I presume that you went into paediatrics because you were interested in, and liked to work with children (if not, you should do something else). You will be aware of the alternative career paths available to the graduating paediatrician, from a predominantly primary care practice to one that is exclusively consultant, and perhaps subspecialty positions involving teaching and research. Paediatricians often get involved in other fields, such as public health, and it is not unusual for them to get into administration: in a child care facility, at a university or elsewhere. Your teaching has probably been centred in a specialized paediatric unit where most of the patients fall into categories of subspecialty requiring exceptional expertise and/or special technical resources. You may have had experience in private practice offices and in emergency clinics where children are seen at the primary care level, but the emphasis has probably been more at the tertiary care end of the spectrum. This training is appropriate if you are aiming to be a consultant, but perhaps not so good if you are going to be doing a lot of primary care.

When I started as a junior partner in a predominantly primary care practice (this was the pattern for nearly all paediatricians in Vancouver, British Columbia at the time), I was confronted with all the concerns about which young mothers expect advice from the paediatrician. I found myself teaching back to recommendations I remembered from my own mother rather than to anything I had learned in preparation for the Canadian specialty examinations. Because I had children of my own, this information was supplemented from personal experience. I knew a little about growth and development, but nothing about child or adult education, and I had been taught no child psychology. Behavioural disorders and school adjustment problems were among the most common conditions for which distraught parents consulted the paediatrician, and I had minimal (and out of date) knowledge of the school system, let alone much understanding of family dynamics. Some of the problems seemed clearly to fall in the realm of psychiatry, but it took forever to get an appointment with a psychiatrist and sometimes longer still to receive any report.

But I enjoyed it. It was pleasant to spend time with delightful children and their usually charming mothers. The clinical problems were repetitive and seldom challenging, but the children themselves and their families’ interactions were full of interest. I just wished I had been exposed to more education in the psychological, psychiatric and educational aspects of child development so my advice could have been less ‘off the cuff’. Parents know much more these days, fortified by the Internet, so one has to be careful they don’t know more than you do.

I got involved with children with long-term disabilities – specifically with rheumatic diseases but then, in an institutional setting, with more severe neurological handicaps. I found myself the member of a team – no longer the sole author of opinion conveyed to parents and others. I learned more about the assessment of physical and mental function, but I had to realize that I knew less in these fields than the physiotherapist or the psychologist. They could be critical of my comparatively amateurish conclusions, but I found that I was sometimes right and that a broader background could be helpful, particularly if I could establish a good rapport with the child. Intense concentration on one particular aspect of a child’s function could lead to a false emphasis, or missing the wood for the trees.

Some interprofessional jealousy is to be expected, and it is important for the physician to recognize that he/she is a partner and not the boss. On the other hand, you are liable for overall conclusions, particularly if you have written the summary report.

I have had to deal with hospital administrators – not always an easy relationship. Administrators have to deal with various hierarchies, including medical, nursing, pharmaceutical etc., who do not (and probably should not) accept the pre-eminence of the physician, while physicians are prone to assume that they know best. They value their independence and may feel they have lost the authority they previously enjoyed. Although they may resent accommodations, which are inevitable in achievement of harmony among any working group, they must be prepared to document their needs, in the same detail as their competitors, in the competition for limited money and space.

Paediatricians frequently land in administration or in situations with a large administrative component. Perhaps this is because they have gained experience with the conflicts of childhood and are thought to have gained expertise in their resolution; adult behaviour, after all, being similar.

As a department head, I found that an appropriate response to members’ problems was often obvious. Nevertheless, I encouraged people to bring their concerns before the department as a whole and often found that they had simmered down, or realized that their concern was unreasonable by the time of the next meeting. I tried to handle significant complaints by referral to a small group for discussion – to be brought back to the next meeting – rather than having a prolonged argument at the time, with participants perhaps ignorant of various factors in the case. I always wrote the minutes myself, so that any conclusions were clearly stated. This was useful if individuals brought up the same issue at a later date, particularly if they had been among those approving the minutes.
A letter to my younger colleagues

of the previous meeting. When we had enough money for only one addition to faculty, and every one of the 10 divisions were clamoring for help, I asked them to prioritize the importance of the various options. Naturally, they all put their own needs first, but there was remarkable agreement between second choices, which turned out to be the same as my first. I felt that my decision might seem less arbitrary if there was a measure of general agreement.

My own experience as a paediatrician has ranged from 12 years spent mostly in primary care, through a period as a teacher and consultant, to appointments of an administrative nature, and finally, a stint as academic department head. I had no idea that my career would go through these stages, but they have all been satisfying. I urge you to keep your mind open to an alternative career move. It is tempting to stay in a comfortable position but a change can be invigorating.

He entered general paediatric practice in 1960 and subsequently became part-time Medical Director of Sunny Hill Hospital (Vancouver). In 1964, he was appointed Director of the Children’s Arthritis Program of the Canadian Arthritis and Rheumatism Society.

In 1971, he left paediatric practice, joining the University of British Columbia (Vancouver) academic department. He served as department head from 1979 until 1986, where he was closely involved with planning for the new children’s hospital, which opened in 1981.

He later served as medical director of the Children’s Hospital and then as head of a new division of developmental pediatrics, working at Sunny Hill Hospital with the Child Development Program until 1994. He is a past President of the North Pacific Pediatric Society.

Dr Hill has authored several journal publications, mostly on juvenile arthritis. Since retirement, he has published two books: Paediatrics in BC: A History, With Particular Emphasis on the UBC Academic Department, and – in 2007– a biography of Dean McCreary, entitled Jack McCreary, Paediatrician, Pedagogue, Pragmatist and Prophet.

Dr Hill graduated in medicine from Oxford University (Oxford, United Kingdom) in 1950, continuing his training and practice in London (United Kingdom), Malaysia, Singapore and Paris (France). His early pediatric training took place at Children’s Hospital in Boston (Massachusetts), and in 1959, he came to Vancouver, British Columbia as chief resident.