The first annual EULAR Congress

The June 2000 congress in Nice is the first annual Congress of the European League against Rheumatism (EULAR). Until now congresses have been organised once every four years, with smaller sized symposia in between. Another change this year concerns the journal of EULAR. In January 2000 the Annals of the Rheumatic Diseases became the official journal of the organisation. For many of the congress delegates, the Annals is well known and a good old companion, being the oldest independent international rheumatology journal. For some of the readership it will be a new experience. As from now on all delegates of the annual congresses will receive the Annals the readership will automatically be considerably increased. The editorial team is well aware of this new situation and responsibility. We will continue our efforts to guarantee a journal of the highest educational and scientific standards. In addition, we will keep you informed about what is happening in EULAR. To this end a special section, “EULAR news”, will be included and focused editorials will be written when appropriate.

In this June issue of the Annals we make a start with the “Series on education”, which is introduced by Anthony Woolf and Michael Doherty (see following editorial). In subsequent issues a number of specialists in the field will discuss various aspects of education and training in rheumatology. Hopefully, this will encourage a lively debate on these important themes. Last but not least the executive committee of EULAR and the editorial team of the Annals of the Rheumatic Diseases wish you a fruitful and, above all, enjoyable stay at the first annual EULAR Congress in Nice.

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Leaders

Education to improve the health of the nation: Who should we educate?

The overall purpose of health care is to maintain health—to prevent and to treat disorders effectively to secure the greatest possible gain in health. Education is an important means of achieving this. In this issue of the Annals is the first of a series of articles on education, each focusing on different aspects that will result in the improvement of outcome of those with musculoskeletal conditions.

Any strategy that is aimed at influencing health must be based on evidence of clinical and cost effectiveness, but also it must be effectively implemented. Implementation requires compliance by the public and patients, in addition to priority and funding. Patients must have faith and confidence based on knowledge. This is especially important with chronic disorders that cannot be cured, are often progressive and, at most points of their natural history, have an effect on a person’s quality of life. The enormous expenditure on alternative and complementary treatments testifies to our inability to meet the expectations of the public and to what lengths they will go to try to achieve their desired goals. This gap between what is desired to be achieved and what can be achieved needs to be closed by better treatments developed by research. However, the gap can more rapidly be narrowed by the better application of existing treatments and by more realistic expectations by patients and public. The more the public drives the provision of care, the more it chases the ideal and not the realistic. Public pressure is important to prevent complacency, but it must be balanced against the harmful effects of creating unfulfilled expectation. Education of patients about what can be achieved and how to gain self management skills, such as developed by Lorig et al and promoted in the United Kingdom by Arthritis Care, can result in greater fulfilment.

There are now effective interventions for many musculoskeletal conditions. For example, pain can be effectively relieved, though not always eliminated, by a variety of pharmacological and non-pharmacological approaches; rheumatoid arthritis in many cases can be controlled by an increasing number of therapeutic agents; osteoporotic fractures can be reduced by bisphosphonates; and osteoarthritic joints can be replaced with restoration of mobility and independence. Clearly there is a need for further advances, but much more can be achieved by optimising the application of our existing management options. Much of the current suboptimal application is due to ignorance—not recognising the clinical need, not knowing sufficiently the role of modern interventions, and still retaining a mistaken negative attitude to conditions that are viewed as chronic, incurable, and often the inevitable consequences of age. As a result the patients’ problems are not properly
recognised or considered important by professionals. Subsequently, many patients think that they should not complain and learn to cope with their condition and its inadequate treatment.

Recognition of the needs of the patient depends on recognising what is abnormal, what is important to the individual, and what priority is appropriate for action. For chronic diseases both short and long term goals have to be considered. This requires an understanding of the disease, its natural history and impact using the biopsychosocial model,2 what can be achieved by interventions, and how to apply them. The use of appropriate interventions depends on knowledge of what is cost effective not only in randomised controlled trials but also in clinical practice to produce health gain. This may be by critical appraisal of the evidence or knowing how to access the assimilated evidence base in systematic reviews such as the Cochrane database.

Recognition of what is abnormal and what is important requires good clinical skills. For conditions as common and pervasive as musculoskeletal disorders, this needs to be acquired from early clinical experiences and reinforced and built on through subsequent stages of training. In many settings the emphasis and exposure to musculoskeletal conditions during training needs to increase to be commensurate with their burden—this is one of the aims of the Bone and Joint Decade 2000–2010. This is particularly true for those who will work in primary care where almost 10% of all consultations relate to musculoskeletal conditions.

Education needs to focus on specific objectives. From these will derive the most efficient methods of learning and appropriate means of assessment. Recommendations for undergraduate education in the locomotor system have been produced in various countries and a core curriculum has been proposed for undergraduate education in Europe.3 These recommendations focus on rheumatology, but it is often more appropriate to integrate fully teaching of the musculoskeletal system both vertically and horizontally. For example, learning about mechanisms of antigen presentation and acute phase response at the same time as assessment and management of rheumatoid arthritis, and learning about medical and surgical approaches to management together rather than separately. Priority within an overcrowded curriculum can be achieved by the value of basic skills, attitudes, and competencies that are essential to locomotor disease management but which also have general applicability in other areas of medical practice.

The evolution of undergraduate education is towards prioritisation of common conditions that reflect the community morbidity; an emphasis on skills and attitudes, as much as essential knowledge; learning that centres around the student; and encouragement of self directed learning that persists throughout their professional life. One of several ways of encouraging these is problem-based learning, which also requires acquisition of problem analysis skills. This approach is used in many medical schools where the curriculum is taught through a limited number of key illustrative cases.

Teaching is a skill that is frequently undervalued in academic establishments. Such establishments often rate research output and grant income above teaching endeavour. However, there is now increasing recognition of the skills that are necessary to be a good teacher and that good teaching is an essential feature of medical institutions. There are a growing number of “Teach the teachers” courses in many countries, and some have been organised specifically for rheumatologists by the EULAR Standing Committee for Education and Training.

Training in the European Community now reflects the mutual recognition of training and the legal ability, and reality in practice, of free movement of doctors. There is a need, therefore, to harmonise training between European countries, not to standardise practice, but to ensure the same benefits of health care are achieved wherever in Europe a person is treated. There are now recommended training standards,4 but audit is needed to see whether the goals are being achieved.

Many of the advances in the treatment of musculoskeletal conditions have been made in the past 10 years, but most current specialists trained before then. Maintaining competency and demonstrating maintained competency is increasingly recognised to be important for the provision of high quality and equitable care. There is a wide range of educational activities to fulfill this need and a move towards continuing professional development. The annual European Congress of Rheumatology will become a major focus of high quality continuing medical education, but it must be used to meet the individual’s needs. Assessment of those in practice is becoming necessary in many countries by visitation and in some by re-accreditation. It is essential that the profession shows that it is maintaining its own high skills if it wishes to avoid external regulation.

The application of any strategy requires priority and funding. This priority is not just political at the highest level, but the recognition of importance must be with one’s peers as well as the public. There must be much greater awareness of the burden of musculoskeletal conditions and of what can be achieved so that there is more priority both in education and also in the application of these interventions to achieve maximum gain in health. This is the aim of the Bone and Joint Decade 2000–2010.

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