

# Highlights from this issue

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Ian Wacogne, Deputy Editor, *E&P*

Sometimes *Education & Practice* has a standout paper; sometimes it is simply filled with standout papers. This month's is the latter—although don't infer from this, please, that when I write about just one paper I don't like the remainder.

I've got a bit complacent about Helen Williams' high quality Illuminations papers, but I shouldn't have. I still ask the new members of my team to read her paper on recognising the normal thymus<sup>1</sup> almost as induction. This month she's delivered for us get another great paper (*see page 15*), this time on an area that I find very difficult; when the pathology isn't where you expect it to be. As hard as I try to reduce the amount of imaging I request, I still manage to generate a huge amount, and I've become very good at being pretty bad at looking beyond where I expect something to be happening. As a general paediatrician I tend to be a 'soft tissue' sort of a doctor, and my review of a chest X-ray will mostly focus on the lung fields. The examples in this paper remind us to beware of this sort of complacency, cultivating a mindset which looks at 'Review Areas' for—in these two instances—some important findings.

Reading Penelope Bryant and Mike South's paper on children with frequent infections (*see page 8*) also made me think of complacency.

It's easy to image polar opposites; the parents terrified that each sniff and snuffle is a significant illness, and the clinicians who become very used to the high burden of infective illness experienced by children. How to get that balance right—how to spot the child who does need the additional treatment and investigation, and to be good at this—is a lifelong challenge. Does the knowledge, presented in this paper, that a child who has had 12 infections in the last year is only on the 95th centile for infections make us more or less complacent? I tried to read this paper as a parent, and found myself swinging wildly between comfort around symptoms—that 12 infections a year statistic—and then being concerned about all the nasty things that can happen. Managing that swing, and ensuring that your clinical comfort that the child doesn't have a serious underlying disorder isn't a consequence of your skills degenerating into complacency—or isn't perceived by the parents to have done so—is a skill that it hard to acquire, and requires constant work to maintain.

A rather different paper comes from Sophie Robertson, Kate Pryde and Kath Evans (*see page 23*); the next in our Equipped Quality Improvement series. This is about patient and family involvement, and it is important to me that

we've included it this early in the series. You might be better at this than me, but I do tend to assume, in a paternal and almost certainly wrong way that I'm quite good at figuring out what children and their families need from the services I provide. These authors describe a helpful set of tools to improve engagement; I was particularly struck by the 15 step challenge (hint: nothing to do with the 12 step programme from Alcoholics Anonymous) since it mirrors my own perceptions of how our services run; I think I can tell how things are in the hospital by wandering around the ward just getting the feel of the place. The 15 steps challenges me to review my complacency in involving children and families in redesigning my services.

So, the theme, if you hadn't picked it up by now, is complacency, and how to manage it. I hope this issue helps you with that. Provided, of course, that you make the time to dip in and out of it, and don't just leave it, taking it for granted...

Ian Wacogne, Deputy Editor, *E&P*  
ian.wacogne@bch.nhs.uk

## REFERENCE

- 1 Williams H. The normal thymus and how to recognise it. *Arch Dis Child Educ Pract Ed* 2006;91:ep25.