Viewpoint

The Making of a Pediatrician

Learning is not attained by change. It must be sought for with ardour and attended to with diligence.

—Abigail Adams

Life is like an unchartered sea. One boards a boat at its shore, takes a plunge inspite of unknown waves, storms and calms. And when you return back to the shore, you can chart the course, the ups and downs and hope that the next boatman would know it better and catch more fish by sharing your experience. Nearly three decades back when a medical student completed the M.B.B.S. course successfully, the first choice for post-graduation fell on medicine, surgery or gynecology and obstetrics. All other fields were second or third bests. Pediatrics was not even considered as a separate discipline. It did not enjoy a favored choice of medical graduates. Although internationally it had attained the status of a discipline for nearly 50-60 years, in India the scene was far different.

Health problems of infants and children were overwhelming and mortality was heavy. The hospital beds were filled to the brim with neonatal tetanus, diarrheas with severe dehydration, complications of pertussis, pneumonia, rheumatic fever, *etc.* Outpatient Departments (OPD) were similarly swarmed with children suffering from infections of all kinds. Knowledge was fragmentary. Most of it was miniatured from adults to children and based on age and size related calculations. The concept that child is not just a small sized adult but a growing and developing individual had not yet taken roots. Books on childhood development, growth and diseases were few. Whatever was available, pertained mostly to conditions in UK and USA. No books by Indian authors for Indian conditions were available.

With the passage of time, more and more experience gathered and thus more knowledge about our own problems accumulated.

These pieces of knowledge were brought for discussion at national and state level forums and received the chisel and polish. Publication in national journals brought the knowledge to the door steps of Pediatricians. The movement gathered momentum. Pediatrics became an attractive option for medical graduates. Competition became keen and stiff and a lot of talent got attracted. In a matter of twenty years the progress in knowledge and experience was phenomenal. So much so, that by early eighties, the need to develop specialties of Pediatrics was felt. The need was expressed by some experienced members of the Indian Academy of Pediatrics at various forums. The momentum started to build up and in 1987, birth of several specialty chapters took place. The last 10 years has seen the movement progress from strength to strength.

The young doctor who now enters the portals of Pediatrics for his future career finds a wealth of knowledge, experienced teachers and a wide choice of specialties to pursue. As progress occurs, some problems get sorted out and new ones crop up. There are numerous problems encountered by subspecialities concerning training, professional avenues and high cost of diagnostic

instruments, *etc.* However, I do not wish to dwell on these aspects. My concern is to bring into focus those facets in the training of a pediatrician which do not receive adequate attention, yet these are the ones a pediatrician has to frequently handle on his own.

1. *Early Detection of Disease*

In a tertiary care center setting such as a medical college, patients often seek advise after the illness has existed for sometime. The illness has generally been managed with a variety of modalities already. Therefore, it presents with complexities of its course and management in a rather advanced stage. Furthermore, residents get fascinated by the process of solving a riddle with the help of various diagnostic tests which are readily available at hand. They are invariably deprived observing early stages of illness, when the symptoms may be vague or far removed, signs are soft and in the gray zone and diagnostic tests are scanty or none at all. At such a time, concentration on each and every narration in history and sharp clinical sense based on eyes, ears and touch are your only guides. Practice and more practice to grapple with this phase of illness particularly in infants and children is the only way to master this art. It is a challenge every trainee should be exposed to which provides confidence to the young doctor that he/she can handle the situation unaided. It is highly beneficial to the patient and family since most illnesses if handled early carry a better prognosis rather than when handled in an advanced stage.

The challenges is to incorporate such training in the present jam packed system of post graduate studies in Pediatrics. There are a few suggestions in this context (*i*) Outdoor services can be utilized to impart this training. Allocation of one or two patients can be made to residents. At the end of each OPD session, these cases can be taken up for discussion with the senior resident or consultant. In case OPD is crowded and service needs take a precedence, then a separate time can be earmarked for discussion of such cases, *(ii)* Teaching material can be generated by the teachers with illustrations from clinical material (a wealth of which is available locally) with the help of audio-visual technology. Lively sessions wherein the resident makes his/her own assessment and later checks with correct interpretation will serve a useful purpose; and *(iii)* An optional time can be given to the resident during which he can expose himself to a governmental or private set up to avail the opportunity of having first contact with the patient in the early phase of illness.

2. Learning About Course of a Disease

Textbooks mention about the classical course of disease. However it is only a narration. Presentation in a textbook is generally imbibed only partially whereas clinical pediatrics is a living and vibrant interaction with a child and his family. Such an interaction needs to be experienced for the full impact.

Residents have rotating posting during the course of their training period. Thus they are not in touch with a patient or family for long enough to learn about the course of illness, particularly for chronic ailments. In order to provide the necessary insight, better follow up records of ambulatory patients and incorporation of hospitalization records is required.

Familiarity with the course of disease provides the doctor insight and anticipation which is of immense help in making an early diagnosis and informing parents in time. This goes a long way in allaying their anxiety and engenders confidence in the doctor.

3. *Recognition of Impending Emergency*

Life threatening events such as peripheral vascular shock, coma, respiratory failure and cardiac failure have pre monitory features. The time preceding the full blown picture is critical to save the life; its recognition at that stage needs to be improved. The signs and symptoms in children and particularly in infants may be soft and in the gray zone. However, it is important to keep a high index of suspicion so that timely help can be rendered. The rewards of early recognition of impending emergency are so significant and gratifying, since children demonstrate remarkable power for full recovery once helped in time. Take the example of impending respiratory failure-besides tachypea, irritability is the initial feature of hypoxia. Waiting for cyanosis or pallor to set in would be too late. In a recent case of foreign body inhalation by an infant, a diagnostic delay of nearly four hours occurred because the doctor did not pay heed to irritability. Similarly, a child who is heading towards shock due to excess fluid losses or septicemia gives sufficient warning in the form of tachycardia, oliguria, *etc.* before the BP falls, pulse volume diminishes and anuria sets in. The battle to save life is much grimmer (and may often be lost) when the latter signs have set in. It is much easier to save the life in the early phase.

Barring a few institutions, training of a pediatrician is deficient in this aspect. Such training is best imparted in an emergency area, specially marked for children and geared to handle these conditions. A specially trained team of personnel should be assigned the task to train residents in recognition of impending emergency.

4. *Learning of Communication Skills*

Pediatricians require skill in communication with the family members to handle various situations filled with anxiety. Doctors dealing with childhood illnesses have the additional task of sharing and helping the family bear the emotional burden. In the curriculum, there is no provision to impart training in the art of communication with the parents of sick children. It is a common complaint of families that they received poor treatment in public hospitals. Often a critical appraisal of the records may reveal that all tests were done and proper treatment was given, yet the family remained dissatisfied. The cause of dissatisfaction basically rests on poor communication by the treating team. A sympathetic attitude and adequately delivered messages about child's condition go a long way in generating a feeling of good-will in the minds of the parents.

Let me take an extreme example of a child where a diagnosis of leukaemia has been just established. How do you break the news to the parents? Talking of all aspects of disease on very first encounter would not be advisable for such a serious disease. It would be advisable to keep dialogue going till diagnosis has been established with certainty and initial treatment for induction of remission started. As the family becomes more receptive and develops confidence in the doctor, the course of disease, management aspects, financial implications can be communicated one by one, giving the parents the time to absorb and cope up with the situation with time. Time factor, patience and sympathy are required in ample measure. Medicine in general and Pediatrics in particular, is not only a science but also an art-science based on hard facts and art based on dealing with family at human plane. An approach based on a mixture of the two is exceedingly gratifying both to the doctor and to the family. There is a test you can give yourself. If the parents or family members of a child who

succumbs to his illness can pause and express a word of gratitude to the treating doctor-that is a testimony to your being a really good doctor.

There are numerous situations in daily professional life of pediatrician which are to be dealt with patience and tact based on the art of good communication. How do you learn it? Mostly the art of communication needs to be self inculcated and practised. However, a few exercises can be organized during the training period wherein a teacher holds a session with parents and resident or two can observe. Outdoor service is a good place to observe communication with parents. Each disorder and every family is different and one has to tailor communication to the parents. The level of education of parents, nature of problem and psyche of parents are all important factors towards organizing your approach to convey.

Parental Counselling is also a part of communication with parents. Conventionally the term pertains to advice rendered to the family for genetically determined disorders. The information should be conveyed to the parents in suitable manner to help them plan their future.

5. *Cost Effectiveness*

This aspect in medicine is progressively becoming an important issue the world over. Scientific progress in medical science has been phenomenal during the last 5-6 decades. More and more sophisticated and accurate instruments are becoming available making it possible to reach areas in body which were traditionally considered inaccessible. It is but natural that advanced technology would place ever increasing financial burden on medicare. However, financial resources are limited, more so in developing countries. The urgent need for adopting cost effective approach is obvious. However, this aspect of medical care finds no mention in the curriculum of a resident. On the contrary, quite oblivious of the cost, a resident may draw a sample of blood, CSF or other body fluids and send it to the laboratory for relevant or irrelevant investigations. The consideration generally is an apprehension that he may be answerable to the seniors for not having asked for an investigation. An attitude needs to be developed on the part of teachers and the taught, to constantly pay attention to cost effectiveness. Before ordering an investigation, a question should be carefully answered-is the test going to substantially influence the management and is the cost justified?. Even in the affluent countries like USA, a big question mark is being raised on the rising cost of medical treatment. The pendulum has swung right back to family practice with greater emphasis on clinical assessment aided by judiciously planned relevant investigations.

6. *Legal Responsibility*

The relationship between a doctor and the patient is established on confidence and faith. A family places a kind of sacred trust on the doctor for the well being of the child who represents the future of the family. The relationship therefore rests entirely on human values. These values can differ with various societies and at different times. Hence the need of a code of conduct. The code of medical ethics was therefore enshrined long ago in the Hippocratic oath-to give your best professional help to the patient as a confidential trust. In addition to the oath which is binding on all doctors, there are laws of the land to ensure proper discharge of professional duty. Negligence by medical persons is punishable under these laws. In the training curriculum there is yet no provision to impart knowledge on the legal responsibility of the doctor. This

lacuna needs to be filled. The Consumer Protection Act has been extended to the medical profession. Redressal of grievance of a patient has been facilitated for prompt action under the Act. It is imperative that training of a Pediatrician should include the knowledge of his legal responsibility.

In my opinion, the following aspects need consideration for possible improvement in the training prograin: *(i)* Short time available to trainee. I suggest that time be obtained by cutting down unproductive activity, for example, thesis writing in current shape. A meaningful research cannot be cramped into a 3 year curriculum of service based training. However, if the purpose of thesis writing is to introduce the methodology of scanning literature, organizing thoughts on a subject and putting down in writing, this can be achieved by much less time consuming process of dissertation or writing of articles in medical journals. The time so saved can be utilized for more relevant training.

(ii) Shortage of time at the disposal of teachers. The unproductive activities that a teacher encounters are numerous. Many of these are simply wasteful of time and paper. Good administration can prune many such activities. The time thus freed can be utilized for production of teaching material. Also it should be rewarded by appreciation and special mention in annual reports.

(iii) A pool of teaching material can be supplemented with the experience of seasoned teachers who have completed their inning but are still actively involved in academic pursuit. This is valuable resource which can be tapped.

In conclusion, education and training of a general pediatrician is a dynamic process, undergoing changes with march of time. In order to remain relevant and meaningful, the teachers must continue to endeavour to identify the lacunae and maintain a resilient approach to modify training programmes to maintain relevance to the community needs from time to time.

Saroj Mehta,
Former Professor of
Pediatric Gastroenterology,
PGIMER, Chandigarh,
1159, Sector 15 B, Chandigarh 160 015.