Letters to the Editor

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Joint examination skills: are rheumatology specialist registrars adequately trained?

Sir, History-taking and clinical examination are the cornerstones of clinical medicine. Most aspects of clinical examination are well covered at both undergraduate and postgraduate level. There is a potential deficit in training in musculoskeletal and joint examination [1, 2]. Rheumatology specialist registrars (SpRs) are involved in educating medical students [3, 4] and junior doctors in locomotor examination [5]. Yet SpRs have commented on the lack of training in this area [6, 7].

The study aim was to assess formal and informal training and SpRs’ confidence in examining the musculoskeletal system. The survey was an anonymous questionnaire, by e-mail and by hand, at the Rheumatologist at Training (RATS) meeting at the British Society for Rheumatology (BSR) Meeting in May 2002. Locums were excluded. The questionnaire was peer-reviewed. The questionnaire surveyed training year and trainee’s region and enquired into education and training in joint examination skills, courses/training days attended, financing of courses, how trainees rate their clinical skills, their perceptions of whether training is adequate, and recommendations to improve training.

In May 2002 there were 199 rheumatology SpRs enrolled with the JCHMT (Joint Committee on Higher Medical Training). Our questionnaire was circulated to a third of trainees, 53 of whom returned completed questionnaires. All years of training and training regions were represented.

Few SpRs felt that their training or overall training in examination skills was adequate. Six felt that they and other trainees were adequately trained in these skills and four of the six were in their first 2 yr of training. This suggests that some junior trainees felt their skills were excellent (contrasting with many senior trainees) and that as trainees progress they become more circumspect—or there is bravado among junior trainees. Rheumatology trainees teach the GALS (gait, arms, legs, spine) locomotor screen and musculoskeletal and joint examination. Yet the majority of respondents feel inadequately trained in examination, casting doubt on the quality of their teaching in this area.

Responses about the educators responsible for training were consistent across the regions. Formal teaching outside of training days was limited to a third of respondents. Much of the training is ad hoc and the assimilation of skills is assumed. The rheumatology MSc courses concentrate on science, with little emphasis on basic skills.

Trainees in the West Midlands were happiest with the quantity and quality of their training in examination skills. Personal interests of trainees have a bearing on the training undertaken, particularly when self-funding, for courses in, for example, sports and exercise medicine. Twenty-one SpRs attended courses containing joint or musculoskeletal examination tuition. The BSR Core Course was most popular [12 respondents (22.6%)]. Regions used Calman training days to teach the core skills of joint examination. These concentrated on a single joint/regional examination. Most felt their skills and confidence improved following the courses. Many recommended the course to colleagues. Few bore the full cost.

There was marked variation between the regions as to the amount of training received.

Respondents provided constructive suggestions to help improve training:

Consultant-led formal training for year-1 SpRs
Formal programme in clinical examination with a designated individual or faculty
Creation of a formal course
Training in examination skills during Calman training days
Inclusion of practical skills in rheumatology MSc courses
Combined training with orthopaedic SpRs and increase the orthopaedic medicine
Multidisciplinary training sessions in examination skills
Increasing the time for examination skills in the BSR Core Course
Master classes in examination at the BSR annual meeting
Use of video

The negative comments included the emphasis on service provision at district general hospitals. Training should not be dependent on external courses.

Many trainees feel training in musculoskeletal examination is inadequate and that formal teaching is weak. Training could be improved by modifying Calman training, forming workshops at the BSR annual meeting and either creating a BSR course or increasing the teaching of examination skills on the BSR Core Course. A steering group within the BSR training committee looking at the core skills may be required.

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Does giving osteoporosis patient information to women who have had a fracture improve access to health care?

Sir. Patients who sustain an osteoporotic fracture are more likely to have further fractures [1–3], however secondary prevention

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