

"A Letter to my Younger Colleagues" is a series of essays written by selected senior Canadian paediatricians, who were named as outstanding mentors by a prominent group of their younger peers. I hope you enjoy and treasure the rich pearls of wisdom that each author offers, based on a lifetime of professional practice and personal reflections.

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### Reflections of a slow learner

Richard B Goldbloom OC MD FRCPC

Being almost ready for carbon dating, "a letter to my younger colleagues" implies writing to just about every other paediatrician in Canada...my largest audience ever.

One reward for a lengthy career in paediatrics is that you never stop seeing children with problems you've never encountered before, and, if you're lucky, you continue to enjoy the satisfaction of trying to help children and their families. That satisfaction never wears thin, which explains why I hope to continue plying my trade as long as I can find my way to the office and remember which end of the baby to feed.

When I start to regale my younger colleagues with heart-stopping stories of my early years in paediatrics – about polio epidemics, iron lungs, tuberculous meningitis and other dramatic conditions most of today's paediatricians will never encounter – my listeners' eyes cloud over, lids droop and heads nod dangerously as they ascend the Glasgow Coma Scale. Ancient history aside, there are lessons learned in my late career that I only wish I had learned decades ago. I would have been a far more effective clinician much sooner. Becoming a good clinician is like learning to play a musical instrument proficiently. It takes constant practice and a keen ear. And no matter how many times you've played the same composition, there is always room for improvement. So here, for what they are worth, are several lessons I wish I had learned sooner:

1. The late C Henry Kempe, who brought the prevalence of child abuse to worldwide attention, once said that whenever you meet a family, you should ask yourself three questions: How do they look? What do they do? What do they say? The order of these questions is significant. We can learn as much (often more) from patients' nonverbal cues as from what they say.
2. Most parents who come to see you carry 'baggage', ie, 'hidden agendas'. These family secrets can take several forms. Common garden varieties include the following:



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- a. Guilt – self-blame for perceived sins of commission or omission, in which parents believe somehow that they may have caused or contributed to their child's condition.
  - b. Fear – that their child's complaint may turn out to be due to something really serious, even fatal.
  - c. Family secrets – the most common are psychiatric illness (especially depression), substance abuse, marital discord, financial worries and domestic violence. The secrets are often known to several family members; however, there is an unspoken family pact not to discuss them. But rooting out such skeletons in the family closet is often crucial to successful treatment. But if you don't ask, they won't tell.
3. Ask every family you see how often (how many times a week) they dine together as a family. Is the television on? Are cell phones or electronic gadgetry permitted at the table? Do they enjoy the experience? What do they talk about? Research has shown that frequent family dining may be one of the most powerful protective agents against a wide variety of behavioural and psychosocial disorders. In many households, family dining is a disappearing phenomenon. It must be revived. You can help. Also, be sure to urge all parents to read to their children every day from earliest infancy until school entry. This may be one of the most effective kinds of immunization you can offer. Good literacy skills confer powerful protection against an array of societal diseases including unemployment, poor health and unhappiness. They also protect against the dementing effects of excessive exposure to television, video games, MP3 players, cell phones and other forms of electronic child abuse.
  4. Remember, the two qualities patients seek most often in their physicians: enough time, and explanations in words

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they can understand. When you're talking to parents, don't misinterpret nods of assent as meaning 'I understand'. The only way you can measure your effectiveness as a communicator is by asking parents, toward the end of any clinical encounter, to reiterate their understanding of their child's problem and of what they can do to help. It takes only a minute. The rewards are huge.

5. Each week, ask several patients you see in your office, clinic or emergency department to call you at a specific, designated time three to seven days after their visit to give you a follow-up report. If they don't call you, call them (they sometimes forget just as you or I do). The value of short-term follow-up contact has been well documented. Completely aside from the huge dividends of parental gratitude for your concern, the value for your personal postgraduate education is enormous. You will learn more about the natural history of disease and about the effectiveness (or lack thereof) of your treatments. And before you say you don't have enough time, lack of time is not an acceptable excuse. We're talking about a maximum of 30 min to 45 min per week! Half a century ago, while conducting a very busy community paediatric practice (including many house calls each day), I scheduled a daily 'telephone hour' (7:00 to 8:00 am). Every patient knew they could talk to me then about any concern, no matter how trivial. It was one of the most self-instructive things I ever did.
6. Be a healthy skeptic about the latest paediatric fads and dogmas. One reward of being long in the tooth is the appreciation that it's only a tiny step from today's diagnostic or therapeutic dogma to tomorrow's malpractice. For example, I remember when most newborns (including preterms) did not receive oxygen for resuscitation (and when retrolental fibroplasias or bronchopulmonary dysplasia were virtually unknown); when gastroesophageal reflux was diagnosed mainly in the elderly with hiatus hernias. In babies, it was just called 'spitting up' and we simply wiped it up, thickened the feeds and said no more about it. No one ever dreamed that gastroesophageal reflux and gastroesophageal reflux disease would become major cottage industries. Two enduring lessons we can learn in paediatrics are that not every symptom must be treated, especially with medication, and that no 'condition' should be treated before its natural history is clearly documented. And on that same note, learn to be an ultraconservative prescription writer. Writing a prescription is the fastest way to get a patient out of your office, but it may not be the best way to treat the child or family.
7. Don't let any child become a partner to his/her parents' anxiety or negativism, especially when the problem is behavioural or emotional. When a parent opens the conversation with a recital of Jimmy's shortcomings, feel free to interrupt and say something like the following: "Look, I know you're worried about those problems, but first I'd like you to tell me all the things about Jimmy that are really great – his best qualities and talents?" Then write down his best features and express your admiration

for his special gifts and watch the youngster visibly brighten and smile. You've just laid the best foundation for effective remediation. Build on the child's strengths, and don't become a partner to focusing on his shortcomings. Our job is to relieve anxiety, not to intensify it.

8. Get involved in your community as an activist, not simply as a preacher of better paediatric health behaviours. Just running a good practice doesn't make you a 'complete' paediatrician. Pick a specific, achievable objective, whose attainment will improve the lives of children in your community and make it happen, no matter how long it takes.
9. Don't preach to the underprivileged, ie, don't try to impose middle-class thinking on people whose life experiences have never permitted them the luxury or privilege of long-range planning. In most societies, poverty (whether financial, emotional or psychosocial) confers on young and older people an extraordinary constriction of their concepts. For disadvantaged young people (and parents), the 'future' may be less than the next 48 h. Therefore, don't be surprised if they have few or no long-range plans for their lives (and therefore, also have diminished feelings for the consequences of their actions). Similarly, their 'world' may end a few blocks from home and they may, therefore, have difficulty imagining themselves as potentially important contributors in a larger world.

These are just a few of many lessons I wish I had learned much earlier in my career. I hope they will help you find ways of becoming even better guides for children and families. I wish you all great success and satisfaction.

#### BIOGRAPHICAL NOTE: RICHARD B GOLDBLOOM

Born on December 16, 1924, Dr Goldbloom graduated from McGill University (MDCM) in Montreal, Quebec, in 1949. He completed his postgraduate paediatric training at Montreal Children's Hospital (Montreal) and Children's Hospital (Massachusetts, USA). He became Associate Professor of Pediatrics at McGill University, Professor and Head of the Department of Pediatrics, Dalhousie University (Halifax, Nova Scotia) and Physician-in-Chief and Director of Research of IWK Hospital for Children in 1967-85 (Halifax, Nova Scotia). Dr Goldbloom also held the following positions: Chancellor, Dalhousie University (1986-2004), Sir Arthur Sims Commonwealth Travelling Professor (1985-86), President of the Canadian Paediatric Society (1985-86), Past Chair of the Rhodes Scholarship Selection Committee (Maritimes), Past Chair of the Canadian Task Force on Preventive Health Care. He has written more than 200 publications, and was the Editor of *The Canadian Guide to Preventive Health Care*, *Pediatric Clinical Skills* and *Pediatric Notes*. Dr Goldbloom received honorary degrees from Dalhousie University, McGill University, Acadia University (Wolfville, Nova Scotia) and Cape Breton University (Sydney, Nova Scotia). He was also the recipient of the FNG Starr Award, Canadian Medical Association. He was Chancellor, Dalhousie University (2002-2008), now Chancellor Emeritus, and Appointed Officer of the Order of Canada in 1986. Dr Goldbloom currently holds a postretirement appointment as Professor of Pediatrics, Dalhousie University. A fourth edition of his popular textbook, *Pediatric Clinical Skills*, was published in 2010.