

Tips for GP trainees working in rehabilitation medicine

At the interface between hospital and community-based medicine, rehabilitation medicine delivers multidisciplinary assessment and treatment for adults with complex disabilities arising from acute events such as stroke, traumatic brain injury, spinal-cord injury, complex trauma, or amputation. Rehabilitation medicine practitioners also manage disability related to long-term conditions such as multiple sclerosis, cerebral palsy, and other neurological and musculoskeletal disorders.

Patients present with a wide range of problems, including physical, cognitive, behavioural, and communicative difficulties. Rather than focusing on just the medical problem, rehabilitation medicine aims to reduce the impact of the disease or injury on the patient's quality of life. This requires a holistic approach with the collaboration of the individual, their friends and family, and a large team of health and social care professionals. An inpatient stay will include a thorough assessment of a patient's problems, followed by a structured programme, based around individualised, patient-centred goals.

It is a hugely rewarding specialty: people's lives are suddenly and irreversibly changed by accidents, acute medical problems, or the onset of chronic diseases. The work of the rehabilitation team enables patients to be discharged, to home when possible, and optimises reintegration into the community, with further review to look at matters such as returning to work.

As a GP trainee in rehabilitation medicine, you will encounter a diverse range of medical conditions, psychological problems, social and ethical dilemmas. Learning opportunities are not always obvious but they are endless! Here are some suggestions:

GENERAL

1. You may find the pace of work slower than in other hospital specialties, as inpatients will often stay on the unit for several weeks or months. Use this opportunity to review

things over time and to watch and wait, as you will often do in general practice when dealing with minor illness or chronic disease. Get to know your patients: they will appreciate your company and you will learn a great deal from them.

2. You will need to interact and communicate with many different teams, both in primary and secondary care. This is a good opportunity to fine-tune your referral skills. If possible, ask for some constructive feedback on your referral letters.
3. It is the work of the whole multidisciplinary team (MDT), (rather than your heroic skills in clinical diagnosis and treatment) that will ultimately lead to the patient leaving hospital. Spend time with different members of the MDT to find out what they do and how they contribute to the patients' care.
4. Where possible, work around patients' therapy sessions. These should usually be given priority over your medical input.
5. Consider how you could improve your general approach and attitude to people with complex or severe disability. People with disability often get a raw deal in the NHS; think about how someone with communication or cognitive problems may be treated on a busy acute ward.

MEETINGS

6. The MDT meeting will be one of the most important parts of the weekly timetable. Contribute where you can; as the doctor on the 'shop floor', your input will be valued. Reflect on each meeting: was it chaired well? Did it run smoothly? How was conflict resolved? Were the opinions of different team members voiced effectively?
7. Try to follow a patient through the system after you have clerked them in. Attend any relevant 'goal-planning' and/or family meetings. This will give you a better idea

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Submitted: 14 January 2013; **final acceptance:** 3 April 2013.

©British Journal of General Practice 2014; **64:** 206–207.

DOI: 10.3399/bjgp14X679516

of some of the issues and anxieties people face as they start to plan for discharge from hospital.

CLINICAL WORK

8. Rehabilitation nurses are trained to carry over what the patient has done in therapy onto the ward. This requires a very different skill set to acute nursing but you will find staff usually know the patients extremely well, so learn from them and take their concerns seriously.
9. Take an interest in patients' long-term medical problems and aim to optimise their management before discharge. Think about appropriate secondary prevention. Take the opportunity to discuss smoking cessation and lifestyle changes.
10. Review drug charts frequently. Can you justify every medication on the list?
11. Familiarise yourself with different communication aids. Learn strategies to help you to communicate with patients with aphasia.
12. Use this placement to brush up on your neurology. This is a good opportunity to get to grips with rare conditions like Huntington's disease and motor neurone disease. You may only encounter a few of these cases in your GP career but it will be important to get them right.
13. Learn different ways to assess cognition; this may be significantly impaired and may not be apparent initially (for example, in patients who have had pathology affecting the right cerebral hemisphere).
14. Learn about autonomic dysreflexia: a potentially life-threatening condition, unique to patients with spinal cord injury.
15. Many patients with neurological conditions develop bladder or bowel problems. Learn to take a good history for incontinence, the investigations which may be helpful and some of the options for treatment. Don't forget, simple things first: do a urine dipstick and pre- and post-micturition bladder scans on the ward.
16. Learn about spasticity: the physical and pharmacological measures that can be used and the indications for more invasive treatments such as botulinum toxin injections or intrathecal baclofen therapy. If possible attend a spasticity clinic.
17. Learn how to assess and manage neuropathic pain. When starting gabapentin, or pregabalin, start low and titrate the dose up every 3–4 days as

tolerated. Introduce this medication at night first, in order to improve compliance.

18. Consider infection as a cause for worsening spasticity, neuropathic pain, increasing seizure activity, or a reduced level of consciousness. Urinary tract infections are common, especially in catheterised patients.
19. Psychological problems are common in this population, either as a preceding comorbidity, reaction to the event, or as part of the disease process itself (for example, post-stroke depression). Learn to screen for depression and anxiety.
20. Think about sexual function; it is important for GPs to be able to counsel patients about returning to sex after a stroke or illness and to understand some of the possible medical interventions for sexual dysfunction related to neurological disability.
21. If you have a patient with a tracheostomy, learn how to change an inner tube, perform sterile suction, and what to do in an airway emergency (for example, accidental decannulation).

OUTPATIENTS

22. Find out about some of the charities that can provide further support to your patients in the community (for example, the Stroke Association, Headway, Multiple Sclerosis Society, and the Motor Neurone Disease Association).
23. If you are based in a unit with a prosthetics department find out how amputees are assessed, and how prosthetic limbs are constructed and fitted. Learn about specific problems such as phantom limb pain.
24. Learn how patients are assessed for, and fitted with, a wheelchair.
25. Learn about some of the weird and wonderful pieces of equipment that are used in rehabilitation medicine, including ankle-foot orthoses, functional electrical stimulators, and dynamic splints (such as the SaeboFlex™).

FINALLY

26. Take time to consider and reflect on the complex ethical dilemmas surrounding this field of medicine. It is important to discuss these with your colleagues and reread General Medical Council guidance.
27. For more information about this diverse and rewarding field of medicine, visit the British Society of Rehabilitation Medicine (www.bsrm.co.uk).

Provenance

Freely submitted; externally peer reviewed.

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