Rheumatology training in the UK: the trainees’ perspective – issues surrounding paediatric rheumatology

We read with interest the letter by Foster et al., highlighting the problems relating to paediatric rheumatology in the UK. Paediatric rheumatology is certainly one of the subspecialties in need of better provision for training as well as delivery of care. Whilst subspecialties like primary care rheumatology, for example, suffer substantially due to suboptimal communication between primary care and secondary care, paediatric rheumatology training is quite a complex issue with a number of factors that need to be taken into account. Alongside inadequate recognition, paediatric rheumatology also suffers from lack of interest among trainees. This may be worsened by the lack of local interest among consultant rheumatologists not involved in the delivery of paediatric rheumatology care. To make matters worse, the teaching of musculoskeletal aspects of the paediatric curriculum appears to be deficient [1]. The challenge we are confronted with now is to find the appropriate assessment tools to ensure that both general and specialty paediatricians are competent in these core areas, have adequate educational plans to remedy the deficiencies, and build on their strengths.

There are a number of ways of trying to bridge this gap between demand and care delivery. Promoting adolescent rheumatology may be one extremely good way of generating interest among adult rheumatologists and rheumatology trainees [2]. Our understanding of the debate relating to the best person for delivery of care in paediatric rheumatology is that the focus should be more on training paediatricians to deliver this, though this is yet to be fully achieved. The demand for paediatric rheumatology in the country is unlikely to be wholly met by rheumatologists, and paediatricians have an important role not only in the facilitation of delivery of care, but also in providing some trainees with an interest in this subspecialty. Perhaps the rational argument at this stage would be that, irrespective of the medical background, it is perhaps more important to have an interest in paediatric rheumatology. For this to happen, perhaps more exposure to the subspecialty would be necessary for medical students, medical and paediatric senior house officers and general practice trainees. Perhaps a study looking into the reasons for the lack of interest in paediatric rheumatology would be extremely useful in understanding these complex issues better. If such a study were to be done, by its very nature it would need to have at least some qualitative component.

The key, however, might be in defining and applying the outcomes of training. Sheffield students would be expected to know about (for example) juvenile arthritis, trauma, irritable hip in children and Perthe’s disease. The key to achieving outcomes of training for specialist registrars is ensuring there is an outcome-based curriculum for specialist registrar training in rheumatology. However, outcomes for general paediatrics, primary care practitioners and new foundation doctors (pre-registration house officers/senior house officers) need to be explored to ensure they have an adequate musculoskeletal component in them.

Another important issue is that of competence. Work at Sheffield has shown that students have the appropriate knowledge by their final year even with limited teaching [3]. Preliminary work suggests that students are capable of converting their knowledge into efficient clinical skills (Basu S, BMedSci thesis, University of Sheffield, 2003).

While our study [4] is not conclusive, it provides an extremely useful insight into the strengths and weaknesses of the current system, and it would perhaps be worth having increased dialogue and liaison about these issues between the paediatric rheumatologists, general paediatricians, adult rheumatologists, medical educationalists and the two Royal Colleges (Royal College of Physicians and Royal College of Paediatrics and Child Health).

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Assessment of endothelial function in complex regional pain syndrome type I using iontophoresis and laser Doppler imaging

Sir, We read with interest the paper by Gorodkin and colleagues [1] describing their use of laser Doppler imaging (LDI) to measure the percentage increase in skin blood flow following the iontophoresis of acetylcholine and nitroprusside in patients with complex regional pain syndrome (CRPS). They found no differences in the blood flow responses of the limb affected by CRPS when compared with both the unaffected contralateral limb and the external control group.

Subtle bilateral changes occur more commonly than perhaps realized in patients with CRPS even though they present clinically with overwhelmingly unilateral signs. For example, warm and cold pain thresholds were different in the unaffected contralateral limbs of patients with CRPS when compared with normal control subjects, suggesting widespread changes [2]. Finger misidentifica-