Interview with GP 2 September 2003

IH Firstly, can you tell me about your undergraduate and postgraduate experience in rheumatology?

GP Errm, I did rheumatology at [Teaching Hospital] but don't really think I saw it As being relevant at the time. Since becoming, a GP, I have been to a refresher course which was very useful and that was held down at [redacted]

IH **Right**

GP That was just an afternoon and it sorted reminded me of how to examine and I did a minor surgery course which showed me how to inject the shoulder and things

IH **OK**

GP That was sort of during my GP training bit

IH **Right OK**

GP So really I have had nothing for three years

IH **And how did what you did prepare you for actually doing the job?**

GP It was quite good because I actually learnt how to examine joints and ligaments and you forget fairly quickly, although you see osteoarthritis every day and then the rarer arthritis stuff you don't see so much and also I was happy sort of examining the knee, but I don't know how to interpret the findings and I think that was my problem really

IH **Right**

GP You know you know there is a shoulder problem, you know there is a swollen knee, what are you going to do with it, what is the next step should I do something myself or should I be referring it on. So it kind of allowed me to examine properly and vaguely know what was going on, I also did MRCPG which had some questions on rheumatology which was quite useful and reminded me about quite a lot of common problems, but it is actually the examination and following it through yourself so you do not have to refer on which is lacking really.

IH **How much of your practice is due to musculoskeletal complaints would you say?**

GP Well I saw ten patients today, two of them had problems with their joints, one has got positive auto immune screen who I have referred to the hospital, the other one, a young mum who has a three year old kid with Down's syndrome who I think has tendonitis.

IH **So 20%?**

GP Yes yes, that is every day something will come in a knee an elbow, osteoarthritis, at least one or two patients a day as we have quite an elderly population

IH **How do you view your confidence in managing musculoskeletal conditions at the moment?**

GP Getting better, I think that seeing them and learning from things that have worked for other patients, you apply it to the others, so osteoarthritis I am pretty confident. I know it is quite limited management and I am very happy with that. I have not actually diagnosed rheumatoid arthritis really, the rarer ones, but because they are rare, I know what to do with those, it is the common sports injuries, the knee problems, 40/50 year old people with gout I am not so sure about.

IH **Right and that is something that you see quite a lot of?**

GP I see gout once every couple of weeks probably every two or three weeks. Knee problems, somebody comes in with knee problems every week.

IH **Back pain?**

GP Back pain, yes every week, every couple of weeks young people usually quite obviously they have suddenly stood up – very limited mechanical back pain. You know what to do with that. It's when it goes on a bit you think what can I do with that - is it suspicious.

IH **Right**

GP I am quite confident yes

IH **And what current things do you do to keep up with educational development in rheumatology? Do you go to clinics or lectures?**

GP No I try to go to lecture if I can, I have not been for a while. I have done the exam last year and that is what reminded about the guidelines on mechanical back pain. I try to flick through Update which is a magazine I get which has a lot of stuff on osteoporosis and rheumatoid arthritis and things like that so that tells me about the drugs and what to use. I was reading about injecting shoulders and whether it is useful which it probably isn't. So it is mainly reading and if I can, ad hoc lectures, evening clinics.

IH **Right. Does that change your practice?**

GP Sometimes it does yes. When I went to [redacted] about three years ago that really helped to change my practice, streamline everything.

IHI **What was that about?**

GP That was a lot of stuff on – reminding me about all the rare stuff, what to do about pain, what to do about osteoporosis.

IH **And what form was the lecture in, was it a lecture or small group work or..?**

GP The other thing I do use is I have a book by [names author] which shows you how to do joint injections which I have used and I feel quite confident because he actually taught me on the [redacted] course and he was very good.

IH **And that was how long ago?**

GP That was 2-3 years ago

IH **How often do you perform joint injections**

GP Not very often – It is more, I have done maybe three or four in the last six months.

IH **Do you feel that is enough to keep up your confidence or would you rather do more?**

GP I would rather do more. I was teaching the registrar the other day and he was saying minor surgery injections and things is something where you need to go to a clinic amalgamate all the patients from all the practice and do a clinic once a week and keep doing it and then you will become confident with injections

IH **Which joints are you confident about injecting?**

GP I think I would be confident injecting a knee and at a push I would probably do a shoulder.

IH **Right. Anything smaller?**

GP I have also done an elbow, which was not very successful, but I did a couple. It is good to actually just do it even though it might not work. But as long as you explain and you say that you think it is worth trying it, but you know, hands I am not happy with, not sure about the but a lot of the shoulder is quite, well it depend how big the patient is

IH **How do you feel, how good are the mannequins that you practice on, are they realistic.**

IH **OK so a lack of standardisation.**

GP Yes there is there is a bit of conflict.

IH **Yes right. What would you say your learning needs are for you to help you develop your rheumatological practice. What would you like?**

GP Probably either you know, occasionally sitting in with somebody who does injections or examines knees and shoulders and you know, maybe not that often may be every couple of months to update yourself again. Or may be sitting with a GP who does a lot of

injections and things and just actually get used to doing it.

IH **What are the barriers to that?**

GP The barriers are there is no facility in the PCT of doing minor surgery in a group of practices, which I think will be a good idea and I am sure things will change with the new contract in the next couple of years. But at the moment that is not possible, our practice is not very interested in doing injections really, no-one is skilled enough, if you want to volunteer yourself then fine, but they are not strong enough to teach you and there is no, there are not enough rooms in our practice and there is not enough time therefore, and so the resources, the lack of rooms, there is no clean space, no clinical space in which you could do it

IH **Right**

GP Once we change I think it will make it a lot easier, because you would have a definite work space for doing injections all sorts of minor procedures that is all going to take two years, until then they are probably going to have to be seen in somebody else's clinic, which is not ideal.

IH **Right so there are infrastructure and time issues around that. And what do you think are the important things around that, I mean obviously it is huge topic like any medical specialty – what are the areas any training course should concentrate on?**

GP I think at the moment a lot of it is evidence based especially as a GP osteoporosis is a major issue, what does it mean to the patient, what do you do with osteopenia, When do you put people on HRT? Especially given the worries about that. You know reminders about how to examine shoulders, which examination means which muscle could be quite useful, the more information you give on a form for physiotherapy, the easier it will be for the physiotherapist to get information and actually get the answers, those are the sort of things we should concentrate on, examiantion.

IH **Drugs?**

GP Drugs yes, how effective are Cox-2 inhibitors. Well I am kind of learning that because they are not much better than anything else and that is by experience, but for a new GP I think learning about all the drugs would be quite useful. Knowing about side effects of drugs for rheumatoid arthritis

IH **Right**

GP Because we have one or two patients with severe rheumatoid who have been put on gold, penicillamine and nasty Methotrexate and only by chance have I come across them and asked for a full blood count and they have been on these drugs for ages.

IH **What about the sort of more rarer connective tissues diseases, lupus, do you think that is important that you need to know?**

GP I think you need to have an idea of it, in a lecture theatre setting to remind you about the rashes, and to remind you about the case history

IH **But not in-depth management?**

GP I don't think so you see that so rarely, what you see every day, someone who can't walk because they have really bad arthritis which does not show very much, but you can see that they are suffering. It is what you do with that patient. You know because it is about management so that they can get about and do their normal activities. They do not want to be told there is a nine month waiting list.

IH **How do you cope with that I mean where do you, every patient that you do you send to secondary cares so what do you do?**

GP I am quite honest with them about what the limitations are in terms of 'Look you've got arthritis, osteoarthritis, it is progressive these things are important, certain things are important, keep fit, keep the weight off, maybe try and do some exercise, cod liver oil, those sort of things I have learnt by trial and error and they do seem to work and being honest, this much we can do, but beyond that you may eventually need surgery – hip replacement, but those things are quite limited and it may not get to that point, lets try and keep you as fit as possible, and being honest with them saying they may do certain things, but they are not going to do anything. Physiotherapy is only limited

IH **What is your access to physiotherapy like?**

GP It is not bad, but sometimes it takes a month to be seen. Most of them go down to [local clinic] ,I mean if you are really worried about someone you can ring them.

IH **It is not bad**

GP It is not bad, I mean it is one of the best facilities really that we have

IH **Do you think you are using them appropriately?**

GP I do sometimes wonder if I am using them a bit too much, but half the time I get the feeling that once I refer to rheumatology there aren't any physios anyway, so what I am trying to do is just get that whole process started, so that when they are seen in clinic they are already in that management.

IH **Yes so at what point do you decide you would refer to secondary care?**

GP I think when the pain level is great, they are limited because they have problems such as gastritis and I have used all the medication I am happy to use or when I think it has got to the point where they are not able to sleep at night or they need to consider surgery then I do

IH **But generally, musculoskeletal problems in general?**

GP I would probably say I would try medication and try physiotherapy, if at that point after a course of physiotherapy they are no better I would refer. I would probably give it a couple of months, but if things are getting worse or there is no improvement at all, then I would refer on. I mean you usually find you can give eight weeks of management and you have a sort of idea that they can take the pain if things are getting better. That is the good thing about GP work you have time to go back and look at it.

IH **Yes do you think that is the practice with the rest of your colleagues?**

GP Yes I think so, I think they are pretty good at containing most stuff. We tend not to refer thousands to rheumatology, partly because we know that they are really busy, but also we may just ring up for advice rather than transfer the lot.

IH **Do you know of other colleagues who have difficult practices?**

GP No I think they are all pretty good, I mean [name of GP partner] probably tries to keep a lot of stuff to himself because he does a lot of acupuncture and he might try that as a method as well, so we also have that to our advantages in the practice. I think on the whole I have learnt my practice from my trainers and they tend to be very pragmatic about it, let's try this, let's try this medication and if not let's refer on.

IH **Do you think that is an appropriate way to learn from your colleagues in primary care or with secondary care?**

GP I think once a year it is important to have an update on secondary care because things are changing so much and I think not necessarily for our practice, but some practices are out of date and so it is really good to be updated by your colleagues and it also give you an opportunity to actually see who you are referring to and have a better relationship with them. So I think a once a year update would be very useful.

IH **And what is your view on outreach clinics**

GP Never heard of them

IH **That is when secondary care doctors come to a GP surgery to do clinics**

GP I think it is a good idea, especially with an elderly population I think it is a really good idea because you have a lot of need and not enough resources, so getting someone into practice once every couple of weeks is like a gold dust, it is a really good idea.

IH **Right yes**

GP I wish it happened more, even if it was, they came to our practice but other practices could refer in. That would be a good idea, because you can go to talk to them about cases you may be worried about and you have ease of access.

IH **So anything else, any training courses given to you how you would like the training to be given, over what period of time?**

GP I mean I think, maybe someone coming into the practice once a year so that you meet other teams……..

IH **That may be more realistic**

GP That is more realistic so you don't have to go to every single practice in a certain area, you could share that person and have an afternoon. Also practical stuff, doing joint injections on mannequins is always very useful as it gives people a chance to talk to the expert about how they are doing it, it may be useful to offer other sessions in the clinic, say you are welcome along if you want to learn about things, make it easier for GP registrars and new GPs who just want to come and sit in and not feel like they are being treated like medical students, but would actually sit and learn. If we knew that that was available to us I think

IH **Do you think that coming to a postgraduate centre for an afternoon and learning you know a small group of lectures would be as good or not as good or?**

GP It is probably not as good as seeing patients. When you see a lot of patient you actually learn a lot more.

IH **Rather than case based teaching?**

GP Well an opportunity every six months to come and do the joint injections and talk about them properly and topical courses, bring your problems with you and discuss them would be useful as well.

IH **Right and do you feel that, talking about injections again, everybody should be doing it or?**

GP Not everyone is happy doing it and I think that those that are happy to do it should continue as they tend to get better, but everyone should be shown how to do it at least once they are a GP Registrar, but you have set skills and you cannot do everything. I think if at least one person from a practice is happy to do it I think that is what you need.

IH **And they should be have top up training every how often?**

GP Every year, every couple of years, if you are doing it all the time, then every two of three years is probably enough, but if you are not doing it that often, then every year.

IH **So should they be doing it all that is the question?**

GP Well limiting yourself to things you are absolutely sure, you know about the landmarks but don't do any joints, but if you are only doing knees for instance .but are not happy doing anything else and that is what I've done and that way you get better at that one joint and then you can move on to doing other things.

IH **Yes**

GP More comfortable

IH **Do you feel that patients with musculoskeletal conditions are better served in primary care of secondary care?**

GP I think we manage them quite well in primary care. We keep a lot of things away. I think the things that aren't managed very well are say occupational things, musculoskeletal problems and that is something else we ought to know more about. Stress injury, back pain, sitting at work doing the same job, how to manage those sort of things, how you write the sick note properly. Those sort of things we need to know more about. On the whole I think we manage quite well in primary care, we keep a lot of stuff away. The rarer stuff always goes to secondary care and I am quite happy with that.

IH **Yes sure**

GP But I think we manage OA and stuff like that very well.

IH **And do you think it is appropriate, best for the patient to be managed in primary care?**

GP I think so, say the GP reads it, you get the physiotherapy access, community physiotherapy and then something like as you suggest may be an outreach clinic is such a good idea because it kind of gives you tips from the expect about what you should do and then they will take them on and it is just ease of access really, so I think primary care is probably easier

IH **Thank you very much**

GP It's a pleasure.