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

Table 1. Responses to benzodiazepine dependency questionnaire.

	Number (%) of patients ($n = 44$)
Importance of medication for coping	
Vital/very important	36 (*82*)
Quite important	6 (*14*)
Not important	2 (*5*)
Concern about being on medication	
Not concerned/slightly concerned	39 (*89*)
Definitely/very much concerned	5 (*11*)
Perceived ease of stopping medication	
Very/fairly easy	12 (*28*)
Fairly/very difficult	31 (*72*)
Opinion about current medication dosage	
Extremely high	0 (*0*)
A little high	4 (*9*)
About right	36 (*82*)
Extremely low	4 (*9*)
Willingness to stop medication	
Very/fairly willing	18 (*41*)
Fairly/very unwilling	26 (*59*)
Feelings if medication were changed	
Not concerned/slightly concerned	30 (*68*)
Definitely/very much concerned	14 (*32*)
Feelings if medication were stopped	
Not concerned/a little concerned	9 (*21*)
Definitely/very much concerned	34 (*79*)

dosage as they have often altered their dosage to the lowest most appropriate level and regard it as 'just about right'.

Our results are in many respects similar to those of King and colleagues and we agree with their statement that 'patients who take benzodiazepines ... have a range of attitudes and responses towards the drugs'. We also concur with their recommendation that patients' views of their treatment should be an important consideration. Indeed general practitioners who have already encouraged their patients voluntarily to reduce to a minimum or stop medication are now faced with a more difficult task in managing the remaining group. A balance has to be struck between risk and benefit to the patient, which in the current climate of consumerism may be difficult to achieve. Nonetheless the risks, especially of falls in elderly patients, argue against a laissez-faire approach.

R J SIMPSON
K G POWER
V SWANSON

Forth Valley GP Research Group
Department of Psychology
University of Stirling
Stirling FK9 4LA

Sir,

The paper by King and colleagues (May *Journal,* p.194) illustrates that patients must be given a choice in the matter of benzodiazepine prescribing, as in all other prescribing. Following the publication of the Committee on Safety of Medicines guidelines on benzodiazepine prescribing in 1989,[1] I set out to audit their use in my inner city single-handed practice with a view to rationalizing and reducing prescriptions. I saw all benzodiazepine users in the practice and gave them a choice: to slowly withdraw their tranquillizers under supervision or continue as before. I had two reasons for doing this. First, I wanted to concentrate help on those motivated to reduce or stop. Secondly, with regard to the medicolegal aspects of long term benzodiazepine prescribing and reports[2,3] of the possibility of litigation in this area of medicine, I considered that if every benzodiazepeine user were seen, advised and offered help, none could later complain about indiscriminate long-term prescribing.

Every patient prescribed any benzodiazepine during a three month period was interviewed, thus catching every known user. The patient was advised that current medical opinion did not favour continuation of such treatment and I was therefore offering to assist them in attempting to phase out the drug.

If the patient chose to continue, the prescriptions would be issued as before, and the outcome was recorded in the notes.

A total of 159 benzodiazepine users were identified (7% of the practice), of whom 105 (66%) were aged over 65 years and 37 (23%) were men. Thirty-three (21%) managed to reduce or stop benzodiazepines in three months, and the remainder either continued as before (72%) or increased their intake (8%). Of the 114 who chose to remain as before, 85 (75%) were aged over 65 years and their most frequent comment was 'why bother changing at my age?'

Thus in my small survey, most patients who were given the choice of supervised withdrawal or continuation preferred to continue taking their benzodiazepines, particularly those aged over 65 years. This implies that many patients taking benzodiazepines are either content with their drug use or cannot contemplate withdrawal because of their circumstances, even when other methods of relieving anxiety and insomnia are available. For prescribing doctors, if the choice of reduction and withdrawal has been offered to the patient and then refused, future patient dissatisfaction with long term prescribing should be less likely.

ROBERT M MALCOLM

7 Collingwood Drive
Beaumont Park
Hexham
Northumberland NE46 2JA

References

1. Committee on Safety of Medicines. *Current Problems* 1988, no. 21.
2. Smyth E. Tranquillisers which destroy your peace of mind. *GMSC News Review* 1988; October: 11.
3. Ashton CH. Dangers and medico-legal aspects of benzodiazepines. *Journal of the Medical Defence Union* 1987; 3: 6-8.

Out of hours care

Sir,

I would like to make some comments in the light of the very interesting paper by Perry and Caine (May *Journal,* p.194).

The practical consideration of returning to the surgery does I feel largely rule out any general usage of the medical records in out of hours care. In a major emergency such as asthma or heart attack the doctor would indeed be negligent if he or she delayed arrival in order to hunt for the patient's notes. Furthermore, where a rota is in operation, I feel many doctors would not be happy for members of other practices to rummage around at night in their premises.

The only solution to this problem would of course be for patients to keep their own notes, and I have worked with just such a system. Unfortunately, it seems unlikely that this would be generally acceptable in this country. If and when patient-retained 'credit card' records are available then the problem may be solved.

Many doctors, however, seriously question the relevance of patient records in the emergency situation. I did a brief study of 300 consecutive out of hours calls and came to the conclusion that 80% of cases were acute self-limiting conditions unrelated to any previous medical condition. A further 18% related to an ongoing medical problem, details of which I could obtain from the patient and a