

## **Editorial**

# **Turf wars in paediatric allergy**

Which physician is best able to manage a child with an allergic disease, a paediatrician without any allergy training or an allergist who has little experience of treating children? Ideally, of course the answer is a paediatric allergist. However, in many parts of the world such specialist expertise does not exist. Under such circumstances the interests of the child are best served by a paediatrician and allergist collaborating in managing the problem. This is not necessarily ideal as neither may have a full understanding of the pharmacokinetics and pharmacodynamics of anti-allergy treatments in children, and the nutritional and allergic consequences of an exclusion diet for food allergy may not be fully addressed.

It becomes even more difficult to decide who should manage childhood asthma, a paediatrician in chest medicine or allergy. Ideally all paediatric pulmonology training programmes should include a considerable component of allergy experience and education and conversely allergy programmes must include respiratory medicine training. Sadly this is not always the case. Furthermore, both disciplines are desperately trying to raise their own profiles and will claim to be able to manage all cases of asthma themselves. Without both disciplines we will never achieve adequate and complete training programmes covering all aspects of allergic airway disease. The same conflict is true for atopic eczema (dermatology or allergy), allergic rhinitis (ENT/ORL or allergy) and food allergy (gastroenterology or allergy).

Recently, the UK Government Department of Health has been conducting a review of allergy with the intention of making decisions about future funding of services. This has polarized the views of some specialist groups and most notably clinical immunologists, who have, to a certain extent, parted company with allergists. Clinical immunologists in UK are required to run the immunology laboratory as well as providing clinical services for immunodeficiency, autoimmunity and infectious disease. This is more than

enough but in the absence of a comprehensive allergy service in some parts of the UK, clinical immunologists have also run allergy clinics. Given the wide range of expertise they require to fulfil all their roles it is very unlikely that they will have received the same intensity of training as a mono-specialist allergist. However, as there is a clear need to expand clinical immunology as well as allergy, the perceived opportunity of extra funding for allergy has led clinical immunologists to claim that they are already well trained and run a substantial proportion of allergy clinics in the country. Separate submissions from dermatologists and chest physicians have also indicated a substantial input to allergy services. On the other hand, the allergists have indicated that there is an enormous unmet clinical need and have recommended a considerable expansion of the numbers of allergists. The conflicting evidence presented to the review has not always been helpful to the allergy sufferer. If several disciplines suggest that they can cover all allergic disease it gives government a perfect excuse to do nothing.

In the current economic climate, even in developed and relatively affluent countries, medical rationing is becoming a reality and each specialist discipline must justify its existence on health-economic grounds. As atopic diseases are high volume and relatively low cost by comparison with many other chronic problems of childhood it is inevitable that turf wars will arise between specialist groups. As hospitals scrutinize their portfolio of specialities, they will be only too pleased to accept that allergy can be covered by system specialists dealing with individual allergic manifestations. No doubt in a private system this will increase the hospital's income but it is hardly the most economical way to treat patients with very common allergic co-morbidity affecting two or more systems simultaneously. Indeed the most coherent claim that allergy is an important mono-speciality is that it provides a one-stop service for all allergic problems that commonly co-exist and

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in childhood follow one another in the allergic march. This may provide the opportunity for prevention of future disease.

In the end the turf wars between disciplines will only harm the interests of allergy sufferers. It is perhaps best to overcome the dispute by defining competencies for treating specific conditions rather than identifying which specialist group is equipped to deal with the problem. The recently published competencies by the World

Allergy Organisation (1) will be of enormous value, in this respect.

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## Reference

1. KALINER MA, DEL GIACCO S, CRISCI CD, et al. Requirements for physician training in allergy. *Allergy Clin Immunol – J World Allergy Org* 2006; 18: 92–7.