Interview with GP 1 October 2003

IH **So could you tell me a little bit about what you have had as a student and junior vocational training in rheumatology?**

GP We had a good training in rheumatology. I trained at [local medical school]

IH **Ah**

GP Which was well known in it's day for having a decent rheumatology department, we, but that is rather esoteric rheumatology, when you come to do general practice it is totally different.

IH **Yes yes**

GP In the vocational training scheme that I did, which was a very long time ago, I don't think we did a lot of rheumatology, but I think what we had was quite well taught, but most of it you learn on the job

IH **Exactly that is my next question really, who taught you and was it self taught or?**

GP Well we run a post graduate education sort of scheme in the practice in that we have people round to talk to us and we have had some good speakers

IH **Right**

GP Dr H taught me how to manage PMR, I don't think we have had [names local rheumatologist] along, but anyway we have different rheumatologists in different things.

IH **And is it mainly lectures or?**

GP well usually lectures in adult education rather than interactive and our post graduate things that we have in our practice are not everyone sitting around usually, it is asking questions that you don't actually know the answer to, to provide a supportive environment in which it is alright to admit that you do not know what to do with osteoarthritis of the knee – then people ask.

IH **How about developing practical skills, how is that managed?**

GP I have been on a lot of courses to develop practical skills. Actually I am not sure that courses are brilliant at teaching you I think really the only way, well it depends on your learning style, some people can learn very well from, can learn easily from a course and go away and see a diagram of a shoulder on a blackboard and then go and inject one, but I actually think that you really have to have a practical approach. I am very good on the models
.

IH **Yes**

GP But I have not actually done the shoulders

IH **Right**

GP Um I am very happy to do some plantar fasciitis

IH **OK**

GP It just depends if that is the sort of practical thing that you mean

IH **Yes**

GP And other practical skills that would be useful would be manipulation, so if you work with a GP with a special interest who can show you how to do that I am sure that will save a few people.

IH **Mmmm**

GP I tried to do it on torticollis. I am not very good and could do with learning. And then of course the other practical skill which is jolly useful in rheumatology is acupuncture.

IH **Yes**

GP But I don't know how to do that, but I would not mind learning.

IH **Yes you are absolutely right**

GP And physiotherapists ought to teach us more so strapping for limbs and how to examine joints and simple exercise regimes to show patients are probably best taught by physiotherapists who actually know how to teach you.

IH **Yes**

GP That would be very good

IH **Yes. What is your spectrum of musculoskeletal disease that you see at the moment?**

GP A very broad spectrum really starting from little children with funny feet and working up to 100 year olds with ache and pains everywhere and encompassing all the other musculoskeletal ailments to which the body is heir and that you might find in a population of 10,000 patients in North London!

IH **Really quite widespread?**

GP What do you actually mean? It's a funny question.

IH **OK I mean what is the common thing you most see?**

GP Common things commonly occur so what are the common things? Mostly it is muscle sprain, aches and sport injuries that get better by themselves and then there is the spectrum of osteoarthritis and wear and tear and out of those you have to pick the nuggets of all the connective tissue disorders. Is that what you meant?

IH **The bulk is very much osteoarthritis, soft tissue, back pain, is that right or, do you see a lot of back pain?**

GP Yes you get a lot of back pain in general practice you certainly do. You will have to come and do some general practice if you don't know .
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IH **On no I do! Your confidence in managing musculoskeletal conditions.**

Is there a point at which you think you, in the disease that you feel less confident about managing or do you feel confident in most aspects of musculoskeletal?

GP That is a tricky question really because it depends what you mean by managing. If you mean do I know what the ultimate end is going to be for say an osteoarthritic knee – I do actually know that, but managing it is also about managing the patient's expectation and patient education.

IH **Yes**

GP And about – sometimes a good part of that is about referring people to a specialist or a specialist laying on of hands, even though you know jolly well that it is actually absolutely useless as part of the intervention to change the course of the disease, but it changes how patients see the problem and so I am confident, that I think I might know what is happening most of the time, I am not confident in examining joints.

IH **Right**

GP I don't feel at all confident that I know whether you have torn your supraspinatous or whether it is I don't know – ruptured deltoid. I would not like, I don't really think I am competent in that.

IH **Right and is that due to not How why would that be do you think?**

GP Partly not bothering, not thinking it is frightfully important because if you have a painful shoulder I have a regime that will treat you irrespective of what the actual underlying cause is, but it would be fun to know.

IH **Right. Are there any other areas which you would like to know a little more. Be more confident?**

GP All of it, I would love to know a bit more about it. It would be good fun to know more about it. Whether it would be entirely useful.

IH **I was going to say would it benefit your patients?**

GP Well it might do if one can say with confidence that you know exactly what is going to happen and what is wrong sometimes that rubs off on the patient who is then happy with your explanation and doesn't cast about looking for alternative strategies.

IH **How would knowing, having increased knowledge about aspects of rheumatology, would that improve your satisfaction in dealing…**

GP Oh yes it would be entirely satisfying being able to refer to rheumatologists to tell them which muscle it is.

IH **That is part of what I want to try and do**

GP What?

IH **Increase primary care and patient satisfaction if we can**

GP Only because it is more fun, but I don't know that it would actually alter, it depends where you are coming from. If you are coming from educating people to enjoy their job, then that is fine, but it is probably jolly useful to know, if you are looking at how to get the case burden of rheumatology through primary and secondary care and out the other side quicker or more better triaged, I don't know whether it would change it.

IH **Right**

GP I think you might be being a bit hopeful if you thought that just because you could make a better diagnosis you would then do anything different about referral patterns or that you would do anything different necessarily about treatments, but maybe that is because I do not know enough.

IH **No I think that is a very valid point**

GP Sometimes when you know more you refer more

IH **That is absolutely right**

GP So if I did know every little muscle in the toe that was upset I might very well send them along for an MRI scan to prove it via you, whereas if I don't know I might well diagnose a painful foot and let them limp for many years. It is an interesting thing.

IH **Yes I mean I think as you said increasing knowledge – I don't think the aim is to reduce referrals.**

GP Right I did not know what your aim was

IH **No no the aim is to provide you know a service for local GPs to increase their knowledge**

GP Yes well that is [IH interrupts]

IH **With a view to I mean not with a view to, they can be either to refer, that is the outcome I want to look at, is what happens after that. Are GPs involved in the training course referring more or less**

GP Or differently

IH **or differently**

GP Or do they just have better letters

IH **That is the kind of thing. There is no sort of. The outcome is to change the balance.**

GP There ought to be an agenda to try and improve the rheumatology throughput

IH **Yes**

GP Because at the moment it is one of the specialties that certainly in our locality in North Barnet where the waits are too long

IH **I mean there is a problem there aren't enough of us around**

GP And there aren't enough specialist rheumatologists around

IH **Yes that's right This is what rheumatologists are dealing with osteoporosis**

GP Are they?

IH **Yes that's right. We are being referred patients with osteoporosis**
GP Because osteoporosis is in a bit of a quandary, because does it belong to gynaecology, does it belong to endocrinology, does it belong to orthopaedics,
IH **Well I don't think it …….**
GP Does it belong to general practice
IH **Well yes….**
GP Or does it belong to rheumatology? I never thought of sending osteoporosis patients to rheumatology. I would have sent them to orthopaedics
IH **I don't think orthopaedics has a role, because I don't think**
GP I thought they would be good because they see all the fractures
IH **Well**
GP And they should treat
IH **But they don't, they don't**
GP That doesn't matter you should teach them to do it
IH **We do we teach them to refer them to us**
GP Oh right
IH **Because audits have shown that the pick up of osteoporosis after treatment of osteoporosis fractures by the department is quite low and it is a process of education. Gynaecologists see a lot of post menopausal osteoporosis. We see a lot, we get referred osteoporosis too. I don't know, it depends where you work. We take the bulk of it.**
GP It depends where you work that's right
IH **You are being very … your giving me a lot today – I am only teasing you, but I think over a period of time that rheumatology has taken on the role**
GP No it would be ideal if you don't think it should be in general practice because I mean I think maybe you can do difficult osteoporosis, but you can't do bone scans here can you?
IH **We go to the [local hospital] for those**
GP And you never get the results do you?
IH **We do, it takes four months**

GP Well it's ridiculous why don't you fight that it is so stupid
IH **We have tried to there have been moves to get a scanner in here**
GP I know it takes four month, but it takes four months for the results to get back
IH **No no four months to get the test**
GP Oh yes, but even after that you don't get the results back from the test, it is a poor service
IH **It is it is. However the portable scanners that are around aren't reliable enough**
GP For what?
IH **The ultrasound scanners and I think for osteoporosis**
GP They are alright for ordinary
IH **I think they are OK to say whether you are at risk or not, but then to monitor if you want to monitor people and there is a whole thing about whether you should**

monitor people by DEXA scan is another argument
GP You probably cannot afford to do that as it is so common
IH **Yes**
GP That you would have too many put through

IH **It is not actually that expensive, it is probably the manpower, rather than the actual test, the time of the person doing it that costs the money. I think there is place for ultrasound machines saying you are at risk, you are not at risk. If you are at risk then you go and have a DEXA scan to confirm what level you are at. That is probably what should happen and I think using an ultrasound machine to say your level is high, medium or low. None of the machines are calibrated with each other, there is no gold standard at the moment. Do you have one in your practice?**

GP No we use [names regional centre]

IH **Yes it's a great service then**

GP Yes

IH **To have two, one in town and one up there, the waiting list is relatively small , but that would be something you would be interested in hearing more about?**

GP Yes Yes I just hadn't thought it would be in your remit

IH **Oh absolutely**

GP I thought you only did painful knees.

IH **No no I am very interested in it myself**

GP You are interested in

IH **Yes**

GP I think osteoporosis is fascinating

IH **Do you see a lot of it directly or more indirectly**

GP How do you mean?

IH **People coming to you worried about it?**

GP Yes we have the primary screening part, and the guidelines have not be drawn quite widely enough to include everybody although they should be and then we've got preventative bit where people who have been on steroids for years for some reason or other and haven't had any bone medication because it was not around at the beginning and who are now we don't quite know what to do about it.

IH **Are you confident with the current treatment regimen available?**

GP What do you mean?

IH **For osteoporosis**

GP I don't know why to use one rather than another

IH **Yes**

GP I don't know why I should send you off with Alendronate and you off with Fosamax. I don't know how you choose between them.

IH **That might be something you would like to know more about?**

GP And what else? Hmmm

IH **I mean the rarer soft tissue disease, do you feel that's something that primary care should know more about?**

GP We find them and send them to you, what you should look at is whether we send them too late, could we have sent them earlier.

IH **Do you feel it is something primary care should be involved in treating, managing long term?**

GP We are involved in treating it long term, because you have your job for a couple of years and you trade up on one of our patients, we keep them forever.

IH **Sometimes general practitioners are happier with looking after patients with soft tissue disease**

GP We do look after them, we look after the patient

IH **Absolutely**

GP The patients who need very specialist management and I don't think it should be actually particularly in primary care.
IH **Right**
AP I think
IH **Oh yes you look after the patient as a whole**
GP The long term management of the person is very important and it is a major problem is the turnover of staff in rheumatology because for instance the connective tissue disorder unit down the road has an enormous turnover of staff, it is a big department and the patients find it very difficult to have relationship an on going continuity of care relationship with each of the different trainees who look after them.
IH **Sure sure**
GP And then are off again and so sometimes that does need to be co-ordinated a bit. I have patients who have been going down 15 years and seen by the registrar every time and the consultant has forgotten what they are like
IH **I think you will find [Dr J] knows everything about every patient. It is quite amazing actually.**
GP He is very good, but it is things like that can happen and it is the GP, the primary care needs to know sort of how they should be watched, not the nitty gritty of it but the type of global view.
IH **Yes yes – when to worry**
GP When to worry and when to say look isn't it time this was looked into. One of my chaps had a rectal bleed which he had been telling people about for the last three years, but in the rheumatology department, but because it was not rheumatological it was not picked up probably - and he did not come back to primary care because he was going the rheumatology
IH **So regularly yes**
GP So rheumatology has a primary care function. They should bounce back to us things that are not really it.
IH **What do you think of the relationship between primary and secondary care in regards to rheumatology.**
GP It is jolly good, I'm surprised you said it wasn't.
IH **No no I meant that in a more analytical sphere, not on a ground level**
GP Oh well I think rheumatology is more or less the last bastion of the general physician as well because you send, well I can send people who I do not know what is wrong with them to a rheumatologist and get them sorted out which you cannot very much do with any other specialty.
IH **Do you feel that is a valuable access to have?**

GP Yes very useful mainly because you can actually think over more than once system, because having your connective tissue disorders you have to realise you can get SLE causing heart problems as well as brain trouble, gut trouble and joint trouble and it is all emcompassing.
IH Is there any way it can be improved further
GP What?
IH **The relationship**
GP I think it is a bit of a personal thing if you are working in an area then I think the rheumatologists are usually sort of known for being quite caring set of intelligent people. I don't know what else you could do.
IH **I mean communication. Do you feel that is good?**
GP Well you need secretaries

IH **Yes**

AP Well that is very important because actually the patient needs a point of contact where in some of your connective tissue disorders they ought to have a quick way to get back when they are not right and your secretarial staff are very important in communications, or if you have got a specialist nurse it would work just as well

GP **What about communication between us and you?**

GP Do rheumatologists talk to GPs do you mean?

IH **Yes**

GP Yes I think you have to.

IH **Do you think there is enough of it, should there be more of it?**

GP The rheumatologists I work with seem to be OK. I mainly work with the rheumatologists at [names hospital] and I think that is fine. I do think rheumatologists have to watch it though because they get burnt out. I have noticed that

IH **Right**

GP But the consultants get to a stage and they cannot take any more of the chronic moaning people when you can't do anything. It gets to them. You have to watch out for that.

IH **Is that different to how you could say the same for primary care?**

GP Well I think primary care is better because you get all the excitement, I mean tomorrow it might be a rare disease might walk in through the door.

IH **Is there a different way of dealing with it or…?**

GP I think, I just think the cases might be, but I don't know. I have noticed the rheumatologists get burnt out and they get cynical and they get a bit short with their patients which they did not used to be early in their careers they become kind of 'Oh no another whatever it is' and they loose compassion

IH **Right is that because of workload**

GP I don't know why it is,I suppose it could be workload or else the frustration. It can be endlessly frustrating rheumatology eventually, not while you are excited by it, but eventually because there is a great big core of people for whom you can do nothing and yet they still come back and tell you that they are still troubled and would like something to be done and you can do nothing and learning how to manage that, so a psychology bit on your course would be useful.

IH **We need to know that**

GP Chronic disease management and how to engender positive attitude. The arthritis care programme. Do you know about that?

IH **Yes**

GP That is really good. Someone who has thought up that, the patient's voice, sort of laymembers voice in your education thing would be very good. As to how to make people put up with not being OK.

IH **Yes well I have been involved in the patient partners programme actually, patient partners with back pain and I was thinking of using them to lead a discussion.**

GP Yes it is another technique and it saves the patient being a kind of heartsick patient, because patients with chronic degenerative disorders are often heartsick patients. The connective tissue disorders you always feel you can do something wonderful for even if it is poisonous.

IH **But how many of one group does outweigh the other in numbers?**

GP Oh yes yes, but knowing how to do nothing fruitfully is a very useful thing if you can pull it off

IH **Oh yes very**

GP And you can learn how

IH Yes there are techniques and you think that would be useful for primary practitioner as well?

GP Yes some sort of cognitive behavioural technique to teach your patient how to put up with a chronic illness would be really good and you could, the other thing would be nutrition, because the osteoporosis and the obesity and so forth it really is important good nutrition, plus the connective tissue disorders. People's immune systems could be made to work properly. Eating is vital and it is a neglected area. So you will find a lot of your connective tissue patients actually do not have their five vitamins every day.

IH **And what form do you think the course should take. What is the best format in your view?**

GP That is incredibly difficult because no format is any good except one that you

can fit in in about 20 minutes, I don't know

IH **What I am trying I mean I am giving you the option of didactic lectures at one end and you've got self directed learning at the other**

GP It depend who you are going to target it at for and you might have a mix because learning curve vary. I would like my 50 shoulders lined up and you watching me do the first two and you say right here is another lot and then I am competent at the end. Right, so for certain things

IH **Yes**

GP For other things just having your enthusiasm rekindled, but it has got to be able to be delivered.

IH **What with I mean from discussions with other primary care practitioners I have had is case based problem solving.**

GP Yes amusing especially if you can bring your own cases and get them solved without having to put in too much effort.

IH **Yes that is right, do you think that is a good way to learn**

GP Yes it is very practical, problem based learning approaches is very cunning

IH **And do you feel that is better or worse than me standing in front of you in a lecture theatre talking about systemic lupus for about 40 minutes?**

GP Well maybe you should do that too, keeping our attention and making us not pick holes in it and actually making us think it is relevant

IH **By doing a case based scenario**

GP A case based scenario would probably capture people's interest wouldn't you because they would be a bit competitive about trying to get to the answer before anyone else. That sort of thing would be fun

IH **And how about the use of computers, the internet as a way of learning, expanding your knowledge. Have you had any experience of that?**

GP Yes I think that is brilliant. Bath does a thing on primary are rheumatology

IH **Yes yes**

GP And I am doing the diploma at the moment. Which is all internet, well 99% of it, and that is really good they have done it really well you ought to

IH **I will have a look at that actually**

GP To see how they have done it

IH I mean that is something for the future, but

GP I think the software is the most difficult

IH **Oh yes**

GP Otherwise that is lovely fun, but I don't know whether you set that up it would be good. You could set that up on the NHS net

IH **Sure there are lots of ways it could be done.**

GP And then you could have a mixture couldn't you? Lectures, MCQs, pictures
.

IH **I think that is the way forward**

GP You could have patient's stories, but it is continuing it that is the thing. Because you can go and have a little burst on rheumatology

IH **Well that is my next question, what is the best way to keep that knowledge up**

GP I don't know, maybe the internet is good at that so you kind of have MCQ's and prizes once a month, a year or something for your 'old' students, allowed to go back and have a refresher.

IH **And how about the practicals, should injections for example? If I took you through your 50 and you were competent**

GP But the trouble is there might not be another shoulder for about three years

IH That's the question then what do you do? After what period of time would you have to come back?

GP **For accreditation?**

IH Yes

GP Well if you look at the family planning accreditation revalidation they have a requirement for revalidation of coils insertion which there you have got to have done I don't know, 12 in a year of something and you cannot get revalidated unless you do it.

IH **Right**

GP So you could have a validated qualification

IH **Yes**

GP For doing say joint injections

IH **It's a good idea**

GP Which would then actually allow other grades of staff to be validated to do it in the same way and therefore we could enlarge to pool of people who are allowed to do say joint injections and I don't see why physiotherapists can't do it

IH **That is happening**

GP And the validation system, there will be one for physios you can bet your bottom dollar and there isn't one for us.

IH **You're right you're right**

GP And you could have quite a lot of people doing this and you could have, the practice nurses could become competent in quite a lot of those techniques.

IH **Yes**

GP And then you ought to train the next set of people up to do epidural injections, there would have to be a specialist

IH **Yes yes**

GP I don't see why not, we are multipotential cells, you can teach us to do anything, we have a differential

IH Thanks for taking part, thanks a lot.