and universally accepted within the UK. This year has seen the publication of the postgraduate curriculum, and it becomes even more important to try to address the undergraduate curriculum in the UK.

The authors have highlighted the fact that leading rheumatology teachers in the UK have expressed a wish for a national agreement about core requirements in musculoskeletal undergraduate education. Very few people would disagree with that. Unfortunately, agreement on such a curriculum has proved elusive and we feel will continue to be so as long as we keep trying to approach the problem from the wrong end. Individual rheumatologists will have their own epistemological view of rheumatology and, consequently, their own opinions on what should be taught, thereby preventing consensus. We feel that the way to approach this particularly tricky issue would be to try to outline aspects that are already common to all of us. As an example, if we look at musculoskeletal examination as part of undergraduate assessment, there are only a finite number of OSCE (Objective Structure Clinical Examination) stations that can be used. Inclusive of the GALS screen, we have a total of nine commonly used OSCE stations for musculoskeletal examination. Virtually all UK medical schools are using some or all of these for undergraduate assessments. It would not be that difficult for rheumatologists to agree on what they expect the student to demonstrate during an OSCE on these stations. This would lay the groundwork, which can then be built upon, accepting that to an extent there will always be some differences between clinical teachers. We should, however, be able to utilize the similarities between us to help develop a core undergraduate curriculum and ultimately help the medical students we teach. This outcome-based approach is one we are adopting for the new curriculum for the University of Sheffield medical school as a whole, commencing in 2003. This approach is also being encouraged by the General Medical Council. Assessment drives learning, and by first agreeing the product (i.e., the required musculoskeletal knowledge, skills, and attitudes of a qualified medical practitioner) as well as what we should assess (i.e., a bank of common OSCEs, EMQs, etc), we will develop a ‘functional’ core musculoskeletal curriculum. With a little more concerted action, the core musculoskeletal curriculum will be readily achievable.

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The GALS examination

We agree with Walker and Kay that the GALS (gait, arms, legs, and spine) screening examination represents a major advance for undergraduate education by enabling medical students to perform a validated, straightforward musculoskeletal examination [1]. We are disappointed however, that GALS has not been more widely adopted by the postgraduate community. Whilst our rheumatological colleagues recognize GALS, little or no awareness of it was found among general practitioners and orthopaedic surgeons in an informal survey in East London.

In order to overcome this, we feel that descriptions of GALS need to find their way into the standard textbooks of medicine and their clinical examination supplements. Dialogue to ensure wider acceptance of the examination should take place between sponsors of GALS, the British Orthopaedic Association and representatives of primary care societies. On a practical level, we make the GALS examination part of our pre-registration house officer induction by showing a descriptive video in February and August to all appointees. Once the CD-ROM version becomes available, we intend to place copies on the trust intranet. We suggest to the Arthritis Research Campaign that copies of the video (currently not available) are produced and circulated to all clinical tutors in the UK, to be shown during induction or as part of an ongoing education programme.

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Reply

We are grateful to Drs Jawad and Dubey and colleagues for their interest in our editorial. Their letters illustrate the general agreement amongst rheumatologists that the examination skills taught to medical