issue challenges the idea that simple sustainable self care or lifestyle changes in patients with osteoarthritis of the hip or knee will be effective when delivered by lay led or expert patient programmes.

It might be argued that only through patients delivering such programmes will sufficient numbers of patients with osteoarthritis be included to have an effect on pain and disability at a population level. Yet even this is brought into question by Buszewicz and colleagues' study. Disappointingly, 30% of participants randomised to the programme group failed to attend any sessions at all. This raises questions about the feasibility or attraction of such programmes as community-wide interventions.

Patients randomised to the programme in Buszewicz's trial did have better self efficacy and anxiety scores after 12 months, although the effect on anxiety was small. We do not know if the modest effect of the challenging arthritis programme on a person's perceived capacity to manage their condition might translate into future improvements in pain and disability. Based on evidence from observational studies that cognitive and emotional factors are important predictors of persistence of pain and poor outcome in people with chronic pain,⁶ beneficial effects on pain and disability might emerge in the long term in patients who received the programme.

What do these results mean for clinical practice and health policy? Evidence about long term clinical

effectiveness and cost effectiveness of many non-surgical treatments—such as self care, analgesia, anti-inflammatory drugs, and physiotherapy directed exercise—is lacking. We cannot assume that generic programmes are the best way to achieve changes in confidence, attitudes, and other psychosocial variables in all patients with osteoarthritis, or that such changes will be large enough to alter the future course of the disease. The government is committed to increasing the number of places on the expert patient programme, which is similar to the challenging arthritis programme, from the current capacity of 12 000 to

100 000 by 2012. The growing body of evidence about self management programmes stresses the need to question whether this policy will achieve its desired outcomes, namely long term gains in health coupled with reduced use of healthcare services.

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Advance care planning in primary care

Uncomfortable, but likely to engender hope rather than dispel it

Of the various trajectories of physical decline, organ failure is often the most difficult to plan for in advance because of its unpredictability.¹ The qualitative study by Davison and Simpson in this week's *BMJ* challenges the notion that early discussion of planning for the end of life will destroy hope rather than create it. Rather, it allowed patients dying of end stage renal failure and their carers to reflect on and reorient their aspirations.² A wealth of evidence indicates that many elderly patients want to discuss these issues with their healthcare professionals, but this rarely happens even when (as in the United Kingdom) continuity of care with a trusted general practitioner is available.^{3,4} The main barrier is probably doctors' reluctance to raise the issue of planning for death because of the largely unfounded fear of destroying hope.

Advance care planning is practised in Australia, Canada, and the United States.⁵⁻⁷ It is also proposed as a cornerstone of the emerging National Health Service national end of life care strategy in England (<http://eolc.cbcl.co.uk/eolc>). It should enable provision of services in accordance with patients' wishes—for example, patients choosing home care rather than other places.⁸

Advance care planning is now defined as a process of discussion between a patient and professional carer, which sometimes includes family and friends. This dialogue has two outcomes—an “advance statement,” which describes the patient's positive preferences and aims for future care; and an “advance decision,” which provides informed consent for refusal of specific treatment if the patient is not competent to make such a decision in the future. The last of these outcomes is especially relevant as the new Mental Capacity Act in England is due to be enacted in April 2007.⁹ The focus of advance care planning is thus shifting from

eliciting refusal of treatment from a minority of patients to identifying the preferences for care of most patients.

Internationally, advance care planning can be incorporated into primary care. In the UK this year, the new general practice contract has established practice based patient registers, including one for people who might benefit from supportive or palliative care and who might die within the next 12 months. Guidance has been developed through the Gold Standards

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Advance care planning: five point plan for primary care

- (1) Identify patients who may be in their last 12 months of life and add them to the practice's palliative care register
- (2) Assess their current health and social needs
- (3) Sensitive raise the following points with patients and their family or carers

What elements of care are important to you and what would you like to happen? What would you not wish to happen? Do you have a person who is willing to be a proxy or have lasting power of attorney?

If your condition deteriorates, where would you like to be cared for (first and second choices)?

Have you any other special preferences, requests, or comments?

Do you have a view on resuscitation if your heart suddenly stops?

These preferences should then be communicated to other services

- (4) Provide proactive personalised care and review this regularly with the patient and family or carers
- (5) If patients do not want a specific treatment should incapacity arise, seek specialist help to initiate a legal “advance decision”

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