Primary Care Special Interests

Musculoskeletal medicine

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Like many things in life, the decision to pursue a particular path from early in one's career is a rarity. Entering musculoskeletal medicine was long in its evolution. There was an early interest in things 'physical' through exposure to an enthusiastic physiotherapist even before medical school days. At times throughout my training and early hospital years I found myself leaning towards the idea of somatic dysfunction long before I knew such an entity existed.

My early days in general practice exposed me to patients for whom my medical school/hospital and even GP training did not prepare me for: patients with musculoskeletal pain. Referrals to orthopaedic surgeons or rheumatologists were frustrating. Once operable or treatable disease was excluded, it was the proverbial 'take two Panadol' and return to your GP for ongoing management, whatever that was. And my querulous patients wanted to know what I was going to do!

My father, who was an experienced GP, suggested the Musculoskeletal Medicine Diploma from Otago. It had been running about four or five years when I enrolled. Initially I did the two Musculoskeletal Association's week-long courses. I was among like-minded primary care practitioners who were interested in similar ideas and concepts and faced the same difficulties of helping patients as myself. Here was a way to make better clinical diagnoses and, more importantly, an armamentarium of office-based techniques to utilise

to help these patients. It was a steep learning curve and the 15-minute appointment often stretched out as I endeavoured to incorporate these exciting tools into my practice. Doing the distance learning diploma modules was a further revelation; suddenly the world of pain pathophysiology was laid open before me and the old rules of anatomically-based neurology could be put to one side, with the new concepts explaining many of the confounding epiphenomena one encountered in pain patients. Inspirational lectures from people like Prof. Nik Bogduk and Dr Mike Butler, who remains an avid distributor of pain information, gave me a new enthusiasm for working with patients with musculoskeletal pain.

And so in 1995, changes to the Medical Practitioners Act allowed our specialty to be vocationally registered. The NZ Musculoskeletal Association moved quickly with our Australian counterparts and the University of Newcastle to establish a faculty with a syllabus and a pathway to specialist accreditation. Furthermore, at the University of Newcastle, Prof. Bogduk and other researchers had developed a series of interventional procedures for diagnosing and treating pain of musculoskeletal origin, especially from the spine.

Many of my colleagues moved out of their general practice into full-time musculoskeletal specialist practice. I elected to remain in a combined practice. For me, general practice is unique with its own set of satisfactions to which I remain committed. There were also some personal considerations for remaining as well. I spend about a third of my clinical time in the specialty and the rest in the general practice. I am fortunate to be well supported by my associates and staff. The specialist bookings are limited to one to two new patients a day and two to three follow-up cases. Most are seen on ACC at specialist rates, with typically an hour for the initial consultation. The bookings are managed so as not to let the speciality unduly intrude into the general practice.

Some cases involve complex musculoskeletal pain issues; education of the patient about chronic pain is a challenge. It is my clinical belief that a well-structured explanation of their symptoms helps a person to decatastrophise their thinking and offers the opportunity for them to consider alternative ways of coping and managing. The paradigm is to take the suffering dependent patient in pain and try to move them towards improved self-efficacy. This takes time. Not everyone responds to this approach, but I see this as being important. It helps break the cycle of endless referrals and investigations. In many instances it is the first time a patient gets the opportunity to give a full narrative of all that has happened; surprisingly many people volunteer symptoms that they too felt uncertain about sharing at a traditional medical interview. Examination is also comprehensive, with attention to both the local and other body regions and the biomechanical/neurophysiological connections that may co-exist. These findings can be fed back to the patient as evidence of their disordered pain processing or mechanical dysfunction. Being able to meld the science with the art or utilise science when it is needed or art when it is needed makes for a comprehensive approach.

There is a great collegiality in the small world of the musculoskeletal specialists. There is also significant positive feedback from the referral base about the value of having a resource in the community that can assess and advise on musculoskeletal pain issues as well as access advanced imaging. The interventional procedures are most satisfying to perform as they can make a diagnosis or relieve pain. Medial branch blocks for posttraumatic lumbar pain and particularly cervical pain not only accurately diagnose a source of pain but lead to a treatment with a highly predictable outcome. Selective nerve root blocks for acute sciatica often allow people to recover naturally from their pain without the need for early surgical intervention. It has been the aim of the musculoskeletal specialists to let the results speak for themselves. We hold regular workshops/roadshows for general practitioners. Our other specialist colleagues have steadily increased their referrals to us as they have gained confidence in what we do. Referrals have come from spinal and orthopaedic surgeons, rheumatologists and sports physicians. Individuals from their ranks are regularly asked to present at our monthly meetings. ACC in particular use our approach and skill set to help diagnose and manage some of their more difficult and long-term cases.

It is a lot more work; fortunately there is sufficient overlap for reaccreditation purposes to make the extra CME requirements manageable. However, there are commitments to being involved on committees and executives of the various organisations that keep musculoskeletal medicine operational in Australasia. Generating the letters back to the referrers takes place in my time and is the main detraction; however it is important to write a good letter as it also serves as an educational opportunity for our colleagues. My general practice has been centred on providing quality comprehensive care and is below the average in its enrolled patient base. I work in a 'well doctored', stable, established suburb and thus the opportunities to expand the practice were not so great. Becoming involved in the speciality came at a time when the future of small general practices was uncertain. The financial benefits of the speciality have been modest but welcome. As a general practitioner, previously recouping a fee commensurate with the long musculoskeletal consultation was traditionally difficult given the lack of third party support.

This combination of practice provides stimulation and satisfaction that neither interest would necessarily provide on its own. Having an area of expertise backed up by nearly twenty years of general practice experience is an asset that I am privileged to offer to the community.

Competing interests

None declared.