Interview with GP 3 September 2003

IH **Could you just tell me a little bit about how long you have been practising and where you work at the moment?**

GP OK. Alright, that's fine. Well I trained as a General Practitioner and did my vocational training the early eighties and I qualified as a fully fledged GP and did MRCGP in 1985. After that I went to work abroad and I worked abroad for many years, 15 years in various aspects of international health and I came back to this country in 1999. After a couple of years doing consultancy work I decide to return to general practice and I am actually a returner.

IH **Right**

GP So although I am quite old I have not been in general practice all that long really.

IH **Yes, yes**

GP I did a six month returner course and then I did a salaried job for a year and then I have been a partner for just about a year and half.

IH **And what was your experience of rheumatology as an undergraduate and pre vocational training?**

GP Erm, it's quite a long time ago

IH **Yes**

GP I should say

IH **Yes**

GP Erm, I don't think we got very much training in rheumatology. I was a student at the [redacted]

IH **Oh right, yes**

GP Erm ……. So we must have had some, but I don't recall it……

IH **Yes, no that's fine, that's fine**

GP Very much. When I was doing my vocational training I was in a practice that did quite a lot of it so - minor surgery and things like that and I did joint injections and so on there. It was quite an isolated practice, it was in [redacted] and the main hospital was in [Town] which was about 50 miles away so obviously we had to do quite a lot ourselves, so I did joint injections and things then

IH **Right**

GP I did a casualty job as well which involved quite a lot of rheumatology and you know things like dealing with effusions and stuff.

IH **Right and how did you pick things up – was it a sort of see one do one? Or was it sort of .**

GP Yes yes absolutely. No formal training

IH **Right**

GP People showed you how to do things and then you did them.

IH **Yes yes**

GP I mean when I was overseas we did not do, I mean obviously you know rheumatology is not a major thing really

IH **Yes**

GP So obviously we did not really do very much of the sort of rheumatology that people do here.

IH **Yes**

GP Although we did a lot of orthopaedics and things

IH **Oh right**

GP Erm you know, dealing with emergency fractures and such

IH **Yes yes**

GP And so when I came back here I what I've done so far is I've done the minor surgery course

IH **Oh yes, Dr. A.**

GP That's right which involved some practice with joint injections on models which is really helpful, but I don't think it has made me feel confident to start doing it again and what I would really like to do – I mean perhaps jumping the gun

IH **No no no absolutely**

GP Actually I would like the opportunity to participate maybe for two days in a joint clinic where I'd get lots of opportunity to do, both to see you know how the consultant deals with problems, but also to get practical experience doing things like joint injections and become confident doing them

IH On a real person

GP Yes on a real person, because although it was alright doing it on a joint it is not the same is it and

IH **No not at all, not at all. And what joints would you be comfortable about injecting?**

GP Erm you mean once I have been doing that?

IH **Yes**

GP I think I would be I would certainly be OK with, you know, elbows and that sort of err medial lateral epicondylitis, probably shoulders erm, I would probably be OK with knees actually.

IH **Anything smaller?**

GP Errm I would be, I mean I know you can do wrists, but I would be a little uncomfortable about wrists I think and I do not think I would be able to do anything smaller than that.

IH **And how often do you think you would require refreshers?**

GP Well I think that once I got going, once I had a really good couple of days with outpatients with lots of doing it, there are plenty of opportunities to do it in our practice.

IH **Right**

GP One of our partners does it

IH **OK**

GP Quite a bit, but of course we don't get much opportunity to share those kind of things within practice because the patients are not there at the right moment when you are both there so it is difficult

IH **Right**

GP So what we generally tend to do is you know if someone needs a joint injection we either refer them to the community clinic or whatever or to the GP in our practice, but I think once I started to do them I would get plenty of opportunity to keep in practice and might only need updating if things change.

IH **Right, yes. How much of your practice at the moment – what percentage of your patients come in with musculoskeletal problems?**

GP Very difficult – it's a lot!

IH **Right**

GP What with the back pain, knee pain and all the rest of it. It is difficult to say really, but I should say maybe 15%? I suppose, I mean I don't know what it is.

IH I **mean standard, the standard from previous studies have been about 15 – 20%**

GP Yes I would say that is probably about right.

IH **Yes and what is the range of conditions that they have mainly?**

GP Mmmm erm knee problems, especially, well, two sorts of people have knee problems – elderly people and then younger people particularly young men of course, knee problems. A lot of back problems, a lot of people with back problems and shoulders. They are the main things, frozen shoulder and elbow.

IH **Right. OK. Osteoporosis?**

GP Umm. We do see quite a few people with that, in generally I feel more confident about that, because the treatment is mostly medical. The problem that we find is that it is very slow to get their bone scans and things done

IH **And you can arrange those directly?**

GP We can arrange those directly – we usually send them to Nuclear Medicine department at the [hospital] but there is a very long …

IH **A couple of months at least wait**

GP Yes very long wait which I think is not great

IH **And what about the sort of inflammatory arthritis and the rarer connective tissue disease, do you see much of those?**

GP Not a lot no – I mean occasionally we pick them up but

IH **Yes**
GP It is not … the main thing is sort of, you know, traumatic wear and tear
IH **Yes**
GP Those kind of things

IH **Yes ok. Um what would be the, for any training course that would be set up – what would be the emphasis – what emphasis would you have – what subject areas?**
GP Well I think as I said the practical issues I think is very good yes I think I mean osteoporosis I think would be a very good area to have in a training course because it is obviously very topical and because now you know we are not doing HRT so much so we need to be much more updated in you know in the alternative ways of dealing with it , so I think those are quite important. I think what else with rheumatology, nothing really springs to mind at the moment – may be if you mention a few things!
IH **Well I think people have said ,I mean OA treatments for OA, back pain, treatment for pain**

GP Yes yes
IH **Soft tissue problems, joint injections, rheumatoid arthritis, the most common inflammatory arthritis**
GP Yes
IH **Those are the things people have said.**
GP Yes I think those are the things we need to know about.
IH **I mean the rarer sort of lupus and things like that, do you feel that is appropriate?**
GP Well I think it is important to be able to recognise those, but I do not think we really need to know a lot about them.
IH **Yes**
GP Because you know we are going to refer them to secondary care, so we need to be able to identify something that is out of the ordinary so that we can refer it.
IH **Yes yes OK And in what form would you get most out of this training course. What form do you think it should take?**
GP Well, I think that - certainly not a training course that is all lectures, because then you just tend to be sort of sitting round passively absorbing it. A few lectures is OK. I think you know very hands on practical – that is my own view very hands on practical is very good, and maybe more sort of small tutorials groups where you could have discussions, because if we are all practitioners we could all bring cases, you know we could have much more case based discussion, what would we do about a particular problem.
IH **Yes so very much a sort of problem focussed, problem based learning rather than didactic lectures?**
GP Yes
IH **Yes OK. Who do you think should give it? Should it be totally from secondary care or should it be a mixture of?**
GP Well I think the people who would be good, I mean I think the, certainly I am quite impressed with the rheumatologists here, they seem to be quite sort of hands on, so you know secondary care specialists do have that kind of approach and also perhaps you know if you've GP specialists who work in rheumatology clinics ,you know on a sessional basis – what do you call them? Clinical assistants? I mean I think those kind of people would be good too.

IH **Right, right. What is your relationship with secondary care as opposed to, with regard to rheumatology?**
GP It has been quite good. I mean um, we don't do a lot of referrals to the Whittington

because you know we are, just because of geographical
IH **So they mainly go to the [Hospital]?**
GP They mostly go to the [Hospital] yes and I would say we get a very good service from them in secondary care
IH **Right, OK. So they are available for you to speak to with somebody?**

GP Erm yes, not so much to speak to, but they respond to letters very well, you know I will write a letter and get a reply.

IH **Right. Are there any areas for improvement do you think generally?**

GP Erm well the waiting time!

IH **Right, right.**

GP And perhaps a more flexible approach to waiting times so that you know, people with more urgent inflammatory very painful joints could be seen more quickly and people with much longer term chronic problems could go, I mean prioritise, I mean I am sure they do do this already, but it can be very difficult when you have someone with a really painful joint to keep coming back and still hasn't been seen.

IH **Yes. At what point do you decide to refer to secondary care?**

GP Well we I usually assess them, we try a lot of things locally. Local treatment, anti-inflammatories, physiotherapy if that is appropriate; we do have direct access at the [Hospital].

IH **Right and what is the wait like for that?**

GP It is very good

IH **Is it?**

GP Yes it is not too bad at all and what we often do we give the patient a form and they go down and book their own appointment. That is very good.

IH **Oh right.**

GP Particularly for patients whose English is not great, erm because they can see the place where they have got to go!

IH **Right yes**

GP And we often do that yes so that's very good and we can do all those things you know and obviously we monitor them, try out inflammatories and so on and it is usually people who are not helped by that approach. Also people who have got obvious mechanical difficulties, they can then be, you know their knees lock and this kind of thing which you know anti-inflammatories will not help that much. I mean there is an incredibly long wait, the wait in secondary care is not so much just them being seen for the first consultation which is often not all that bad, there is a huge long wait there for scans and I see that as a problem.

IH **Yes no I agree with you there completely. Do you think a training course would alter your referral patterns?**

GP I think it would help us to do more, yes. Certainly for me anyway. I mean maybe if you have been in general practice for longer you are more confident about rheumatology and how to because it is not so much obviously you are not necessarily looking for a cure, but you want to help people feel better don't you?

IH **Mmmm**

GP So I think there is a lot more that I personally could do at a local level to reduce my referral.

IH **With regard to – could you give some examples?**

GP Well I think the shoulders and things like that.

IH **Yes. How important, obviously you know primary care has lots of targets and lots of agendas. How important do you feel rheumatology is?**

GP Erm well it is very important in terms of workload/patient satisfaction as obviously it causes a lot of disability in the community so you know it is distressing for patients, but it is also expensive in terms of time off work you know, disability payouts and all this kind of thing. So I think it probably is very important. I do not know how you would set a target on it.

IH **Mmm I think that is very difficult**

GP It is a difficult one to target

IH **No we have targets enough. Would you feel that with everything else you have to do that there is enough time to deal with rheumatology patients rheumatology problems who often have other sort of psychological/social issues around that. Do you think you have enough time?**

GP Well I think we do. Certainly in our practice I think we do. You know if we feel that people need longer discussion and things we can book a double appointments for them and this sort of thing and we do do that. I think as general practitioners you are very well placed to know some of the other issues in people lives and how it affects them.

IH **And what would your views be on rheumatology as a specialty being in primary or secondary care completely?**

GP Ummm well I think the way it is moving at the moment it is quite ……. I think you do need to have a specialty. I think some of it, especially the more neurological aspect perhaps tend to be very ……..

IH **Yes, yes**

GP Umm, but you know the way it is going more with community based work as well as you know secondary care in clinics, I think it is the probably the way, I mean I think it can go further that way

IH **Right**

GP It has been very useful having the rheumatology coming out to the [name of clinic] and being able to refer direct

IH **Right, how does that work?**

GP Umm we write a letter, our secretaries can ring up and book the patient an appointment and send the referral letter at the same time and she tends to see problems that are not too complex – she says the referral criteria should be fairly well circumscribed properly, you know some guidelines and that sort of thing. It is really good for older people who can't make it out.

IH **Yes. And do yourselves or other partners sit in or is that not?**

GP We - I haven't done – I do not think the others have, I suppose we could

IH **Is that due to pressure of time and really?**

GP Yes and also not thinking about it, not organising it

IH **Do you think that would be helpful?**

GP Yes I think that would be very helpful

IH **And would you like to see that sort of outreach clinic become more frequent?**

GP Yes definitely, I think it is great for the patients and very helpful for the GP

IH **Yes and does Dr B give you feedback immediately or do you get a letter that covers..**

GP We get a letter, well she is not actually at our practice

IH **Oh I see**

GP She is at a different place, but quite close

IH **Right so you will get a letter afterwards in the normal way**

GP Yes

IH **And patients anecdotally have given you good ….**

GP Yes we have had good feedback from going there.

IH **Right excellent.**

GP They like, especially the more elderly people obviously don't, you know, for them it is a big plus that they do not have to go so far.

IH **Yes yes OK, and do you feel that the consultant being there, they have access to all the other investigations that they might need? Because some people say that without ……'Oh I don't have my x-rays, I don't have this'**

GP Yes I am not sure what happens, I mean it may be an issue, and I do not know how easy it is for her to organise those, but presumably she has the same access to secondary care investigations as she would do if she was in a clinic.

IH **Yes and if you organise your current referral criteria as you say then it would minimise the need for that sort of problem ok. So just in conclusion, you feel that rheumatology forms a significant part of your practice**

GP Mmmmm

IH **And that you would personally like to gain more confidence in aspects of rheumatology such as joint injection and examination of joints? Or**

GP Yes always can be updated and improved on that.

IH **What about aspects such as the new drugs that are available now for rheumatoid arthritis?**

GP I think well I think in our practice we have a fairly clear idea of the progression through and then you know when to use the Cox-2 inhibitors. I mean we tend not to initiate anything like that because we've got quite a lot of prescribed immune centred targets and those are very expensive drugs. I mean we would use them if they did not initiate them in secondary care, so I do not think we have very much problem with the actual prescribing aspect.

IH **And the disease modifying drugs what, how do you use them?**

GP Oh what sort of thing

IH **Like Methotrexate and**

GP Oh we would never initiate that sort of thing

IH **No, no, but sort of being comfortable with working with them and**

GP Yes we would guess, I mean one someone's been seen in secondary care, if they have been prescribed those kind of things we are happy to continue with it with hospital direction we can also do monitoring like blood tests if necessary.

IH **Yes would that be something that you would like more information on do you think or…?**

GP Mmmm yes I think so, but that to me is more the next level up, you know, I mean it is quite useful to know what is going on, but they usually get quite a lot of information in the hospital letter.

IH **Right and that's not for the majority – it would not affect the majority of your patients?**

GP It wouldn't no, it would not be a priority

IH **Yes yes**

GP As I said you know we are happy to do monitoring and so on and of course that helps make it easier for the patient.

IH **OK well thank you very much for coming that is brilliant.**

GP OK just at the end our training programme, I don't know what it is like with most practices, but with our practice w do all our rotas about three months in advance

IH **Right**

GP So we do all our planning forgoing on courses and days off for study leave and all the rest of it quite a long time in advance. It is absolutely essential that notification of opportunities to go on these things is …

IH **Right, so if I am looking at February then we need to advertise in late October/early November time.**

GP Yes absolutely

IH **Ok that's a great point thank you. Thank you for coming to the interview.**

GP No problem.