

SPECIAL ARTICLE

The complete paediatrician: attributes of good practice

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ABSTRACT

The attributes which the author considers help to make up good paediatric practice are discussed. Some of the problems associated with their achievement are examined. All of these ingredients can never be possessed by any one of us though each of us should have them as our aim. Their full spectrum, to be evident in practice, needs us to be members of a team.

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The complete paediatrician: reflections of a former professor at the Makerere Medical School

I have chosen this title, not because any of us could attain to 'completeness', but we can each share parts of the attributes of a "complete paediatrician", and my own incompleteness will guarantee that there will be many other attributes which I have not seen or uncovered. As a paediatrician I may not have been born in Uganda, but I was certainly weaned and brought up here and it was here that I learned a great deal of what I am sharing with you. So what do I see as some of the ingredients in the make up of a complete paediatrician?

THE CHILD AT CENTRE STAGE

First of all such a person has the child in the midst, at centre stage. The reference for this is to be found in the Bible, Mark ch.9 v.36: "he (Jesus) took a child and put him in the midst of them". For so long children have been marginalized. For so long their size and powerlessness have denied them the care and attention they need, especially, until recently, by the medical schools and care facilities. Children have such enormous potentials, they are a family's, a community's, a nation's future resources. The child is truly father to the man. Furthermore they are so vulnerable. Five minutes damage to brain or vital organs in utero or at birth; a period of deprivation, neglect, abuse or malnutrition at a critical period of development can alter a whole life and reduce

a whole potential. In contrast, children influenced for good, deeply stimulated, in good health and well educated can benefit a whole generation.

In the last two decades, children have been moving centre stage in the world's attention, influenced greatly by UNICEF's initiatives under James Grant. To quote from the annual report on "The State of the World's Children" of 1996, (p.73) "It has been a long struggle to have the lives of children taken seriously, it has consumed half a century to put children at the centre of the international development and human rights agenda. But they are there and nothing will now dislodge them. It is therefore possible to say, even amid the horrors of conflict and deprivation, that the 21st century will belong to children." Sadly, so far, there is no indication that this will be so. Far too often they come under the heading of 'collateral damage'.

SECONDLY THE PAEDIATRICIAN NEEDS A 'RADAR' GAZE.

Seeing a child requires a directional and penetrating look. There is a difference between 'looking' and 'seeing'. I can see the very visible appearance of the child and mother or guardian as they come to me. I can so easily fail to see so much more about them, without looking beyond what presents to my immediate visual field and behind what preoccupies my immediate response.

Two things seem to me to be important for the paediatrician to look for in any child.

One is the **quality of the child's life**. I was one of those who were disturbed when James Grant developed UNICEF's crusade entitled "child survival" (later with the addition of "and development", perhaps in deference to the dissenters!). I understood the original title was aimed at underlining the seriousness and magnitude of infant and child mortality, and the need to apply simple, vertical, preventive measures so readily at hand. Survival is

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important, without it you cannot have health. Vertical measures make a deeper impact than horizontal pressures. Survival, the converse of mortality, is also much easier to measure and therefore to evaluate. Quality concerns imponderables, care, love, stimulation, play, a stable extended family, mental and emotional support, and is much less visible and, as a result, much less measurable. But survival falls so far short of the deeper and more important need for those qualities of life which children need and deserve. As paediatricians we have to look for and seek those ingredients which make for quality in children's lives.

The second thing we need to look for is '**wholeness**'. Splitting and specialisation has accompanied an ever increasing body of knowledge, including not only the specialisms of 'what', but also of 'how', that is of management, methods and economy, etc. They have been an essential part of hospital, clinical, curative care and have now affected primary health care.

With the success of smallpox eradication, the child survival 'revolution' adopted top down, monovalent interventions (the GOBIFFF programme) in an aggressive attempt to cut down infant and child mortality and morbidity. Measurably this has met with some success, particularly in immunisation, though it still has to be shown to be sustainable. But it has led to specialism or 'partialism', a blinkered approach to children and to a tendency for the means becoming almost more important than the end, a healthy, whole child. UNICEF has begun to realise this too. To quote its 50th anniversary, 1996 report:- "In the future UNICEF would consider the needs of children along with those of their parents and nurturers, and would take into account the 'whole' child. Instead of treating the child as a set of parts of which the only ones of concern were those related to physical wellbeing, UNICEF should be willing to address the child's broader intellectual and psychosocial needs".

As paediatricians, even when specialised, we must be aware of the whole physical, emotional and spiritual relationships and influences surrounding a sick infant or child. We need always to look beyond the withdrawal of medical care, accompanying and responsible for his or her cure or rehabilitation, to the family and community 'lay' care on return home. We need to consider the social and economic environment which will envelop the child and often is the chief cause of the original

illness. Deprivation, neglect and child abuse are not limited to the developed world. It may be impossible for the mother to look after her child on return home. Unwanted, disfigured and disabled children are often severely neglected or abandoned. There is little value in correcting a contracture in a cerebral palsied or polio child unless the parents or carers at home are taught how to maintain the position of the limb. Many years ago, Dr. John Orley started epileptic children on a new lease of life in Buganda by living himself in a rural area for a period. By accompanying his teaching with the distribution of phenobarbitone tablets he was able to share how the attacks can be largely prevented and that epilepsy is not an infectious disease. Remarkable things are happening in Africa in the care and management of HIV infection through the attention being given to the whole person within the community, something which is sorely needed in other parts of the world.

In practice, this wholeness approach is easier said than done! When I started as a paediatrician at Makerere University Medical School I was a product of the curative, tertiary care 'crystal palaces', attempting, for the most part, to fill a bucket with a hole in it! In the attempt to patch the hole in the bucket and prevent a recurrence of illness on returning the child to his home environment, we began to try to reach out into the community while continuing to meet the demand for cure. It was, and always is a difficult balancing act. We paid lip service to the importance of the balance between prevention and cure. The outreach suffered from the pressure of curative demand, the difficult and less satisfying task of evaluating prevention, and the unfamiliarity of working outside our structured technical facilities and their support systems tended to pull us back to the hospital. We added "and Child Health" to the name of our Department of Paediatrics and began to train health workers to teach health, identify 'risk' and try to pre-empt critical illness or epidemics in the hope of seeing referrals change and less children return with the same complaint. But however far we got from the hospital and close to the home and local environment, the care was still institution dependent, vertically directed, top-down and applied from outside the community. Medical and health care had a 'they' relationship with the people and health was not seen as necessarily a very important part of 'our' (the community's) life as a whole. Taking the 'bucket' analogy a step further, we began to realise that patches tend too fall off too easily when applied on the outside! What about applying them from the inside? At 'Mwanamugimu' Nutrition Rehabilitation Unit, Gladys Stokes and her colleagues had shown the potential of fully convinced mothers in changing their sisters' knowledge, attitudes and practice about the causes and prevention of

their children's malnutrition. Professor Latimer Musoke started training school leavers as nutritional scouts to detect and remedy early malnutrition amongst their under 5 siblings. In leprosy and tuberculosis treatment centres, cured patients were being used very effectively to distribute drugs and improve compliance.

The pendulum began to swing away from institution based to community based health care. The emphasis moved to strengthening the ability of lay people to recognise the roots of many of their health problems in their own life styles, to care for their own family and community health and to perceive when it becomes necessary to seek further help and advice.

The result has been perhaps an over-swing. There has been a trend in the health care services towards neglect and rejection of the hospital, regarding curative services as even counterproductive in the achievement of health care for all. Money spent on curative services could so much better be spent on preventive care. This swing has been encouraged by the emergence of non health professional managers on the scene, introduced into the system because lack of success was seen as a management problem. Doctors, in particular paediatricians, began to feel irrelevant to health. Many withdrew to, or remained in their curative roles in hospitals to continue what they had been trained to do and for which there is always a demand and great satisfaction. The danger now is that institution based (mainly curative care delivery) and community based (mainly preventive and promotive self help) care may spring apart and develop separately, the one hand not knowing, or even caring about what the other is doing! It seems to me that there are an ever increasing number of community based primary health care programmes developing outside, and without real reference to established medical health facilities. Likewise many medical facilities know very little about what is going on in the community or the likely impact of such programmes on the services they supply.

So a mere balanced development between cure and prevention, between top down delivery and bottom up self help is not enough. The complete paediatrician will need to practice a combination of both, to make up 'whole health care'. Both are essential to each other. The practice of one without the other is impaired. The impact of both together is greater than when both are

acting on their own. Let me illustrate with five examples of this interaction between cure and prevention.

USE CURE TO TEACH PREVENTION

One is **the use of the cure to teach prevention**. Withdrawal of medical treatment during the convalescent period of the curative process provides a great opportunity for introducing reciprocal replacement of 'lay' or community care. This avoids the vacuum of lay dependence (the 'they' relationship between the community and the health professionals) on medical remedies for preventable disease. The means of getting the child well are often the means of keeping the child well. This is particularly true in malnutrition during the feeding and stimulation of the child during the rehabilitation process, but also, for instance, in the oral rehydration therapy of dehydration. The mother can leave with a knowledge of the cause and management of her malnourished or dehydrated child and a 'we' relationship with health professionals.

USE OF COMMUNITY BASED DIAGNOSTIC AND TREATMENT CRITERIA

The second example is **the use of community based diagnostic criteria and curative treatment in increasing child survival**. The early recognition and first aid treatment by trained community health workers of often fatal infections such as pneumonia, dehydrating enteritis, malaria, meningitis, etc. and by traditional birth attendants of risk factors in pregnancy and delivery can prevent many fatalities. This practice, adapted and supervised for different conditions, has been part of the complete paediatrician's concern for some time. It has now been adopted comprehensively by WHO and given the acronym IMCI, the "integrated management of childhood illness". The aim is to enable the detection and diagnosis of the main perinatal and childhood killing or disabling diseases and their risk factors by medically untrained health workers through the use of algorithms. Initial evaluation of established programmes seem to indicate that health workers trained in this practice have an impact in reducing illness and mortality. The danger is that algorithms do not deliver a view of the whole child. Just as specialism rules out the horizontal, integrated picture of the sick child so algorithms fail to cover the vertical, natural history of the child and his or her illness. They fail to cover the many protean manifestations of disease processes which can only be learned by long experience. Unfortunately it is not possible to put the paediatrician at the point of first contact with a child and mother. While acknowledging the advantages of IMCI, its inherent limitations should be recognised.

A third example concerns **the building of confidence between health workers and the community as a result of successful synthesis of curative and preventive care**. Neglect of the curative care of the sick may lead to lack of confidence and credibility in the health care services with resultant rejection by the community of any preventive care or advice.

Fourthly **surveillance and compliance can be improved considerably in the long term treatment** required in such diseases as tuberculosis, leprosy, epilepsy, diabetes, hypertension, disability etc. Healed or rehabilitated patients, convinced of the importance and value of such long term management, have been used as community health workers in the control of these diseases. This is particularly true in the reduction of transmission and drug resistance resulting from the adequate, curative, DOTS treatment of tuberculosis and leprosy. The reduction of transmission of HIV has resulted from adequate curative treatment of other sexually transmitted infections. I believe that, in the same way, the control and prevention of HIV infection will be immensely enhanced when treatment with anti-retroviral drugs becomes totally available, particularly with respect to vertical transmission.

A final example is **the improvement in the collection of health information and surveillance** arising from such a whole approach to the child and his or her environment. In the development of community based care, the people are made aware of the importance of recognising the onset of epidemics or famine situations, of the numbers of births and deaths and of the presence of remediable disabilities such as contractures or epilepsy in their community. Such health surveillance, arising from the interaction of health care delivery and community based care, also prevents the dangers of totally unsupervised distribution of drugs and contraceptives.

We need to recognise in our practice the need for a whole integrated approach to care. We have to try therefore to look beyond the confines of disease and therapy and their measurable indicators to the child as a whole person. The complete paediatrician is involved in curative, rehabilitative, preventive and promotive practice within the family and the community.

MAINTANANCE OF STANDARDS

Maintenance of standards is a third character

or quality for which we should strive. This is easy to say and perhaps to do when you have all the resources and no difficulties! So often standards are equated with resources. I salute those paediatric colleagues who continue to maintain a high standard of practice in very resourceless situations. You show clearly that limited resources do not preclude a high standard of practice. Indeed technology, though it carries large possibilities and advantages, may carry a threat. It can spew out often meaningless and repetitive jargon and suffocate thought. It can create dependency. It can discourage the challenge of working in needful but impoverished situations.

Maintenance of standards requires a number of disciplines in the face of lack of resources, lack of time and overload of work, which we need to recognise and accept.

We need to know our own limits and the limits of our resources, to be able to say 'no'! Many of us, myself included, find this difficult to do. It is very necessary because weariness can sap our strength and concentration stealthily and steadily, like Samson when his hair was shaved off in sleep! and we don't realise what has happened, though very often others do. We have to prioritise, but how?, when bombarded by needy people especially those we know. There is a prayer, apt for this situation: 'Lord, give me the strength to do what I can do, the courage to refuse what I cannot do, and the wisdom to know the difference.'

We need to be able to step back or withdraw, essential when a community based health care programme is contemplated. It is not easy to go at someone else's speed when it seems so much better and quicker to get things done ourselves, but at the risk of being top down and of crushing initiative or creating either dependency or resistance. This is where donor agencies can be so difficult, impatient for action or results to justify their grants!

We need to be self critical. This doesn't mean looking over at our neighbour's patch and seeing the grass growing greener, so that we come to either envy or despair. We need to recognise the boundaries of our own framework of reference and how it may differ from others.

We need to think! To test all things and hold fast to what is good. There is a need for scepticism about some of the statements in the most eminent books and journals. Training so often increases our knowledge but reduces our thinking and reasoning. I studied under a professor of pathology before starting paediatrics. I always remember when he was reading or trying to think about a problem you might often hear him repeat "*yes, but..yes, but..yes, but*".

The 'yes' meant a solution, the 'but' meant a doubt.

Lateral thinking is also a great gift. This does not mean side stepping the issue. It's what the incoming tide does when it meets a large rock, an immovable object. It just sweeps around it! When there are problems unyielding, too hard to solve, we should try to think around them. Mr. G.K.Chesterton, a famous writer and philosopher in the early part of last century, met a pompous man in a narrow lane twirling his umbrella. "Stand aside", said the man to Chesterton, "I never make way for fools". Chesterton obligingly stepped to one side and replied "I always do". That is lateral thinking.

A GOOD TEACHER IS A GOOD COMMUNICATOR

Fourthly, **the complete paediatrician should be a good teacher and communicator.** Very few of us are born teachers. Most of us are bad communicators and have never been taught to teach or communicate. We stay with this, the lecture or article, and sometimes behave as if we are pouring our wisdom into empty vessels. Paulo Friere was a pioneer of the so-called psycho social adult learning methods by which he 'conscientised' the people among whom he worked in South America and helped them to achieve 'people power'. The characteristics of his method of teaching was the shift in emphasis from a teacher centred, problem resolving, passive receiving approach to a learner centred, problem posing, action oriented exercise. As result of this the recipients were enabled to discover the potential within themselves for discovering answers to problems and remedies to difficulties. Such a practice is unnerving for the classical lecturer, like myself, who is used to having, and prefers a tame audience into whom (s)he can pour his or her wisdom and knowledge often into one ear and out the other! In the participatory method the teacher casts him or herself on the participants so as to draw out their real and felt needs and their own solutions to their questions and problems. This method has now been fairly widely adopted in the primary health care field. An example of what might be suggested for the teacher showing a slide might go like this:-

Teacher: 'What do you see in this picture?' this is description and clarification.

Teacher: 'What do you think is happening?' this is perception and recognition.

Teacher: 'Have you ever seen this happen in your own community?' this is identification and relevance.

Teacher: 'Why do you think this is happening?' this is causation and self discovery.

Teacher: 'What are you going to do about it?' this is problem posing and action requiring.

Teacher: 'How are you going to know if what you do works?' this is evaluation.

Small groups in a circle are the best arrangement. Back seats in a lecture room allow for short attention span but any teaching, particularly the lecture, has to be very good to maintain interest for over half an hour! Finally teaching is more than just informing. Rather it consists of informing, motivating, enabling, and withdrawing with each step important. Sometimes withdrawing for a teacher is the most difficult. There is a time to stay, but there is also a time to go and unless teachers withdraw they will never likely experience the great privilege of seeing those they have taught enabled to develop and achieve sometimes far greater things than they have done themselves.

EVALUATE WHAT IS BEING DONE

Fifthly **the complete paediatrician ought to be able to evaluate what is being done and exercise this ability.** Care needs to be taken over this. Sometimes we are at risk of allowing evaluation to overwhelm our vision and our objectives. In emphasising the importance of having measurable indicators of progress, we limit our objectives to these and fail to seek out those objectives which may be immeasurable and therefore difficult to evaluate. Our donors want objective criteria. Process, the quantification of how things are done, is very much easier to measure than outcome. As a teacher I can easily count the number of participants in a class, the number of lectures given and the time spent in their delivery but it is very difficult for me to assess how many listened, far less to discover how many learned and put into practice something new. Furthermore we have to consider what we will regard as success. This involves our interpretation and the time factor. One might count the results of an evaluation as a success, another as failure, while others would want to add qualifications. One fully convinced individual at the end of a teaching session might be of more value than whole class approval! Time too is important. Most programmes are evaluated after one, two or three years, often while enthusiasm is hot and routine has not set in or memory lost. But what about looking for

traces or influences of a programme after ten or twenty years or longer?

We must also be careful that the demand for evaluation does not restrict flexibility. Donor pressure may hem us in through our objectives and their evaluation. They become tailored to the donors needs, demanding success and inflexible. We become so busy convincing ourselves and the donors of our 'success' that we fail to learn from our failures, or to notice a significant lateral 'spin off' which indicates a promising new direction to follow. The mould on Fleming's culture medium turned out not to be a nuisance contaminant but the discovery of penicillins.

EXPLORER

The complete paediatrician should be an explorer. The no mans land between different disciplines is often, as between countries, a lonely, difficult, dangerous terrain, unmapped but providing a new way through a problem, otherwise unsuspected. I have had the privilege of exploring other disciplines and finding solutions and simple technologies which can be appropriated by health services to great advantage. We need to be prepared to be a member of a team in which health is only one of a number of important components of development.

READING

The seventh essential to make up a complete paediatrician is reading, though it is often the most difficult thing most of us do or can do, either because of lack of time or energy or of the necessary facilities. The library is the kitchen for thought! It provides us with mental nutrients and keeps us in touch with medical and health practice and advances throughout the world. There has been an information explosion in the last decade or so. But it threatens to divide even further those who have from those who do not have. Textbooks and journals are being replaced by computerised information; slide and overhead projection by power point digital display. Many international journals are accessible on the internet free of charge. Many textbooks and journals are available on compact discs. 'Teaching aids At Low Cost' (TALC) have commenced producing health learning material in CD Rom format. 'Telemedicine', or the visual means of sharing information between medical centres of excellence

is burgeoning.

Those who can afford, or acquire the use of the technical equipment, and have the knowledge to access the internet and the world wide web have an opening to a volume of information only limited by their capacity to take it all in, prioritise it and record it. Those who do not have these facilities are finding it increasingly difficult to obtain written information. The current trend is for the establishment of 'information resource providers' or 'gateways' who will then distribute information in an accessible form to their outreach network. Can this redress the imbalance in favour of information flow from developed to developing countries resulting from the computer technology and perpetuating those top down disparities and irrelevancies which have left unanswered so many of the third world's needs? So the complete paediatrician needs to master the exciting, though formidable information explosion, but yet not be mastered by the computer.

DON'T NEGLECT YOUR FAMILY

The final attribute, which I would include in this counsel of perfection, is that **the paediatrician must avoid neglecting her or his own family.** One's own family is so often the blind spot in our field of vision

I have covered some of the ingredients which, in my opinion, go to the making of a complete paediatrician. In summary such a person:-

- holds the child in the midst;
- looks beyond the presenting sickness, measurable survival and life statistics to the qualities of the child's life;
- looks beyond the child as a set of parts or diseases to the whole child in the midst of the family and community;
- incorporates the cure or rehabilitation of the child into the prevention of further disease and the promotion of better health;
- tries to maintain standards, accepts his or her own limits and knows when to withdraw and avoid dependency;
- is self critical and learns how to think and prioritise in the midst of the present information explosion;
- is a good teacher and communicator, achieving real learner participation;
- knows the place, value and practice of evaluation;
- is prepared to explore, cross disciplines and be a member of a team;
- gives time and effort to reading;
- and must be aware of the needs of her or his own family.

All of us fall short of our completeness in one way or another. Often we reveal the very defects of our virtues, such as when we become blinkered to a wider need in focussing our attention on a narrow achievement. We need to be members of a team where our incompleteness can be made whole.

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