

Highlights from this issue

doi:10.1136/archdischild-2013-305524

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People say some daft things about being a paediatrician, especially when you announce it as a career choice. I remember someone saying to me “Ah, well, you can’t like kids that much then”—based on an assumption that I would spend the rest of my professional life causing pain and distress to children. Someone else said to me “Oh, I’d be a paediatrician, if it weren’t for the parents ...” Reflecting on this over the years, the combination of working with children and their parents has been much of what has made work so satisfying and rewarding. I’m not trying to make out that I’m a saint or something; in fact far from it, and I have my share of families who I would describe, in the open pages of a journal like this, as ‘challenging’. But working with a family who are genuinely distressed and taking them to a point where they are calmer, more rational, and able to cope a little more can be fun to the point of intoxication.

Talking with students and new training doctors I remind them that paediatrics is different to other areas of medicine in that you’re likely to have, in any one consultation, one possibly unwell person—the child—and then any number of adults, each of whom are at their height of attentiveness. While the

child has excellent antennae for what Holden Caulfield would have described as ‘phony’ behaviour—I reckon a child can always tell if you don’t like them—the adults are highly attuned to detect fear, indecision and lack of experience. They’ll forgive the lack of experience, but only if you can be clear about what you are doing to be as safe as possible with their child.

In this month’s journal the Editor’s choice is an article which I hope that those students, doctors in training, and perhaps some of us who have been around a bit, will read and re-read. It’s by Sheila McKenzie and is a Fifteen-minute consultation on Troublesome crying in infancy (*see page 217*). The title took a little work—in particular to find that word ‘Troublesome’, which I think is an excellent description—since it neither rules in nor rules out pathology, but it does acknowledge the impact of the symptom on the child and the caregivers. I’ve read the couple of pages of this article several times now; and while there are bits at which I protest ‘Well, I’d struggle to deliver that’, it’s hard to fault. Good, sound advice, especially to those embarking on a career in paediatrics, and who will therefore likely see a couple of families in this situation for every night they do on call. I was wondering about how to summarise

the messages from this article as briefly as possible, and thought “How to do as much of nothing as possible” for a minute, until I realised that it’s not actually doing nothing. After listening carefully and coming to a conclusion, the confidence to decide not to investigate and not to treat—with a medicine—does not come easily. In fact, investigation and treatment are easy because very often they defer the problem onto someone else; it wasn’t until I became a consultant that I really learned how not to do things—perhaps because I could no longer plan for the problem to come up in someone else’s shift.

A senior manager, having observed a clinic of mine, remarked “You don’t do much medicine, do you?”—meaning I didn’t do many tests or write many prescriptions. Actually, I probably did quite a lot of medicine in that clinic, and it was probably a lot more fun and interesting than requesting X-rays. I’d put the ‘not much medicine’ as alongside the other daft comments above now, and regard it as a sort of a compliment. After all, requesting the chest X-ray is the easy bit; it’s not requesting it that takes the skill.

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