For Debate . . .

Clinical rheumatology *has* advanced

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British Medical Journal, 1977, **1**, 1015-1016

What an unjust impression of rheumatology Professor Watson Buchanan and his colleagues give.[1] If ever rheumatology was the "Cinderella of Medicine," as they suggest, surely she is now "Belle of the Ball" with a clear future. Rheumatology has had excellent recruits. After all, we have recruited the Glasgow group, haven't we?—and they (usually) are a bright lot. And what's this about arthritis and rheumatism lacking in excitement? Quite apart from specifically rheumatological emergencies[2] patients with rheumatic diseases are, if anything, more prone to a wide range of medical and surgical complications than the normal population.

Now that the major organ systems of the body are increasingly taken over by specialists rheumatology becomes one of the last strongholds of general medicine. Rheumatoid arthritis (rightly called by Ellman[3] rheumatoid *disease*) may also affect the heart, lungs, eyes—there is no part of the body that cannot at some time be affected by it.[4]

What in fact have the Glasgow group shown? That some jobs in rheumatology are more attractive than others, and some medical students are attracted to rheumatology and some are not. Interesting, but hardly surprising. What is surprising is the mental non-sequitur that there has been a failure to advance the specialty. This is nonsense. This is a changing and rapidly developing specialty. In the past 30 years rheumatic fever has disappeared, and gout and polymyalgia rheumatica have ceased to be hospital problems. The new tools for treating patients with rheumatoid arthritis enable us to keep far more of them in remission, or at least in reasonable working order. Productive close relations have developed with surgical rheumatologists, who are now replacing so many damaged joints that they have created a crisis of supply. The specialty has developed its own diagnostic and treatment skills, such as arthroscopy, synoviography, and intra-articular injection. Perhaps more than any other, it practises the total care concept in looking after patients in partnership with colleagues in the remedial professions.

Some doctors are temperamentally unsuited to the care of patients with chronic diseases, which means growing old with our patients and becoming their friends. People who cannot do this should not enter rheumatology in the first place.

Rehabilitation

It is time that some logic was injected into the vexed word "rehabilitation"—a beguiling word meaning all things to all people. Politicians and the public believe that it somehow gets patients back to work or to the maximum enjoyment of life after the "ordinary" doctors have finished treating them. So the doctor labelled "rehabilitation" is identified with the man who looks after the incurables and untreatables. In contrast again, the physiotherapists and occupational therapists sometimes regard rehabilitation as what *they* do, and some of them think they have the monopoly of it. Others, with axes to grind, have squeezed the word to include the resettlement of patients after injury (meaning finding a job); the rehabilitation of addicts (meaning cure); the rehabilitation of the mentally subnormal (meaning education); the rehabilitation of the brain-damaged (meaning very little); the rehabilitation of the educationally, politically, or economically underprivileged (meaning compensation for social inequalities); and even the rehabilitation of old furniture (meaning mend). It is time the dratted word was banned in serious medical discussions, never to be used unless qualified by saying who is being rehabilitated and for what.

A consultant leading a team concerned with rehabilitation should be a rheumatologist, neurologist, cardiologist, or whatever is the most appropriate diagnostic specialty. His job description could certainly include his managerial responsibilities if they give a general direction to a modern system of remedial departments or liaison with community medicine. Specialties are divided by organ system (cardiology, rheumatology, neurology, etc). Rehabilitation is none of these. It is a subdivision by treatment department. Therefore inevitably any discussion of rehabilitation gets bogged down by semantics. Let's not use the word; it has caused too much trouble. (Or if we do use it let's reserve it for those academic or regional centres which are in business to evaluate new or existing techniques applicable to a wide range of disabilities in collaborative studies with colleagues.)

Once we do this a number of anomalies glare at us, asking to be put right. Firstly, the DHSS should cease to regard rheumatology and rehabilitation as interchangeable, and should cease to count trainees and specialists with these labels under the same heading. It leads them to assume that a rheumatology service exists when it does not. Secondly, the specialty can rationalise unnecessary duplication. Two professional societies when we need only one. Two journals struggling for existence when one would do. In each case the duplication occurs because one society or one journal also carries the additional tag of rehabilitation.

Needs of the rheumatologist

But Buchanan and his colleagues are right to protest if any job advertisement in clinical rheumatology is not up to standard. The specialist accreditation rules of the Royal Colleges of Physicians insist that a clinical rheumatologist must have a wide background in general (internal) medicine, including experience of medical emergencies, and must possess the MRCP or equivalent in addition to his specialist knowledge and skills. While rheumatology is exceedingly varied, in practice much

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work at hospital level will concern rheumatoid arthritis and its complications, and those diseases that resemble it in some way.

A clinical rheumatologist is therefore trained to be a full member of the division of medicine in the hospital where he works, and he has the same need as other medical colleagues to admit and care for those of his patients who are seriously ill in medical beds in the district general hospital with full facilities for diagnosis and investigation and adequate junior staff support. He also needs time to help train his junior staff and, if he wishes, some time to research and improve aspects of his work.

It is an obsolete concept of rheumatology that it should be some type of outpatient specialty, dealing with physical medicine treatments, a decanting facility for orthopaedic and other failures, and professionally isolated from other branches of medicine. The Glasgow group are right in denouncing this. Poor jobs lead to frustration and emigration of younger rheumatologists trained along the lines that the colleges advise. But, equally, to suggest that rheumatology has failed to advance in Britain will also boost the brain drain.

The cure lies with us as rheumatologists. Our medical colleagues are often fully aware of the need for rheumatology services. And it is they at district general hospital level who initiate new consultant jobs in rheumatology or change old ones to include it. The problem is they are often not fully aware of what we need to do our job, and they may not be able to offer all that we would like. Therefore we need to be more adaptable and recognise that it is not too easy for them. The guidelines issued by the Specialist Advisory Committee of the Joint Committee of Higher Medical Training of the Royal Colleges seem to rule out accreditation of "general physicians with an interest in rheumatology." This really means that people should not practise rheumatology unless they have some training in it, but it has been too rigidly interpreted and many such people provide excellent services. Administratively, it is easy to arrange double accreditation in both general medicine and rheumatology, and in many hospitals, particularly the more remote ones, this may be the only way of getting specialist advice.

We should accept double accreditation, which would be popular with junior staff. And we should, through our professional and support associations, help whoever is appointed as much as possible. Why not arrange rotating junior staff appointments in rheumatology between, say Glasgow and Pembroke? It would probably work out extremely well and to everyone's benefit. In less peripheral centres, the rheumatologist and his junior staff should be encouraged to care for patients with acute medical conditions. Most stay in for only a few days, and most hospitals have excellent arrangements for internal consultation and referral to cope with special problems. Near to the larger towns and teaching hospitals the rheumatologist will probably not want to do this, and in the teaching and postgraduate hospitals it is already evident that some will specialise within rheumatology —its immunological, metabolic, and other aspects are advancing so fast that it is difficult to keep up with all fields at once.

And is rheumatology in "a very much healthier state in the other English-speaking countries of North America"? One-third of all papers of the recent American Rheumatism Association's scientific meeting at Miami Beach concerned systemic lupus erythematosus—hardly one of the more common problems of rheumatology. In contrast, only one clinical trial reported a treatment for rheumatoid arthritis and that was an uncontrolled anecdotal trial drawing unjustified conclusions from inadequate evidence. If I had rheumatoid arthritis I would infinitely prefer to be treated over here.

References

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3 Ellman, P, and Ball, R E, *British Medical Journal*, 1948, **2**, 816.
4 Thompson, M, in *Progress in Clinical Rheumatology*, ed A St J Dixon, p 10. London, Churchill, 1965.

(*Accepted 7 February, 1977*)

What is the value of bran tablets in treating diverticular disease?

Bran tablets are a perfectly acceptable form of bran. They consist of processed bran and calcium phosphate. The calcium phosphate blocks the phytic acid that is said to reduce calcium absorption. Manufacturers assure me that it is clever to make a bran tablet because it is difficult to get the constituents to stick together. Nevertheless, when chewed they act exactly like natural bran.[1] I prescribe bran tablets rarely because they are paid for by the NHS, whereas if the patient can be persuaded to buy processed bran from the health food store it is one less charge on the State.

[1] Taylor, I, and Duthie, M L, *British Medical Journal*, 1976, **1**, 988.

I was taught that constipation is not important because the toxic products of the decomposition of food are not absorbed from the gut. Is this still the accepted wisdom?

Certain products (such as indoles, skatoles, etc) may be formed by bacterial degradation of intestinal protein and nitrogenous matter in the colon and absorbed. Although production or absorption or both of such toxic products may be enhanced in patients with constipation, there is no evidence that they contribute to "intestinal toxaemia," as they are degraded to harmless metabolites by the liver and excreted. In patients with severe liver disease or portosystemic shunting, however, failure to detoxicate such products may contribute to hepatic encephalopathy. In these cases constipation should be avoided, and purgation or other measures to reduce intestinal protein content and to inhibit colonic bacterial proliferation are indicated.

The advice given to prospective travellers abroad sometimes includes the administration of gammaglobulin. I thought that once a patient had been given gammaglobulin it was necessary to reimmunise against all the frequent illnesses. Is this so?

Hepatitis is one of the commonest illnesses acquired abroad, and 0·5% of normal immune gammaglobulin given intramuscularly just before departure reduces the incidence of infective hepatitis but probably has no preventive effect on hepatitis B. This injection is usually given after completing a full schedule of vaccinations for foreign travel, but it is not necessary to reimmunise after a gammaglobulin injection.

What is the best treatment for a fractured rib?

The modern treatment of a fractured rib does not entail strapping. There are various reasons for this. The first is that whether the patient is allergic to strapping is unknown and the ensuing reaction may be much more distressing to the patient than the pain and discomfort of the fractured rib. Secondly, the immobilisation of the chest that accompanies what used to be called adequate attempted immobilisation of the rib militates against chest expansion, which is a bad feature. The modern treatment consists of explaining to the patient how to cough with his hand over the fractured area. It is also possible to inject a solitary fractured rib with a local anaesthetic, such as bupivacaine hydrochloride (Marcaine 1%). This acts for quite a long time and breaks the reflex arc of pain, swelling, and pain. Most cases of fractured ribs take their own time to settle down in spite of any treatment, and this is about three to six weeks.