General Practitioners and Rheumatologists: new bridges for a successful cooperation

da Silva JA[1], Cernadas R[2], Canas da Silva J[3]

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Rheumatic and musculo-skeletal disorders (RMDs) are amongst the most common, costly and disabling of human diseases. Their extraordinary burden at an individual and social level is well demonstrated worldwide[1] with social impacts that are already overwhelming in developed countries[2,3] and increasing fast in middle-to-low income regions of the world[4]. In Portugal, a recent national health survey[5] concluded that over 50% of the adult population suffers from some form of RMD, including 26% with low back pain, more than 20% with knee, hand or hip osteoarthritis and 10% with osteoporosis. *Circa* 4% were affected by inflammatory rheumatic disease. Portuguese adults with RMDs had significantly lower quality of life and higher scores of disability and anxiety than people without these conditions.

The societal costs of these conditions will tend to increase strongly over the next decades due to the expected demographic changes, given their chronicity and strong relationship with ageing.

The outcomes of treatment of RMDs have improved remarkably over recent decades, not only due to new medications, especially for immune-mediated diseases[6] but also to new management strategies[7-9]. These developments make use of medications that are expensive[10] and potentially hazardous, which requires the contribution of highly differentiated rheumatologists. On the other hand, recent progress established that it is essential to recognise patients early in the course of the disease, which depends on the contribution of appropriately trained general practitioners. Optimal treatment of RMDs frequently requires a multidisciplinary approach with an intensive program of re-evaluation and adjustment of treatment, which is impossible without a close cooperation between rheumatologists and general practitioners. General practitioners may play a crucial role in early recognition, rapid referral and intensive treatment follow-up of patients with rheumatic diseases.

Cooperation between these two medical specialties is, therefore, an obvious ethical imperative both from the perspective of the individual patient (who is entitled to the best possible treatment) and from the perspective of society, which dully expects the cost-effective and judicious use of resources.

This cooperation faces a number of hurdles and opportunities. Among the most important difficulties lies the limited exposure of general practitioners to rheumatology both during the undergraduate education and the specialist training, which is in sharp contrast with the epidemiological importance of RMDs and their frequency in medical practice. This has an important negative impact not only in the ability of performing timely diagnosis of early conditions but also in the communication process indispensable for cooperation. In fact, RMDs are especially demanding on soft clinical skills related to the evaluation and valuing of essentially subjective symptoms, such as pain, stiffness, fatigue, and signs, such as swelling and crepitus. Personal cooperation and even the understanding and application of guidelines and practice recommendations depends on a common language that is frequently absent. Difficulties in recognizing mild swelling or inflammatory pain rhythm, for example, are common among non-specialised physicians[11,12] and represent an important obstacle to communication, especially as they cannot be conveyed by objective lab or imaging results.

Recognizing this problem suggests that effective cooperation between rheumatology and general practice requires more than practice guidelines and written recommendations. Case-based training and effectively sharing the care of real patients seem essential to build the indispensable common language. This used to be very demanding in terms of time and resources but can be remarkably facilitated by the appropriate use of

1. Rheumatologist, Rheumatology Department, Centro Hospitalar e Universitário de Coimbra, Portugal
2. General Practitioner, ARS Norte, ACES Espinho-Gaia, Portugal
3. Rheumatologist, Rheumatology Department, Hospital Garcia de Orta, Almada, Portugal

modern technologies, such as tele-medicine and the simple exchange of audio, image and video files. This should, ideally, be streamlined through officially established channels of personal communication between primary care and hospital-based rheumatology practitioners organised in patient-centred shared-care communities. General practitioners should aim to help patients to achieve optimum quality of life by using a holistic approach and by allowing maximum choice and control over their diseases. Proper management can not only improve quality of care, but also increase job satisfaction and reap rewards under a new contract.

In Portugal, Functional Coordinating Units for maternal and childhood health exist, by law, since 1991 and have strongly contributed to the extraordinary progress of quality indicators in these areas observed since then[13]. A similar experience regarding Diabetes care was recently launched.

The ever-increasing burden of RMDs imposes the need to bring down the traditional barriers between medical specialties and the hurdles created by bureaucracy and shrinking resources, substituting them by bridges routed in medical competence and professionalism.

CORRESPONDENCE TO
José Canas da Silva
Rheumatology Department,
Hospital Garcia de Orta,
Av. Torrado da Silva,
2801-951 Almada, Portugal
E-mail: canasj@sapo.pt

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