General practice training in musculoskeletal disorders

Sir,

Recently there has been considerable discussion over the role of a national curriculum in general practice vocational training.[1,2] All general practitioners have special interests, but it is still essential that they should have an adequate education in all aspects of medicine in order to act effectively as the first line of treatment for their patients, and as a referral service when necessary. The recent white paper[3] means that the general practitioner will be faced with an increasing choice as to the timing and location of any referral. In order to make these decisions in a way which will provide maximum benefit to the patient as well as to practice and National Health Service finances, the general practitioner will need a working knowledge of each of the major specialties.[4] Musculoskeletal disorders form a major part of the general practice workload, accounting for 15.1% of consultations for male patients and 9.8% of consultations for female patients.[5] Among chronic diseases the rate of consultation for chronic rheumatism (arthritis) is second only to that for hypertension, and 10% of the cost of all general practice prescriptions relate to rheumatic disorders (Health and Personal Social Service Statistics, 1982).

The third national study of morbidity statistics from general practice reveals that 17.6% of patients consulting with conditions falling into the category of musculoskeletal or accident/injury/violence are referred for hospital treatment.[5] This is lower than the percentages for neoplasms, pregnancy and congenital anomalies but higher than those for the remaining categories of disorder.

Posts in orthopaedics are generally unpopular with general practice trainees as they are believed to have little relevance to general practice. The statistics quoted above suggest that this may be an unrealistic attitude. As interests and priorities are often established at undergraduate level we recently conducted a postal survey of medical schools in the United Kingdom. This revealed that only 2.7% of the undergraduate clinical curriculum is devoted to orthopaedics with an additional 1.7% to accident and emergency and 1.2% to rheumatology. There would seem to be a considerable disparity between the priorities allocated in undergraduate teaching and the importance in the general practitioner's daily workload. However, it must be conceded that a proportion of undergraduate teaching is devoted to teaching general principles of medical examination and treatment common to all specialties.

We also surveyed 20 general practice vocational training schemes. This revealed that only 10.5% of vocational training schemes included orthopaedics and 33% accident and emergency. Interestingly, a survey by Styles[6] of trainees receiving their certificate of vocational training in 1987 showed that 67.3% had done accident and emergency jobs. Part of this difference may be explained by a proportion of trainees realizing that their training would benefit from being more broadly based. Most concerning of all, was the priority allocated to musculoskeletal problems in vocational training half day release sessions. Our survey revealed that a mean of only 1.3 sessions had been allocated to musculoskeletal disorders per scheme in the last year. These sessions were almost exclusively devoted to sports injuries and low back pain.

The quantity of teaching devoted to a particular subject is only relevant if the quality is high and the trainees are interested. As a result of *Achieving a balance*[7] there is an increasing shortage of district general hospital junior staff in orthopaedics. It would seem that this provides a great opportunity for orthopaedic and general practice departments to collaborate to their mutual benefit. It will require increased effort from both parties to make these posts attractive, and to ensure that the teaching during these attachments is relevant to general practice. There would, however, be significant benefits in terms of patient care and the quality of future referrals, as well as an improvement in the general practitioners' ability to cope with some of the demands of the white paper.

A BOOTH

Department of Orthopaedics
Leeds General Infirmary
Leeds

References

1. Hull R. Training for general practice. *Br Med J* 1989; **299**: 996.
2. Hughes T. Hospital jobs in GP training. *Practitioner* 1990; **234**: 515.
3. Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients (Cm 555)*. London: HMSO, 1989.
4. Marinker M. The referral system. *J R Coll Gen Pract* 1988; **38**: 487-491.
5. Royal College of General Practitioners, Office of Population Censuses and Surveys and Department of Health and Social Security. *Morbidity statistics from general practice. Third national study*, 1981–82. London: HMSO, 1986.
6. W McN Styles. Analysis of hospital experience completed by general practitioner trainees in 1984–1987. *J R Coll Gen Pract* 1989; **39**: 96–97.
7. UK Health Departments, Joint Consultants Committee and Chairmen of Regional Health Authorities Steering Group. *Hospital medical staffing: achieving a balance*. London: UK Health Departments, Joint Consultants Committee and Chairmen of Regional Health Authorities Steering Group, 1987.

Long-term use of benzodiazepines

Sir,

In a recent paper, King and colleagues (May *Journal*, p.194) highlighted the lack of attention paid to the opinions of long-term benzodiazepine users and argued that users' attitudes about their own medication regimens should be taken into account in the debate about tranquillizer dependence.

We have recently presented a paper describing the characteristics of 205 long term benzodiazepine users (January *Journal*, p.22). From this population we contacted a random subsample of 145 patients, who were sent a letter on practice notepaper, signed by a research administrator (VS), on behalf of their general practitioner, inviting them to attend their own health centre, to discuss their treatment with benzodiazepines with one of two researchers. The invitation in no way suggested that attendance would result in their being withdrawn from benzodiazepine medication. Forty-four patients attended for interview and completed a semi-structured interview, four questionnaires of psychological ill-health, a measure of social problems and a 'benzodiazepine attitude questionnaire'. (Results from this research have not yet been submitted for publication in their entirety). Responses to a series of questions from the benzodiazepine attitude questionnaire are presented in Table 1.

These results bear interesting comparison to the study on minimal intervention with long term users reported by Cormack and colleagues (October 1989 *Journal*, p.327) where 22 out of 71 patients were able to stop or reduce their drug usage to below 100 doses per annum.

Unfortunately, in our study only 30% of those invited attended and completed all the assessments. Patients may have feared that attendance would result in withdrawal of drugs. If this is so then the figures on benzodiazepine dependency and willingness to modify or stop medication may represent an over-optimistic picture. It may be that the characteristics which determine non-attendance in such studies also predispose towards continued benzodiazepine dependence. It is therefore likely that a large proportion of long-term benzodiazepine users will be unwilling or unsuitable voluntarily to enter primary care withdrawal programmes. We have illustrated that long-term benzodiazepine users are characterized by a picture of physical ill health in a predominantly aged population. This patient group also exhibits a level of benzodiazepine intake that is usually below the originally prescribed