

## Teaching rheumatology in primary care

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General practitioners (GPs) are, by name and by training, generalists. They have an extraordinarily wide knowledge base, and, in the course of a morning surgery may deal with all ages from the new born to the elderly, with minor self limiting disease to terminal care, with almost insoluble social problems to major illicit drug dependency, and with clinical problems in every specialty from gynaecology to psychiatry. It would, therefore, be impossible for all GPs to have specialist abilities in all subjects, though many primary care physicians do have in-depth knowledge of certain diseases.

Although GPs cannot be expert in all areas, they should have basic competencies in all the major diseases that they deal with each day. A problem with the musculoskeletal system is the third commonest reason for a patient seeking a consultation in general practice, and these problems account for 15% of all consultations in primary care.<sup>1</sup> If such patients could be adequately diagnosed and treated by the primary care team and with the resources within the community, this would reduce some of the pressure on secondary care and leave rheumatologists free to deal with inflammatory and connective tissue disease.

### Need for rheumatology education in primary care

In 1995 Lanyon *et al*, in collaboration with the Primary Care Rheumatology (PCR) Society,<sup>2</sup> evaluated rheumatology education and skills during vocational training using questionnaires sent to all GP trainees in the United Kingdom and their trainers. The survey concluded that rheumatology education needed to be improved, especially the component provided by GP trainers and local postgraduate centres. To date, however, little has changed.

There have been two main blocks to this process:

- Rheumatology is not considered a core subject by the Joint Committee of Postgraduate Training for General Practice
- There is no standard core curriculum as suggested by Lanyon *et al*.<sup>2</sup>

Efforts are underway to deal with these problems. The British Society for Rheumatology Research and Training Committee, together with the PCR Society, is in the process of discussions with the relevant bodies to try to make rheumatology a core subject. The issue of the curriculum has been also been tackled, and, under the chairmanship of Dr Martin Underwood, members of the GP Working

Party of the ARC Education Sub-Committee, together with members of the Steering Committee of the PCR Society, and representatives of the Royal College of General Practitioners have produced a core curriculum which we hope will be adopted for vocational training.<sup>3</sup> This curriculum was developed initially at a weekend meeting where the structure and general content were decided by the multidisciplinary group. This content was then refined by postal consultation in two stages before being sent to various educational authorities for comments.

### Core curriculum

The core curriculum includes:

- (1) A list of core clinical topics
- (2) A general framework for considering each topic
- (3) A list of drug treatments appropriate for the management of musculoskeletal problems in primary care
- (4) A list of professional groups relevant to the management of patients with musculoskeletal problems.

The clinical topics considered to be core include:

- Acute back/neck pain
- Chronic back/neck pain
- Shoulder pain
- Knee pain
- Soft tissue disorders
- Osteoarthritis
- Osteoporosis
- Somatisation/fibromyalgia and allied syndromes
- Pain management
- Acute arthropathies
- Chronic inflammatory arthropathies
- Polymyalgia rheumatica and allied conditions
- Awareness of rare diseases
- Chronic disability.

For all topics, the group considered it essential to be able to take a suitable history, perform a relevant examination, and have a knowledge of the relevant epidemiology.

Each core clinical topic is then considered in a general framework which includes the following themes—each assessed under the headings of “knowledge” and “skills”:

- Clinical assessment
- Functional assessment/patient impact
- Epidemiology
- Attitudes
- Team working

- Prevention
- Patient empowerment
- Principles of rational management
- Management of the impact on patients and society.

The full guide, entitled, *Learning Guide for General Practitioners and General Practice Registrars on Musculoskeletal Conditions*, is available from the Arthritis Research Campaign.<sup>3</sup>

### Specialist general practitioners

GPs with expert knowledge in specific disease areas are often influential in improving knowledge and education in primary care. GPs working in practice are much more accepting of educational activities arising from within primary care itself, rather than those imposed by secondary care. There may be several reasons for this:

- GPs working in primary care understand the nature of general practice, with its specific opportunities and stresses
- If a GP can undertake specialist treatments and educational activities while still working as a GP, other primary care physicians can accept that such activities are both possible and reasonable
- GPs with specialist knowledge usually have a good working relationship with secondary care staff; thus facilitating improved working of the primary care/secondary care interface
- There is a greater sense of ownership and partnership, rather than being seen as a “second rate” practitioner by some members of secondary care
- Some secondary care practitioners, while decrying the knowledge and skills of GPs, nevertheless fear GPs becoming too skilled, as they may then represent a threat. There is no doubt, however, that the better doctors are educated, in both primary and secondary care, and the more aware we are of each others strengths and expertise, the better care we will give our patients and that should, of course, be our ultimate aim.

### How to teach

When considering how to teach rheumatology in primary care it is important to include several different target groups:

- GP registrars who are training for three years in vocational training schemes with a mixture of hospital and GP rotations
- GP principals who are established in a practice
- GP assistants, locums, and retainer scheme doctors
- The practice team, including practice nurses, health visitors, district nurses, and other practice support staff.

Each group has different needs at different times and educational activities must be sufficiently flexible to deliver what is needed at the appropriate time.

GP registrars may have a rheumatology hospital post as part of their training, but there is no requirement for this. Rheumatology training is, therefore, largely delivered by the local postgraduate centre and by the GP trainers. As a result, the quality of this training depends on

the interests and enthusiasms of the people involved. Many postgraduate centres concentrate heavily on the quality of the teaching offered and run courses on “Teaching the teachers”. This, however, does not ensure that rheumatology is well taught because until it becomes a core subject with a recognised curriculum, vocational training in rheumatology will remain of variable quantity and quality.

Since 1992 established GPs have been required to gain 10 Post Graduate Education Allowance (PGEA) points every year, spread between disease management (DM), health promotion (HP), and service management (SM), in order to qualify for the PGEA. In most areas the older fashioned standard lecture format has been superseded by short talks, with more small group work, including practical demonstrations and case history based presentations. Meetings qualifying for PGEA points often concentrate on a particular disease and require input from hospital consultants as well as general practitioners. As a result, such meetings have had the potential for improving the interface between primary and secondary care locally.

### How can we improve education in primary care?

Cantillon and Jones describe three sequential factors needed to ensure change in medical behaviour.<sup>4</sup> These include predisposing factors (preparing doctors for change), enabling factors (relating new skills and knowledge to day to day work), and reinforcing factors (using reminders and feedback).

Ideally, educational activities should encompass all of the above and from a practical point of view, for education to be successful, it should be relevant to the doctor’s daily work, it should help to improve patient care, and should produce an outcome which the individual doctor can see.

Over the past few years postgraduate centres have looked closely at the kind of educational activities provided for primary care and have devised many interesting and challenging programmes. Those relevant to rheumatology include such topics as:

- Workshops on alternative treatments
- Cognitive approach to pain management
- Soft tissue and joint injection workshops using models.

Since 1997 more innovative ways have evolved by which GPs can gain PGEA points.<sup>5</sup> These activities have included:

- Practice based meetings
- Audit
- Personal learning plans
- Clinical attachments
- Critical incidents review.

Since 1998 it has also been possible in some areas to undertake a formal assessment of performance, including assessment of clinical skills, with an audit, a video of a consultation, and multiple choice questions.

### Continuing professional development

Continuing professional development (CPD) for general practice was defined by the chief

medical officer in 1998 as “Lifelong learning for all individuals and teams which enables professionals to fulfil their potential and which also meets the needs of patients and delivers the healthcare priorities of the NHS.”<sup>6</sup> This has the potential for significantly altering the way in which continuing medical education (CME) is delivered in primary care. GPs may now identify specific areas, which may need to be addressed either at a personal level, or at a practice level, and work out a plan to achieve CME. In rheumatology this could include:

- Audit—for example, long term use of non-steroidal anti-inflammatory drugs in osteoarthritis
- Critical event review—for example, a patient with a swollen joint
- Practice based meetings—for example, the long term management of patients with rheumatoid arthritis receiving disease modifying antirheumatic drugs
- Clinical attachment—for example, to learn joint injection techniques
- Personal learning plan—for example, techniques for pain management in chronic musculoskeletal disease
- Computer based self assessment—for example, the management of acute and chronic gout
- Distance learning—for example, Diploma in Primary Care Rheumatology by the University of Bath and the PCR Society, available as a six module complete course or as individual modules on a particular theme.

All of the above would increase the doctor’s knowledge, and his or her sense of achievement, and facilitate team working within the practice, while at the same time improving patient care.

### Structured educational plans

There are more structured ways of providing this kind of individual professional development and multiprofessional development. As an example, the West of Scotland Postgraduate Medical Education Board has created a number of different projects, which are at present being piloted.<sup>3</sup>

#### INDIVIDUAL PROFESSIONAL DEVELOPMENT

Computerised Evaluative Learning Tool (CELT) is a software program incorporating self directed learning, which is linked to clinical work within the practice.

#### MULTIPROFESSIONAL DEVELOPMENT

Team Involvement in Development and Learning (TIDAL) is a project which helps practices to develop their own learning and development plan in line with whatever are seen to be the priorities in an individual practice. This might depend on service needs or on the particular interests of the staff concerned.

Quality Education and Service Delivery through Teamwork (QUEST) is a cooperative venture between the Department of Postgraduate Education, the Health Board Training Department, and a management company, which aims at providing education and at the

same time establishing and improving efficient working relationships among all staff.

These innovative educational activities have great potential not only for fulfilling all the criteria already mentioned for education to be successful, but also for increasing cooperation between practices and providing a focus for educational activities within primary care groups (PCGs).

The advent of PCGs provides increasing potential for educational activities tailored to suit the needs of the local population. The providers of these educational projects face interesting challenges in producing and supervising packages that fulfil the needs of doctors, patients, and other health professionals.

Many educational resources, using information technology, are now available to help GPs individually. Most GPs use a computer in their daily practice and have ready access during their working day to guidelines, protocols, and patient information sheets, which can be printed off as required. Increased familiarity with the internet gives access to evidence-based clinical guidelines, databases, scientific papers, and review articles from well known and well accredited sites. Interactive CD Roms also provide education on various topics and give instant feedback to the participant.

Although many new educational activities are taking place in primary care, Cantillon and Jones point out that many of these have not yet been fully evaluated and that methods of evaluation have yet to be developed.<sup>4</sup>

### Evaluating clinical outcomes in primary care v secondary care

Trying to compare clinical outcomes between primary and secondary care may be quite inappropriate and not relevant to improving patient care. Conditions dealt with in primary care are often quite different from those seen in secondary care and the best and most appropriate treatment in these situations is in the community.

Such conditions might include:

- Soft tissue problems
- Osteoarthritis
- Polymyalgia rheumatica
- Fibromyalgia
- Mechanical back pain
- Osteoporosis
- Gout.

Patients with such conditions may of course sometimes need to be referred to secondary care, but with access to community physiotherapy, occupational therapy, dual x ray absorptiometry scanning, etc, primary care is well equipped to deal with most of these problems.

Patients may require referral for a variety of reasons:

- To confirm diagnosis
- To help with management
- To facilitate access to specialist treatments—for example, physiotherapy
- Because of patient pressure:
  - Patients may insist on a second opinion and this can happen quite often even within one general practice with a patient

- consulting different partners
- Patients with chronic painful disease may become disillusioned with their care in general practice and feel that nothing is being done for them.

Referrals for these reasons are perfectly justified, but one has to be aware that the patients referred are an entirely different group from those managed within primary care. Outcome may be poorer in referred patients for a variety of reasons, both physical and psychological:

- There may be increased severity of disease
- Failure of initial management might indicate unusual or more complex problems
- Waiting time to outpatient appointment may increase chronicity of the problem making management more difficult
- Waiting time may increase the likelihood of work related issues
- The patient's perception of failure of initial management of a chronic condition may lead to inappropriate expectations from a secondary care consultation.

On the other hand, the time lapse until patients are seen at outpatients may produce a natural remission in symptoms, leading to those working in secondary care wondering why the patient had been referred in the first place.

Patients with inflammatory joint disease and connective tissue disease or with unusual or complex problems should, of course, be referred to secondary care. Comparison of outcome in these circumstances would again be inappropriate.

#### **Clinical evaluation—the way forward**

Comparison of outcomes is only valid if we compare two similar groups. For the reasons already stated the patient population differs considerably between primary and secondary care. The way forward in evaluating clinical outcome should include an appraisal of how all patients with musculoskeletal disease are treated at present and should consider the best way forward to improve their care. This should involve close cooperation between primary and secondary care together with community services such as physiotherapy, occupational therapy, and social services, and with input from relevant patient organisations, to provide the best care possible within the existing limitations of staffing, time constraints, and financial restrictions.

Primary care groups have the potential to deliver this kind of service, especially in the field of chronic musculoskeletal disease. Over the past few years some chronic diseases, such as diabetes, asthma, and hypertension, have been targeted for increased attention, with most GPs now running clinics for monitoring the care of such patients. With these conditions, it is possible to measure definite end

points such as HbA1C in diabetes, peak flows in asthma, and blood pressure in hypertension. Although it is possible to monitor patients with chronic musculoskeletal disease using algorithmic indices and other instruments, this is much more difficult and time consuming than with many other diseases.

With a chronic condition such as osteoarthritis, good management requires practical help and advice, repeated patient education, and encouragement and support by all members of the practice team during times of disabling and painful flares of disease. The ability to provide such management over many years is one of the attributes of a caring primary care physician. PCGs, hopefully, will look at the problems presented by these patients in the community and take steps to provide for their needs by:

- Encouraging closer cooperation between primary and secondary care
- Identifying lead primary care physicians to provide services to PCG populations and to act as liaison between primary care and secondary care
- Increasing education for general practitioners, practice nurses, ancillary staff
- Improving lines of communication between all staff concerned
- Encouraging closer cooperation between practice staff and community staff
- Involving patient representatives and support groups
- Providing educational resources both for professional staff and for patients.

Over the course of a GP's professional life huge changes will occur owing to advances in medicine, organisational changes in the way primary care is delivered, increasing emphasis on cost effectiveness, and changes in society itself. Unless a primary care physician takes part in lifelong learning he or she will not be able to maintain and continue to improve patient care. As medicine becomes ever more complex, it is increasingly important that all involved in patient care continue to work together to provide continuing education and support. We can all learn from each other and from our patients.

- 1 Office of Population Censuses and Surveys. *Morbidity statistics from general practice—4th national study 1991/92*. London: HMSO, 1995.
- 2 Lanyon P, Pope D, Croft P, in collaboration with the Primary Care Rheumatology Society. Rheumatology education and management skills in general practice: a national study of trainees. *Ann Rheum Dis* 1995;54:735–9.
- 3 *Learning guide for general practitioners and general practice registrars on musculoskeletal conditions*. London: The Arthritis Research Campaign, (in press). ISBN 1 901815 00 5.
- 4 Cantillon P, Jones R. Does continuing medical education in general practice make a difference? *BMJ* 1999;318:1276–9.
- 5 Kelly D. Lifelong learning. *Scottish Medicine* 1999;18:14–15.
- 6 Chief medical officer. *A review of continuing professional development in practice*. London: Department of Health, 1998.