3.20 THE CLINICAL EXAMPLE ON

Care of People with Musculoskeletal Problems

This statement is part of the curriculum produced by the Royal College of General Practitioners (RCGP) which defines the learning outcomes for the discipline of general practice and describes the skills you require to practise medicine as a general practitioner in the National Health Service (NHS) of the United Kingdom. Although primarily aimed at the start of independent work as a general practitioner, it must also prepare the doctor beyond the training period and provide support for a professional life of development and change.
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KEY MESSAGES

- Each year 20% of the general population consult a GP with a musculoskeletal problem
- Research evidence supports the effectiveness of simple positive approaches for many patients, and general practitioners (GPs) should encourage appropriate self-care.
- Common musculoskeletal conditions such as back pain and osteoarthritis are the dominant cause of chronic pain, disability and work loss in the UK.
- As a GP, understanding the psychological and social dimensions of chronic pain and disability is fundamental to your management of musculoskeletal conditions.
- Taking an effective history and making a simple, focused examination in general practice is likely to be more important than imaging and serology, which on their own may be falsely reassuring.
- Early diagnosis and treatment of inflammatory arthritis, such as rheumatoid arthritis, has a major impact on long-term outcome. Urgent referral to specialist care is indicated if there is clinical suspicion of inflammatory arthritis.

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1 Arthritis Research UK National Primary Care Centre, Keele University. *Musculoskeletal Matters: what do general practitioners see?* Bulletin 1, October 2009, [www.keele.ac.uk/media/keeleuniversity/ri/primarycare/bulletins/MusculoskeletalMatters1.pdf](http://www.keele.ac.uk/media/keeleuniversity/ri/primarycare/bulletins/MusculoskeletalMatters1.pdf)
### CASE ILLUSTRATION

Susan Andrews, a 45-year-old care assistant in a local residential home for older persons, presents in surgery complaining of worsening pain in her lower back during the past four weeks. The pain is confined to her back and does not radiate down her leg. It becomes worse in the course of a day and sometimes wakes her at night. She also has some pain in her neck and right shoulder, and pain, longstanding but occasional, in her left knee when walking.

She dates her back pain to an episode in her workplace where she had to lift a patient off the floor unassisted. She offers the information that staff illness and absence rates in her workplace have been higher than usual in recent months, with change of personnel in the senior management of the home. ‘It’s not like it used to be – it’s more stressed – there are not the people around to help with lifting and moving like before – but I still like the place.’

On questioning, Susan says her appetite and weight have been steady but she now wakes at night, has started to feel a bit low, and she gets more tired than before towards the end of the day. She has had episodes of back pain in the past but it has never lasted this long. She reports no fever, and no significant neurological symptoms or history of malignancy. She lives with her husband, a local council gardener, and her one child is enjoying work as a nurse in a town 20 miles away. She expresses her concern that she might be developing a long-term problem which will make her work difficult.

On examination, she looks generally well and is moderately overweight; there is some curvature in the lower spine which disappears when she bends down to touch her toes – she can almost reach her toes but slowly and with some difficulty. She has some difficulty putting her hands behind her head.

You advise Susan about work and physical activity and provide an advice leaflet explaining the simple messages around back pain and how to protect the back when lifting and doing heavy work. You suggest that she tries to lose some weight with the objective of reducing the strain on her back. You recommend simple but regular analgesics, especially at night.

Some elements of Susan’s history raise your concerns about a possible poor prognosis for improvement and associated increased risk for time off work.

You discuss with Susan the need for a follow-up appointment and the possibility of a referral to a physiotherapist. You also suggest that she discusses her concerns about the lack of help for lifting with her supervisor.

She tells you that a friend of hers had a scan and a special injection for her back pain which really helped. She wonders whether you think she should be referred to a specialist for this?
To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

<table>
<thead>
<tr>
<th>Category</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care management</td>
<td>What are the differential diagnoses for Susan’s symptoms? What is the diagnosis likely to be? What options do I have in treating this problem? What follow-up arrangements would I make?</td>
</tr>
<tr>
<td>Person-centred care</td>
<td>What would help Susan to stay at work? How might I negotiate any conflict over time off work? (E.g. if Susan requests ‘a sick note for a few weeks until I feel better.’)</td>
</tr>
<tr>
<td>Specific problem-solving skills</td>
<td>What aspects of Susan’s case cause me concern about a possible poor prognosis for improvement? What place might investigations have in this situation?</td>
</tr>
<tr>
<td>A comprehensive approach</td>
<td>What self-care and health promotion advice might I provide to Susan on this occasion? How might I manage Susan’s ‘yellow flags’?</td>
</tr>
<tr>
<td>Community orientation</td>
<td>What are the advantages of a local back pain service? How might I go about establishing one? What other options might I have in managing musculoskeletal disease in the community?</td>
</tr>
<tr>
<td>A holistic approach</td>
<td>What steps could I take to facilitate continuity of care for Susan? How might Susan’s problem impact upon the health of her family?</td>
</tr>
<tr>
<td>Contextual features</td>
<td>What provision might my practice make for patients and staff with musculoskeletal disorders?</td>
</tr>
<tr>
<td>Attitudinal features</td>
<td>What is my own attitude towards people who I believe are falsifying or exaggerating their musculoskeletal symptoms?</td>
</tr>
<tr>
<td>Scientific features</td>
<td>What barriers might I face in providing the ‘best’ care for my patients as defined by national guidelines? What tools are available to stratify those at risk of developing chronic low back pain? What tools are available to measure pain and loss of function caused by musculoskeletal problems?</td>
</tr>
</tbody>
</table>
LEARNING OUTCOMES

The following learning objectives relate specifically to the management of musculoskeletal problems. These learning outcomes are in addition to those detailed in the core statement, Being a General Practitioner. The core statement and this statement should be used in conjunction with the other curriculum statements. In order to demonstrate the core competences in the area of musculoskeletal problems, you will require knowledge, skills and attitudes in the following areas.

The RCGP areas of competence

1 Primary care management

This area of competence is about how you as a doctor manage your contact with patients, dealing competently with any and all problems that are presented to you. (This is not limited to dealing with the management of the practice.)

This means that as a GP you should:

1.1 Identify ‘red flags’ that relate to infection (e.g. septic arthritis or osteomyelitis); cancer (e.g. bony metastases and osteogenic sarcoma); fracture (e.g. fragility fracture in osteoporosis); neurological compromise (e.g. cauda equina syndrome); and inflammatory arthritis (e.g. rheumatoid arthritis, ankylosing spondylitis)

1.2 Refer those conditions which may benefit from early referral to an orthopaedic surgeon (e.g. internal derangement of the knee, ruptured achilles tendon)

1.3 Identify and manage acute systemic inflammatory conditions that are appropriately treated in primary care such as gout and polymyalgia rheumatica

1.4 Diagnose common, regional soft-tissue problems that can be managed in primary care (e.g. tennis elbow, trigger finger)

1.5 Diagnose and manage the common, regional pain syndromes such as osteoarthritis, back pain and fibromyalgia

1.6 Consider rare conditions such as connective tissue diseases (e.g. lupus) which may present with non-specific symptoms and affect extra-articular organs such as blood vessels, skin and kidneys

1.7 Identify musculoskeletal conditions in children, the ages at which they commonly present and how pathology is differentiated from variations of normality, e.g. ‘bow legs’ (varus appearance) is a normal variant and usually resolves by age three

1.8 Be aware of how musculoskeletal problems may be a manifestation of injury not only from trauma but also abuse
2 Person-centred care

This area of competence is about understanding and relating to the context of your patients as individuals, and developing the ability to work in partnership with them.

This means that as a GP you should:

2.1 Communicate health information effectively to promote better outcomes, e.g. use positive terms such as ‘wear, flare and repair’ and avoid unhelpful terms like ‘crumbly spine’ and ‘ruptured disc’

2.2 Explore the perceptions, ideas or beliefs the patient has about the condition and whether these may be acting as barriers to recovery or return to usual activity or work

2.3 Use simple techniques and consistent advice to promote activity in the presence of pain and stiffness, e.g. GPs play an essential role in promoting the message that when it comes to long-term musculoskeletal health patients need to ‘use it or lose it’ and stay active within their individual capabilities

2.4 Agree treatment goals and facilitate supported self-management, particularly around pain, function and physical activity

3 Specific problem-solving skills

This area of competence is about the context-specific aspects of general practice, dealing with early and undifferentiated illness and the skills you need to tolerate uncertainty, and marginalise danger, without medicalising normality.

This means that as a GP you should:

3.1 Assess the importance and meaning of the following presenting features:
   3.1.1 pain: nature, location, severity, history of trauma
   3.1.2 variation of symptoms over time
   3.1.3 symptoms which help distinguish inflammatory from non-inflammatory conditions
   3.1.4 loss of function – weakness, restricted movement, deformity and disability, ability to perform usual work or occupation
   3.1.5 systemic manifestations of rheumatic disease

3.2 Assess the possibility that musculoskeletal symptoms can be compounded by psychological causes

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3.3 Be aware of the concept of ‘yellow flags’ in musculoskeletal disease and the tools that can be used to stratify those at risk of progression to long-term pain and disability.\(^6\),\(^7\)

3.4 Understand that reducing pain and disability rather than achieving a complete cure could be the goal of treatment.

3.5 Understand indications and limitations of plain radiography, ultrasound, CT and MR scan including the use of decision-making tools such as the ‘Ottawa Rules’ (guidelines for deciding if a patient with a foot or ankle or knee injury should be offered X-rays to diagnose a possible fracture).

3.6 Understand the limitations of blood tests for diagnosing musculoskeletal conditions where ‘negative’ tests may not rule out disease and where diagnostic criteria are often not clear-cut. This is particularly the case with inflammatory arthritis (e.g. rheumatoid arthritis) where early referral should be initiated on clinical suspicion rather than based on the results of tests.\(^8\)

## 4 A comprehensive approach

This area of competence is about how you as a general practitioner must be able to manage co-morbidity, co-ordinating care of acute illness, chronic illness, health promotion and disease prevention in the general practice setting.

This means that as a GP you should:

4.1 Know the problems that can be caused by the treatment of musculoskeletal disorders and explain their primary and secondary prevention (e.g. NSAIDS and gastrointestinal bleeds, cardiovascular disease risk and renal impairment)

4.2 Identify and treat depression to improve clinical outcomes for patients with musculoskeletal conditions

4.3 Apply local shared-care guidelines for safe prescribing and monitoring of disease-modifying anti-rheumatic drugs (DMARDs)

4.4 Be aware of increased cardiovascular risk in patients with rheumatoid arthritis, connective tissue diseases and gout

4.5 Be aware of increased fracture risk in patients with rheumatoid arthritis

4.6 Be aware of the burden of treatment for patients with long-term musculoskeletal conditions like osteoarthritis, many of whom will be attending the GP surgery regularly for appointments about other long-term conditions

4.7 Know what resources are available locally and nationally and how to access them, e.g. patient information material from Arthritis Research UK and patient support organisations such as Arthritis Care (see also Web Resources below)

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5 Community orientation

This area of competence is about the physical environment of your practice population, and the need to understand the interrelationship between health and social care, and the tensions that may exist between individual wants and needs and the needs of the wider community.

This means that as a GP you should:

5.1 Be aware of the potential effect on the health of patients where services are deficient and frequently have long waiting times
5.2 Understand the huge impact on the community of incapacity for work caused by musculoskeletal conditions, and how you can facilitate a patient returning to work by giving consistent advice and the use of ‘fit notes’

6 A holistic approach

This area of competence is about your ability to understand and respect the values, culture, family structure and beliefs of your patients, and understand the ways in which these will affect the experience and management of illness and health.

This means that as a GP you should:

6.1 Consider the physical, psychological, social, occupational and financial impact of musculoskeletal conditions on individuals and their carers (e.g. problems with fatigue, altered body image, work, impact on family relationships and sexual issues)
6.2 Be aware of cultural differences in the expression of emotional distress and how this may present as pain and loss of function
6.3 Incorporate a bio-psycho-social approach to assessment and management of chronic musculoskeletal conditions that is tailored to the diagnosis. e.g. addressing the patient’s worrying thoughts around experience of pain and providing a consistent message regarding activity and return to work

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The essential features of you as a doctor

The three essential features (EFs) below are concerned with the features of you as a doctor which may influence your ability to apply the core competences to real life in the work setting.

### EF1 Contextual features

This essential feature is about understanding your own context as a doctor and how it may influence the quality of your care. Important factors are the environment in which you work, including your working conditions, community, culture, financial and regulatory frameworks.

Examples of this are:

- **EF1.1** Thinking about how your workplace facilitates access for people with disabilities
- **EF1.2** Examining what systems are in place at your workplace to help prevent practice staff developing common problems such as back pain
- **EF1.3** Thinking about how your workplace facilitates return to work for staff with musculoskeletal problems

### EF2 Attitudinal features

This essential feature is about your professional capabilities, values, feelings and ethics and the impact these may have on your patient care.

Examples of this are:

- **EF2.1** Awareness of your own attitudes to patients presenting, for example, with modest back pain and seeking time off work
- **EF2.2** The challenge that many musculoskeletal conditions might be better and more confidently managed by other healthcare personnel rather than GPs because they do not fit neatly into the biomedical model of pathological diagnosis and cure, and because most GPs do not gain the necessary treatment skills during their training
- **EF2.3** Recognising the frustrations that chronic, painful but non-fatal conditions, with few spectacular cures, can have on both patients and the general practitioner
**EF3 Scientific features**

This essential feature is about the need to adopt a critical and evidence-based approach to your work, maintaining this through lifelong learning and a commitment to quality improvement.

Examples of this are:
- **EF3.1** Describing the key national guidelines that influence healthcare provision for musculoskeletal conditions and the potential problems in applying these guidelines based on local availability of services
- **EF3.2** The difficulty with developing and measuring outcomes in musculoskeletal conditions where diagnoses are often not clear-cut and response to treatment is related to symptoms rather than ‘hard’ outcomes such as improvements in blood tests or other disease markers
- **EF3.3** Understanding the issues and debates about use of complementary therapy and opiate analgesia for chronic pain
**LEARNING STRATEGIES**

**Work-based learning – in primary care**

Given the number of patients with musculoskeletal problems that present to their GP, you will have no shortage of clinical exposure during your time in primary care. You will see a wide range of conditions and it is worth keeping a log of the cases – to demonstrate that you are becoming confident in managing the conditions as you become more experienced.

Musculoskeletal problems offer the opportunity for you to develop clinical skills and reflect upon the utility of investigations in managing uncertainty and complexity.

Management of long-term musculoskeletal conditions is often criticised for not being aligned with national guidelines and standards of care. Take the opportunity to improve this situation by undertaking simple practice audits, e.g. cardiovascular risk screening for people with rheumatoid arthritis, gout or systemic lupus erythematosus (SLE), or treating urate levels to target in gout.

The first contact with a patient is crucial and one of the great things about general practice is time and the opportunity for continuity of care. Following your patients up can provide a very useful insight into the natural course of musculoskeletal problems and give valuable clues in the clinical conundrums we all face.

Listen to the language your patients use to describe how their ‘brittle bones’, ‘crumbly spines’, ‘grinding’, ‘worn-out’ joints are affecting them; how they feel their bodies have let them down. And see how positive language can influence the perception of their pain and improve both how you feel about what you can do to help and the outcome for the patient. So when a patient states that ‘all I need is a new pair of knees, Doc’, ask yourself whether you have done what you can to help, using pharmacological and non-pharmacological interventions to help with pain and to improve function as recommended in the NICE guidance.

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Work-based learning – in secondary care

Few GPs in training will get significant exposure to a core musculoskeletal speciality during their time in secondary care but many of the patients you will see during your training, especially the elderly, will have significant musculoskeletal problems. So take time for a brief, focused examination of a painful joint, and ask about mobility issues, work problems and function around the home, in order to get a feel for the impact that musculoskeletal conditions can have on the individual.

During placements in A&E you will see plenty of common musculoskeletal problems, including acute back pain. Think about whether you would be confident in managing these patients in the GP surgery setting and whether these patients might be more effectively managed in primary care.

Try to spend some time with speciality nurses and pharmacists engaged in shared-care prescribing of disease-modifying anti-rheumatic drugs (DMARDs). Can you think of some of the benefits and potential pitfalls of shared-care prescribing? What issues do the nursing team have? How are problems communicated to all involved? Think how you would, as a GP, ensure a safe service for your patients in the community.

Consider attending an orthopaedic clinic and explore the decision to undertake a joint replacement for osteoarthritis. What factors influenced the decision? Were they the same factors for each patient you saw? Were Patient Decision Aids\(^\text{14}\) being used?

Many areas have interface or tier 2 musculoskeletal services in the community or hospital setting. The GP with a Special Interest (GPwSI) or Extended Scope Physiotherapists who work in these services may be able to help you improve your clinical skills, and the patients are a rich resource of common musculoskeletal problems. Think of the factors that may have influenced the decision to refer patients to these services. What might the advantages and disadvantages be for GPs and patients of such services?

Time spent in a local chronic pain service can give a valuable insight into the multidisciplinary approach to managing patients with chronic musculoskeletal and other pain. Pause to reflect on the barriers that patients face to getting back to normal functional levels and also the factors that may have contributed to the development of chronic problems. Were there missed opportunities that may have presented to address their problems earlier – perhaps preventing progression to a more chronic problem?

Non-work-based learning

It’s highly unlikely that you will go through the duration of your specialist training and not experience musculoskeletal aches and pains of one sort or other, from the minor through to the more significant. Perhaps you are involved in sport and have noticed some new ache or pain when you are training. How

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\(^{14}\) Patient Decision Aids are designed to help patients make difficult decisions about their treatments and medical tests. They are used when there is no clinical evidence to suggest that one treatment is better than another and patients need help in deciding which option will be best for them. Research shows that PDAs are effective in helping patients make informed choices about their healthcare and increase patients’ awareness of the expected risks, benefits and likely outcomes. See also \[http://sdm.rightcare.nhs.uk/pda/\]
does it make you feel? Are you worried that the pain will get worse? What if you can’t do the things you enjoy? What about work? How would you cope if your pain and disability prevented you following your chosen career path?

Reflecting on such issues provides a valuable insight into how your patients may be feeling when they come to see you. Asking about such worries forms part of the thorough assessment of a patient. If you do not address these concerns, you are less likely to help that person and may miss acting on cues that could prevent the patient from developing a chronic problem.6,7

**Learning with other healthcare professionals**

It is worth spending time with allied health professionals including physiotherapists, occupational therapists and podiatrists to see how their methods of assessment differ from yours. In particular, time with physiotherapists learning clinical skills and improving your ‘handling skills’ will be well spent and will also help your understanding of what patients should expect when they are referred to physiotherapists.

You may be surprised by the number of patients who have paid to see a ‘complementary’ therapist before coming to see you. Osteopaths, chiropractors, acupuncturists and massage therapists may play a role for some patients. Do you know what these practitioners do? Do they have registered governing bodies? Would you recommend them to patients?

Other members of the practice team, including nurses and healthcare assistants, spend the most time with patients with chronic diseases. They have valuable insights into how patients are getting along. Do you know if their assessment includes asking patients about pain and level of function? Which validated tools can be used to measure this?

Carers, both professional and informal, may be the best-placed individuals to inform how a person is coping at home and in the community. You often get a very limited view of the stoical patient within the confines of the surgery.

All GPs have a role in advising patients about fitness for work. How this advice is communicated has a significant effect on the future of that individual’s working life. Discussion with occupational health physicians and those involved in DWP (Department of Work and Pensions) work-capability assessments can help you understand how decisions regarding work fitness are made and how you as a GP can facilitate patients to stay in work, for example by delivering a consistent message around back pain.6,9

**Formal learning**

Look out for core musculoskeletal skills courses, aimed at GPs, which offer the opportunity to refresh your history-taking and clinical skills, as well as keeping you up to date with the latest evidence and opinion on best practice.
You may also consider attending courses offering joint injection training. But remember that, while injection skills can be very helpful, you should not run before you can walk – the core skill for GPs is competent assessment of patients with musculoskeletal problems and, as a general rule, if you don’t know the diagnosis you shouldn’t be injecting the patient. One of the fundamental skills is knowing what not to inject rather than what to inject.

There are many e-learning resources available to learners though they cannot replace the clinical ‘hands on’ skills that are fundamental to effective practice.
LEARNING RESOURCES

Web resources

Arthritis Care
www.arthriticcare.org.uk

Arthritis and Musculoskeletal Alliance
http://arma.uk.net

Arthritis Research UK
Arthritis Research UK is the charity that is leading the fight against arthritis. This website is a resource for patients and professionals on all musculoskeletal conditions. There are specific pages for GPs and other health professionals with links to Arthritis Research UK publications, GP trainee prizes and training bursaries for GPs.
Use the search functionality of www.arthritisresearchuk.org to access thousands of high-standard, musculoskeletal educational resources from around the world such as clinical guidelines, podcasts, e-learning modules, videos, images and interactive resources. All resources have been reviewed and assessed as high quality by subject specialists working with Arthritis Research UK.
www.arthritisresearchuk.org

Resources available from Arthritis Research UK include:

Hands On and Synovium
Each issue of Hands On contains practical advice about managing musculoskeletal problems within primary care. Hands On also aims to inform GPs about current relevant topics within rheumatology and musculoskeletal medicine. Synovium presents a digested overview of current hot topics and research in musculoskeletal conditions. Paper copies of these publications are distributed with the British Journal of General Practice and are also available on the website.
www.arthritisresearchuk.org/health-professionals-and-students/reports.aspx

Clinical Assessment of the Musculoskeletal System: a guide for medical students and healthcare professionals
This handbook covers 50 core competencies in musculoskeletal examination. The guide is accompanied by a DVD demonstrating the widely used GALS (gait, arms, legs, spine) screening examination and a detailed regional examination of the musculoskeletal system (REMS).
www.arthritisresearchuk.org/health-professionals-and-students/video-resources/remsv.aspx
Paediatric gait, arms, legs, spine (pGALS) assessment
Short videos and supporting text that demonstrate a simple, quick and effective way to screen the musculoskeletal system in school-aged children.
www.arthritisresearchuk.org/health-professionals-and-students/video-resources/pgals.aspx
www.arthritisresearchuk.org/~/media/Files/Education/Hands-On/HO15-June-2008.ashx

BackCare
National charity for back health.
www.backcare.org.uk

Birmingham Arthritis Resource Centre
www.barc.org.uk

British Institute of Musculoskeletal Medicine
www.bimm.org.uk

British Sjögren’s Syndrome Association
www.bssa.uk.net

Children’s Chronic Arthritis Association (CCAA)
www.ccaa.org.uk

Expert Patients Programme
The Expert Patients Programme (EPP) is a self-management programme for people who are living with a chronic (long-term) condition. The aim is to support people who have a chronic condition by increasing their confidence, improving their quality of life and helping them manage their condition more effectively.

FRAX
The FRAX® tool has been developed by the World Health Organisation to evaluate the fracture risk of patients. It is based on individual patient models that integrate the risks associated with clinical risk factors, including rheumatoid arthritis, as well as bone mineral density (BMD) at the femoral neck.
www.shef.ac.uk/FRAX

Lupus UK
www.lupusuk.org.uk
National Ankylosing Spondylitis Society  
www.nass.co.uk

National Osteoporosis Society  
www.nos.org.uk

National Prescribing Centre  
This organisation supports the NHS, and those working for it, to improve quality, safety and value for money in the use of medicines for the benefit of patients and the public. They provide excellent multimedia e-learning resources for primary care, which make this resource essential for learners.  
www.npc.nhs.uk/therapeutics/pain

National Rheumatoid Arthritis Society  
www.nras.org.uk

Paget’s disease  
Paget’s Association.  
www.paget.org.uk

Polymyalgia Rheumatica and Giant Cell Arteritis (PMR-GCA) Scotland  
www.pmrandgca.org.uk

Primary Care Rheumatology Society  
www.pcrsociety.org

The Psoriasis Association  
www.psoriasis-association.org.uk

QRISK  
QRISK®2-2011 is a cardiovascular disease risk calculator. You can use this calculator to work out heart attack or stroke risk over the next ten years by answering some simple questions. It is suitable for people who do not already have a diagnosis of heart disease or stroke and it factors in the additional cardiovascular disease risk for rheumatoid arthritis.  
http://qrisk.org
**Royal College of General Practitioners**

The e-GP Rheumatology and Musculoskeletal Problems course includes back pain, joint pains, arthritis, connective tissue disease, osteoporosis and various problems in children. The e-GP course also includes sessions on a variety of musculoskeletal physical examinations.

[www.e-GP.org](http://www.e-GP.org)

The RCGP Online Learning Environment (OLE) has Essential Knowledge Updates on a variety of musculoskeletal topics including management of rheumatoid arthritis, polymyalgia rheumatica and osteoarthritis.

[www.elearning.rcgp.org.uk](http://www.elearning.rcgp.org.uk)

You can also download a decision flow chart and an illustration of the most frequent anatomical locations of musculoskeletal problems:


**RSI Action**

National repetitive strain injury charity.

[www.rsiaction.org.uk](http://www.rsiaction.org.uk)

**Scleroderma Society**

[www.sclerodermasociety.co.uk/newsite/index.php](http://www.sclerodermasociety.co.uk/newsite/index.php)

**Work and employment resources**

**Decision Aids**

Decision Aids can be used in your consultation. They offer 'bite size' pieces of information, access to downloadable leaflets and useful links that you might want access to during your discussion with a patient.

[www.healthyworkinguk.co.uk/decisionaid](http://www.healthyworkinguk.co.uk/decisionaid)

**Fitness for Work – Sick Note or Bust**

Produced by the Department for Work and Pensions and Cardiff University, this interactive online module shows case studies and video examples of consultations around back pain. It explores some of the problems GPs face and takes a look inside the fitness-for-work consultation.


**Health, Work and Well-being**

Health, Work and Well-being is a cross-government initiative to protect and improve the health and well-being of working-age people. The initiative promotes the positive links between health and work and aims to help more people with health conditions to find and stay in employment. It brings
together employers, trade unions, healthcare professionals and other partners and builds on a growing evidence base that working is good for health. The initiative began in 2005.

www.dwp.gov.uk/health-work-and-well-being
ACKNOWLEDGEMENTS

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