



Highlights from this issue

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A long time ago a geriatrician showed me a brief glimpse of why his specialty was fascinating. “I don’t know how to do it. I reckon I could learn to do an endoscopy or a cardiac catheter, but I can’t get that little old lady home by using a formula or a technique’. I’ve spent a lot of time thinking about this since. Not about the geriatrics—that interest didn’t stick for more than a couple of seconds. But I learnt about what I’d find interesting; whether I’d find more interest in what I could do, or in what I couldn’t do. Let’s reframe that. We start much of our acquisition of medicine by consuming, processing and internalising immense amounts of data. Treat a urinary tract infection? Yes, there’s a whole bunch of stuff to learn, some by rote, some by understanding the controversy, some by being interested enough to go deeper into the evidence. But after a while, that’s mostly sorted although of course you can always find folk prepared to argue with you about what you’ve done, especially if you publish a guideline about it.

But what if you don’t know how to do something? What if you’re faced with a puzzling or perplexing situation which you can’t take a formulaic approach to? I think that this is one of the reasons the

fifteen-minute consultation section is so popular—because it provides readers with a clinical situation and then provides them with rough framework of how to approach it. It’s rarely a textbook chapter telling you everything about, say, urinary tract infections. More often, it is about the child with some dysuria, who might present some other diagnostic dilemma.

So far, so good. You’ve approached the child with dysuria, established that they have a urinary tract infection. But then there is what we might call the ‘difficult’ family. The ones who cannot engage with the treatment, or who struggle to work with you to help get their child better. I’m going to be careful to keep the word ‘difficult’ in quotes: Annie Swanepoel does the same in her paper (*see page 178*)—her description of ‘parents who may present in ways which are difficult to manage’ is very fair. I’d be willing to bet that most of you who have read this far are nodding in some sort of recognition. The helpfulness of this paper is that it places it into a useful model, she uses attachment disorder and applies it to the behaviour of the whole family. I’ve referenced here before the near-perfect George Box quote: ‘All models are wrong, but some are useful’ and this is certainly at the top end of

useful for me. It gives me a whole new framework for approaching and thinking about these families who absorb so much of my effort. This paper, about difficult to manage doctor patient/family relationships, is my Editor’s choice for this month.

While we’re on the subject of the interesting—and most time consuming—parts of a career being the bits that you don’t really know how to do, because you can’t know how to ‘do’ them, I hope you also make the time to read the paper from Mark Clayton and Jan Aldridge on considering children’s spirituality in advance care planning (*see page 170*). For what it is worth, I’m not a person of faith, and so I struggle with the concept of spirituality, although I’m told that my atheism isn’t a bar on my being spiritual... Again, in this paper there are some fascinating things to think about, in our career-long aim to do our very best for children, young people and families in our care.

In case you think I’ve all gone soft this month, I should emphasise that there are some great bits of good hard transactional medicine here too, there should be something for everyone. As well as some guidance for any of you thinking of writing for us. Please do get in touch.

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