



Highlights from this issue

doi:10.1136/edpract-2021-323751

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In the years I've been in this role I've tried to be careful with my conflicts of interest. If anything, the possible conflicts have increased—not because I've become more interesting, but because the requirements have become, appropriately, more inclusive. In fact, usually I act in a way which actively biases me against needing to declare the conflict. However, this month I'm going to declare a big conflict of interest while drawing your attention to an excellent paper written by friends and colleagues of mine, Geoff DeBelle, Helen Morris, Nick Shaw and Adam Oates. It places a framework around a clinical scenario which is increasingly familiar to me—the child with complex issues, who is non-ambulant, and who has sustained a fracture (*see page 15*). One of the aspects of paediatrics that I really love is that it requires engagement with and integration of very diverse skills. In this instance we've got some really interesting biomechanics and clinical chemistry, shared with the profound importance of appropriate management of position of trust issues. Tremendous harm has been done in the past when we've been too ready to dismiss the chance that health-care workers have deliberately harmed a child—and of course huge harm occurs when false accusations

have been made. The flowchart in figure 1 of this paper is incredibly helpful—which I can attest to as I've used it in the clinical environment. This paper is this month's editor's choice.

Another conflict of interest: I work with the first author, Michael Harris, who with two other co-authors, Chris Oakley and Mohammed Ryan Abumehdi, gives us a really helpful stepwise checklist for interpreting ECGs (*see pages 24 and 26*). We're hoping that Mike and colleagues will be able to use this scheme to lead you through subsequent papers and identify ECG problems; they do that with their first example in this same issue. Personally I find the normal ECG one of the bigger challenges—I can usually spot those that are grossly abnormal but still struggle to be confident that I've not missed something. I understand that nearly all cardiology doctors in training develop or adapt their own process and so I hope that by referring back to this first paper you'll come up with your own similar process for this clinical challenge.

Right, I think I'm out of conflicts of interest now. Except to describe that I struggle each month to pick the best of the papers we have here, in that I feel I know many of the papers and certainly many of the

authors—both from having worked with them clinically and worked with them as authors. It feels very positive that we have both authors who have written for you before, and new folk who are keen to share their knowledge and passion with you.

This edition has two new features. The first is that as college members quite a few of you will have opted out of having a paper copy. I struggle to remind myself that many of our readers around the world have never actually seen the paper copy. I hope that if you have opted out you will continue to engage with the content as actively as before. The second is that we're now up to 80 pages per issue—which is great for us as it means we can continue to bring you great papers in a timely fashion. Of course, if you've not opted for a paper copy this might be less obvious to you. However, I'd like to just take this opportunity to remind you to subscribe to alerts in whatever manner suits you for the journal. It's really easy to do—just go to ep.bmj.com and at the bottom of the page you'll see the instructions. Meanwhile, enjoy!

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