

## COMMENTARY

### Do we need help from our pediatric colleagues?

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I believe we in pediatric rheumatology could use some help and support from our pediatric colleagues. I don't know, you may not agree. Why may we need help? I think that we as pediatric rheumatologists still have many problems to address. We are still in a manpower shortage, even in North America and Europe. We are not teaching many medical students and graduates. As we have mentioned before in this column, 1/3 of US medical schools do not have a pediatric rheumatologist (PR). Many other countries could use more PR's. Some countries are just starting to develop a pediatric rheumatology program or have never thought of having a PR. We do not have enough researchers. To me, there is no doubt that we need some help and assistance.

In the US, I remember visiting one medical school without a PR several years ago. One of the first comments I heard was that there were not enough patients for a pediatric rheumatologist to be hired on that medical school faculty. The rheumatologist cared for the JIA patients, the nephrologist the lupus patients, the neurologist the dermatomyositis patients, the dermatologist the scleroderma patients, and so on. No one was making an effort to collect these patients with rheumatic diseases into one clinic and thus any estimate about prevalence and need was likely to be inaccurate. These physicians were preserving the status quo and not open to the need for a pediatric rheumatologist. No one was teaching the residents and students. These manpower and teaching issues are a problem in North America and likely in nearly every country. How many medical students and pediatric and family medicine residents are graduating each year without any significant teaching about most musculoskeletal and rheumatic diseases in children around the world?-thousands per year.

We also may have one or two PR's in a center but not nearly enough PR's to establish a first-class clinical and research center (minimum of 5-6 PR's). How many of us believe that we could have better support from our pediatric departments in funding, nursing, salaries, research grant opportunities, training in research, and many support areas; Probably a majority of us. Can we look to adult rheumatologists for this support? We can't in most centers. They often have their own needs, priorities, and funding challenges.

#### **Workforce**

I heard the same refrain when I started at one medical center years ago as the first pediatric rheumatologist in the region: "What are you going to do with yourself? There are not any

of those types of patients around here". Within several years I was too busy. I think that we can say without fear of contradiction that if you don't have a specialist for a particular subspecialty at a particular center or medical center, you will not see many of those patients. These patients will be spread out among many physicians and subspecialists, many of whom believe that they are competent to care for these children (some are, some not). So at many of these underserved medical schools and medical centers, we need to spread the message that pediatric rheumatology is needed at every medical school and pediatric training program. We need help from our pediatric colleagues, our chairperson, our adult rheumatologists, our nephrologists, our infectious disease specialist, to spread this message-We need them to believe, to believe that rheumatology is an essential pediatric subspecialty everywhere, despite the overwhelming challenges of HIV, malnutrition, and TB and other infectious diseases in many countries. We need them to believe that research in our area is as worthy as any research.

This is true in many countries where experienced pediatric consultants (in the British model) diagnose and treat rheumatic diseases in children among their many other patients but there is no one to teach, search for and collect these patients, and to set up a center. It's our challenge to convince these consultants that this present system is not sufficient and that even in a situation of very limited resources, it is better for the kids and the society to have at least one pediatric rheumatology center in each country. One of these pediatric consultants would make a perfect candidate to train to become the director of a pediatric rheumatology center in that country.

### **Teaching**

One medical school I visited had another deficiency, the teaching of pediatric rheumatology and musculoskeletal diseases in children to students and residents. It was typical of their view of the universe that they did not have me meet with medical students at all during my 3 day stay. Some of these programs are graduating 100 medical students and 20 residents a year who do not have the skills to do a good musculoskeletal (msk) exam and furthermore, don't think that it's important that they have such a skill. The students and residents have not had a talk on the proper use and the misuse of rheumatologic labs (e.g., the ANA) and radiographs, how to recognize rheumatologic rashes, or how to differentiate one rheumatic disease from another or from a non-rheumatic disease such as leukemia or SCFE.

The time to teach these young physicians and physicians-to-be is **in school and training** before they have decided that a good msk exam skill is not crucial to their practice or subspecialty or that rheumatology involves weird, unusual diseases that they don't need to know much about. I would suggest that it is much harder to teach the majority of generalists a good msk exam and basics of rheumatology than a student or resident. You can set up Continuing Medical Education programs for generalists but the generalists you need to reach usually won't come. **They just**

**don't believe.** With medical students and residents, you have an opportunity to convert them early in their careers. With time, the generalists will know and believe.

So we need help from pediatricians and especially the chairperson of a pediatric department, the medical student clerkship director, and the pediatric residency director. This can be a challenge as the chairperson often comes from neonatology, PICU, interventional cardiology, or basic research with a very limited idea of the true prevalence of these msk problems, what we do in our normal hectic routine, and what our children require. Resident or medical student directors often are generalists who don't believe. One generalist who heads a medical student program suggested to me that he as a generalist could teach about rheumatologic and msk problems well enough and didn't need help from a rheumatologist for a student lecture. I wondered to myself how many msk exams I've done-I then calculated it in the shower, >20,000; It seemed to me that this generalist may have done a lot less (200? 400? 800?) and likely may not be as good at teaching the msk exam. I digress.

With the help and support we can get for our pediatric colleagues, we must advocate for student and resident rheumatology lectures, grand rounds, teaching rounds on the pediatric unit, rotations of students and residents through rheumatology and other msk clinics, and similar chances to get our message across. This message must come from only a pediatric rheumatologist-not an orthopedist, sports medicine specialist, adult rheumatologist-their worlds are different and their viewpoints often more limited in scope. Pediatric rheumatologists are needed at each medical school for this effort.

### **Common experiences**

You may believe that our best model and ally is our adult colleagues, the rheumatologists. They treat similar diseases with similar medications and other therapies. I believe that other pediatric subspecialists are equally our model and colleagues. They treat often similar chronic illnesses in similar hosts in the same pediatric hospitals and departments. We can learn from observation of their efforts to develop a viable subspecialty section of at least 5-6 subspecialists with clinical and research components. We can learn about promotion in the pediatric milieu, grant submission efforts, development of the resources for nurses, secretaries, therapists, and the team approach, how to advocate for better salaries, and other pediatric departmental issues. You may be lucky and be located in a center with an outstanding adult rheumatology program that carries you along in its wake, but most pediatric rheumatologists find us as more a part of the pediatric department than the adult rheumatology section. We need to thrive in the pediatric environment and develop programs that benefit the children we care for.

In sum, we as pediatric rheumatologists need help from other pediatricians in our medical schools, medical centers, cities and countries. We need support that pediatric rheumatologic problems and musculoskeletal problems are common, not rare and obscure, and that they need

to be a regular part of a medical student and resident curriculum and clinical experience. We need pediatric chairpersons to recruit pediatric rheumatologists to start new programs and to support the development of existing programs. We need more nurse and team support, better salaries, support for fellow training, help with career training and advancement, more research focus and support, and in other areas. We must advocate and cajole when the chairpersons are slow to help. No doubt, we must try to pull our weight to deserve such help. We need to seek many opportunities to teach both medical students and residents and have them lay hands on our patients in clinic, not just care for our sickest lupus patients in the PICU. We should observe and learn from how our pediatric colleagues have developed successful programs in pediatric centers. As one of the youngest and still underdeveloped pediatric subspecialties, there is a lot we can learn. Yet we should be optimistic and aggressive in pursuing help in our pediatric environment. We can and will get better.