Personal View

The art and essence of childcare: Personal perspective

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Abstract

Paediatrics is a dynamic specialty because it deals with an evolving, varying size (<1.0 kg to >50 kg) and functional maturity of children. The basic aim and goal of paediatrics is to ensure that every child is assisted to achieve his or her optimal genetic potential for physical growth and mental development. A physician must be humane, sensitive, systematic in his approach and genuinely interested in the welfare of children. Paediatricians should approach children as children (not patients) with tact, gentleness, warmth and genuine concern. He must have a scientific bent of mind and use logical systematic steps to arrive at a diagnosis with the help of core knowledge, clinical skills and basic principles. The methods of physicians are like those of a detective, one seeking to explain the disease, the other a crime. Just as evidence is crucial for a detective to identify the culprit, sound evidence as collected by history, physical examination and investigations is of fundamental importance to solve the diagnostic dilemma. After having made a tentative diagnosis, one should prescribe the single most appropriate therapeutic agent, which should be administered in an optimal dose through the most convenient route, instead of instituting a "shot-gun" therapy with half a dozen drugs. We must provide global care to the child rather than a mere cure against a disease process. In order to improve the reach and coverage, there is a need to provide holistic care by harnessing the local health traditions and exploiting virtues of complementary and alternative systems (CAS) for treatment of common day-to-day illnesses. Communication is indeed the key to strengthen the doctor-patient and the doctor-parent relationship. We should be ethical in our dealings with patients/parents and make concerted efforts to resurrect the declining image of the medical profession by promoting the sublime art of medicine and acquiring the divine gift of healing. We should not allow technology to further dehumanize medicine.

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The attributes of a physician

"The medical student must exhibit a calm and generous disposition, besides being virtuous and of a noble mind. He must be tolerant of others and exhibit patience and perseverance in his academic pursuits. Although of sharp intellect, he must be both rational and modest. He should possess a pleasant appearance and good looks, with a well-proportioned body, which should be free from physical defects or any obvious diseases. Above all, he must be compassionate. He must exhibit deep interest in the art and science of healing. He must use his intelligence to discuss facts about the disease and to understand the clinical significance of symptoms. Such knowledge he must use not only for his own intellectual enrichment, but also for acquiring requisite skills in practical management. He must be humble and loyal to his teachers and instructors. He should be free from any addictions, greed, arrogance and intolerance.''

—Charaka Samhita (900–600 BCE)

The basic aim and goal of paediatrics is to ensure that every child is assisted to achieve his or her optimal genetic potential for physical growth and mental development. The ideal paediatrician must have a genuine interest and love for children. The opportunity of nurturing one's own children or grandchildren is a great learning experience for a paediatrician. He must be humane, systematic in his approach and genuinely interested in the welfare of his patients. He should exude confidence, patience and politeness to elicit cooperation of patients and his attendants. These qualities are crucial to generate faith of parents in his capabilities, which is a great healing force. The physician who exhibits evidences of hurry, worry, and indecision is unlikely to inspire any confidence in his patients. *To augment the process of healing, the*

patient must have faith in his doctor and the doctor must have faith in himself and his medicines.

The paediatrician should approach children as children (not patients) with tact, gentleness, warmth and genuine concern. He should have a sober and affectionate look so that children are not afraid of him. *Unlike adults, children distrust the man who looks into their eyes.* He must have a scientific bent of mind and use logical systematic steps to arrive at a diagnosis with the help of core knowledge and basic principles. He should not be dogmatic and should be aware of the limitations of his own knowledge and of knowledge in general and should never hesitate to say, "I don't know". He is a perpetual student, constantly learning and unlearning to transform knowledge into wisdom. The attributes of a paediatrician are listed in the *Box 1*.

Box 1. The attributes of a paediatrician

- Good physical and mental health
- Knowledge and communication skills
- Wisdom
- Confidence
- Patience
- Politeness
- Humility
- Common sense
- Pleasant demeanour or bedside manners
- Experience and expertise
- Tact
- Compassion
- Kind and affectionate look
- Love for children
- Intuition
- Healing touch

The welfare of the patient must be considered as supreme and should take precedence over all other considerations including his personal pride or commercial gain. Nevertheless, he should not under-estimate his own ability to make new and original observations. Above all, though medicine is a profession, life should never be weighed in gold—it is too precious! According to Mother Teresa "Medicine must be viewed as a mission and it should not be downgraded as a profession or business".

The paediatrician must conduct himself with dignity, seriousness and respect towards parents regardless of how deviant their behaviour may appear at times of distress. He should establish a warm and cordial interpersonal relationship with his team members by virtue of qualities of his head and heart. He must demonstrate impeccable bedside manners and serve as a role model to his students. He should not merely be a healer but truly serve as a philosopher and guide to his patients, parents and students.

The approach to diagnosis

The methods of a physician are like those of a detective, one seeking to explain the disease, the other a crime. There are no short cuts for making a physical diagnosis. It is learnt only by practice, not a dull, dreary monotonous practice but practice with all the five senses alert. The astute physician is endowed with sharp and sensitive special senses (especially keen observation) and must harness the skills of a lawyer, a detective and a judge. During the last three decades a revolution in imaging technology by introduction of ultrasound, computed tomography scanning, magnetic resonance imaging, and positron emission tomography has eroded the confidence and enthusiasm of clinicians. Instead of causing disuse atrophy of clinical judgment, the newer technology should be fully exploited and harnessed to improve clinical judgment and enhance the understanding of pathogenic mechanisms underlying the disease process. It is a sad reality that physicians are becoming more of technocrats and losing the art of medicine. The patient is being fragmented into systems, organs, tissues, cells and even DNA! It is crucial that we should not lose sight of the totality of the patient and his interactions with social and ecological milieu. Our focus should be the patient and not the disease because every patient is unique. The correct diagnosis of the underlying disorder and its probable aetiology are crucial for rational management and prognostication[1]. The diagnosis is based on elicitation of correct evidence and its analysis and interpretation of findings and observations in the light of core knowledge, wisdom and experience of the paediatrician (Figure 1). The correct diagnosis is crucial to institute rational therapy

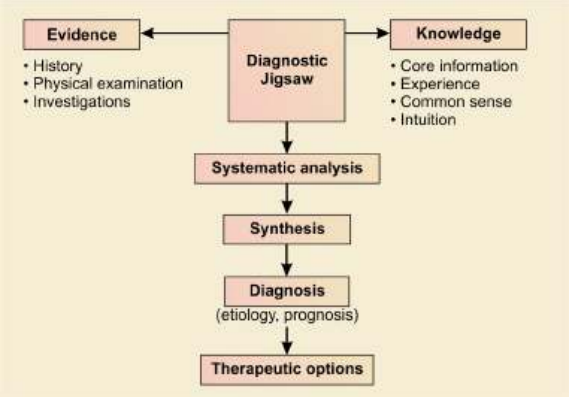

Figure 1: ***Key elements to solve diagnostic puzzle***

The evidence

Just as evidence is crucial for a detective to identify the culprit, similarly sound evidence as collected by history, physical examination and investigations is of fundamental importance to solve the diagnostic dilemma.

History

Good history taking is an art and it needs inquisitiveness, persistence and tact. You must emphasise the important, minimise the unimportant and suppress irrelevant information. During history taking, provide positive non-verbal cues to enhance doctor-patient/parent communication. You should lean forward, listen attentively with interest, maintain eye contact, nod appropriately and not cross your arms or exhibit any sense of superiority or arrogance. The history should be sifted off undue parental anxiety and concern in order to obtain a lucid chronological story with special emphasis on the onset and evolution of the disease process. Through a process of detailed review of various symptoms and systems, an attempt should be made to identify the organ(s) affected by the disease process. Identify whether a single system is affected or you are dealing with a multisystem disorder. An attempt should be made to identify whether a disorder is acute, subacute, chronic or insidious and classify it into static, resolving or progressive in nature.

The psychological, social, ethnic, geographical, ecological and genetic factors influencing the disease process should be identified. Sir William Osler rightly said, "Medicine is about sick people, not about diseases". Race and ethnicity play an important role in the expression of disease. In addition to genetic factors, individuals with similar ethnic backgrounds share cultural, nutritional, environmental, economic, and social characteristics that influence the disease.

It is important that no observation of the mother, whether apparently trivial or unimportant, should be ignored or set aside if it fails to fit into the tentative diagnosis. Indeed, it may be the most important clue or hint to unravel the diagnostic puzzle. It must be remembered that over 75% of diagnoses can be correctly made by virtue of a good history alone.

Physical Examination

"*A great part, I believe, of the art of medicine is the ability to observe. Leave nothing, to chance, combine contradictory observations and allow yourself enough time."*

—Hippocrates

The history tells of events, which have led to the present condition of the patient while clinical examination reveals the status of the patient at a given moment. Accuracy of history depends upon the education, memory, intelligence and concern of the attendant while the yield of physical examination depends upon the experience, skills and thoroughness of the paediatrician. Most errors in medicine are made by making a cursory or incomplete examination and not due to lack of knowledge and skills. The approach during examination should be both humane and systematic. The paediatrician must have an inherent fondness and love for children and examine them with warm hands and a warm heart. The examination chamber should be warm, familiar, well lighted and stocked with soft toys. Deep yellow or blue coloured curtains should be avoided in the examination chamber because they may interfere with the interpretation of jaundice and cyanosis. *The children must be treated as children and not patients and examination should be conducted in an unstructured playful manner.* Patients must be handled with the utmost care and reverence, as they are the real books of physicians. The maximum time should be devoted to observation of the child and to the system or organ, which appears to be predominantly affected on the basis of history.

"To study the phenomena of disease without books is to sail an uncharted sea, while to study books without patients is not to go to the sea at all …"

—Sir William Osler

Physicians must sharpen their observation skills by enhancing the capabilities of their special senses. Paediatrics deals with children from birth to adolescence, varying in size from less than 1.0 kg to over 50 kg and having different grades of functional maturation of various organs. Paediatrics has been likened to a flying bird, which deals with dynamic, evolving and changing size and maturity of children. The knowledge regarding developmental anatomy,

developmental pharmacology, developmental biochemistry and developmental biology in general is crucial for proper evaluation of normal children at different ages for appreciation of abnormalities or deviations due to various diseases. You must have information regarding normal variations at different ages before you can pick up the abnormalities. The developmental or functional status of the child affects the incidence and expression of various diseases and conversely diseases may adversely affect the growth and development of children. The lymphoid tissue is physiologically hypertrophied in children leading to development of large tonsils or cervical lymphadenopathy following minor infections.

Laboratory Investigations

They are useful to assess the degree of organ dysfunction, assist in confirming the diagnosis, help in monitoring, management, prognostication and follow-up. *There is no justification to undertake routine investigations in every patient.* Instead, appropriate and relevant investigations should be ordered depending upon the diagnostic possibilities entertained on the basis of a detailed clinical evaluation. The paediatrician should be aware of the limitations of all laboratory tests and follow the philosophy that the laboratory should be used as a slave and not a saviour.

The physician must have faith in his clinical acumen and use the laboratory as an aid for confirmation of the diagnosis in order to provide effective and rational management to the patient. *The approach should be to treat the patient and not his laboratory reports.* Nevertheless, diagnosis should not be delayed by postponing essential investigations. Timely laparotomy may be life-saving in a child with acute abdomen, undiagnosed lump and for differentiation between neonatal hepatitis and extra hepatic biliary atresia. The children with cervical lymphadenitis should not be given a trial of anti-tubercular therapy unless the diagnosis is confirmed by fine needle aspiration cytology or lymph node biopsy.

The core knowledge

The evidence generated by a painstaking history, physical examination and investigations should be viewed in the light of available knowledge and experience of the paediatrician. Every paediatrician should be aware of the essential features and criteria of common childhood disorders. It must be remembered that no symptom or sign has a 100% frequency or specificity in a disorder because no two patients are alike. In general, the manifestations of diseases are rather atypical among neonates and infants. The paediatrician must have an up-to-date knowledge pertaining to the current state-of-the-art for diagnosis and management of common paediatric problems; otherwise he or she will get rusted and outmoded.

A large number of systemic disorders, genetic or chromosomal diseases in children can be diagnosed on the basis of a typical facies or facial dysmorphism. The physician must be equipped with some core knowledge because chance favours only the prepared mind. *It is well known that what the mind knows, it is more likely to explore and discover in the patient.* The diagnosis of acute post-streptococcal glomerulonephritis can only be made if one knows that it is characterized by acute onset of puffiness and oedema of feet, oliguria and smoky urine (microscopic haematuria), hypertension and azotaemia following two weeks after an inadequately treated attack of acute streptococcal pharyngitis.

The art of diagnosis

"Oh God, let my mind be ever clear and enlightened. By the bedside of the patient, let no alien thoughts deflect it. Let everything that experience and scholarship have taught it be present in it and hinder it not in its tranquil work. For great and noble are those scientific judgments that serve the purpose of preserving health and lives of thy creatures…"

—Moses ben Maimonides (1135–1204 ACE)

The diagnostic process is one of the greatest challenges in medicine. The patient should be viewed as a jigsaw puzzle and you should be patient, relaxed and methodical to solve the dilemma[2,3]. The evidence (demography, epidemiology, symptoms, signs, investigations) pertaining to the patient should be sifted and analysed through a process of logical thinking in the light of core knowledge, experience and clinical judgment of the paediatrician to arrive at plausible diagnostic possibilities. All the points in favour and against a particular diagnosis should be carefully weighed to arrive at a final diagnosis. The physician should have a thorough understanding of basic principles to solve the diagnostic puzzle and be aware of the limitations of his own knowledge to avoid dogmatism. There is no place for expressions such as NEVER and ALWAYS in medicine. The greater the ignorance, greater is the dogmatism. Be humble and don't have a "know all" attitude. It is wiser to confess ignorance than to "beat about the bush" or give silly explanations. According to Sir William Osler, "Medicine is a science of uncertainty and an art of probability." *We must keep in mind that our knowledge in matters of health and disease is like a pond while our ignorance is Atlantic.* The following principles are useful to keep in mind while making a diagnosis.

1. The psychogenic label is the commonest refuge of the diagnostically destitute. The functional disorder should be diagnosed both by exclusion of an organic disorder and by the presence of positive evidences of a psychogenic disturbance. Attention must be paid to the whole child along with his environment rather than merely to his body organs. The focus should be the child and not his disease. Ask the mother how the index child differs or compares with other siblings. The behaviour and personality disorder in a child is a reflection of parental discord and the child should be considered as a barometer of the family's emotional health. The psychological symptoms in a child are a signal to implore us, "please help my family."

2. Remember the stark reality that common diseases occur more commonly. *The rare manifestations of a common disorder are more common than the common manifestations of a rare disorder*[A]. According to Henry Cohen, "No observation, however small or apparently trivial, which fails to fit into a tentative diagnosis, should be put aside as unimportant." When a symptom or a sign is commonly found in a large number of diseases, its absence is more significant than its presence for making a specific diagnosis.

3. Give due credence to the diagnosis made by the previous physician but do not accept it as a gospel truth. You should make your own decision regarding the likely diagnosis based on the sequence of events, course of the disease, leads obtained on investigations and response to medications.

4. Efforts should be made to fit the total clinical picture into a single diagnostic entity. This is more often possible in a child as compared to an adult. No diagnosis should be taken for granted, even when it is attributed to a reliable physician or a renowned medical institution, unless it is based on sound evidence and logic.

5. Avoid masking symptoms and signs by giving drugs to a patient with an evolving disease process. Do not instill mydriatics into the eyes for examination of a fundus or give sedatives to a child with head injury because this would compromise the diagnostic utility of pupillary size and level of consciousness. In a case of undiagnosed acute abdomen or head injury, strong analgesics and sedatives should be avoided.

6. Do not delay the surgical diagnostic procedure or a laparotomy whenever it is indicated.

7. The diagnosis of a curable disease should not be overlooked. When the clinical picture is compatible both with tuberculosis and Hodgkin disease, it is preferable to confirm the diagnosis by lymph node biopsy before starting treatment.

8. Do not allow the social position of the patient or family to limit your examination. Undress the child completely whenever necessary. Incomplete or cursory examination is the most important cause of diagnostic misadventures.

9. Be confident but don't be biased or dogmatic in your approach. Be humble and considerate.

10. The diagnosis may be made in stages and don't hesitate to revise your diagnosis after a period of observation. The appearance of new symptoms and signs, as the disease evolves, may offer additional diagnostic clues. Sir Robert Hutchison, the legendary clinician, has enunciated several don'ts for the diagnosticians (*Box 2*).

Box 2: Don'ts for diagnosticians

- Don't be too clever
- Don't diagnose rarities
- Don't be in a hurry
- Don't be faddy
- Don't mistake a label for diagnosis
- Don't diagnose two diseases simultaneously
- Don't be too cocksure
- Don't be biased
- Don't hesitate to revise your diagnosis
- Don't be dogmatic
- Don't be arrogant
- Don't ignore your intuition and common sense

The diagnostic possibilities

In modern or allopathic system of medicine, most diseases can be classified into eight broad aetiologic groups (Table I). Infections account for over 75% of all diseases. In children, protein-calorie malnutrition and deficiency of micronutrients (vitamins and minerals) constitute the core health problem, which makes children susceptible to develop infective disorders, which are likely to run a relatively fulminant course. Over-nutrition and obesity are emerging as public health problems among adolescent children belonging to affluent or well-to-do families. Most genetic (inborn errors of metabolism), chromosomal and developmental disorders manifest during childhood. The degenerative disorders due to aging are uncommon in children but there is a need to identify various clinical and laboratory markers for these disorders so that preventive strategies can be instituted during childhood to reduce the burden of these diseases during adult life. *We must remember that seeds of most adult diseases like obesity, hypertension, type 2 diabetes mellitus and coronary artery disease are sown in childhood*[5]. After clinical assessment, a tentative diagnosis should be made and various differential diagnostic possibilities in the order of their probability should be listed before ordering investigations.

Table I: ***The spectrum of diagnostic possibilities***

Aetiology	Spectrum of diseases
Infections	Viral, bacterial, spirochaetal, fungal and parasitic
Exogenous toxins and injuries	Drugs, chemicals, foreign body, trauma, burns, electric shock
Deficiency states or disorders of abundance	Hypoxia, dehydration, protein-calorie malnutrition, deficiency of vitamins, minerals and hormones Hyperoxia (retinopathy of prematurity), over hydration (over infusion, low oncotic pressure, capillary damage), obesity, hypervitaminosis and excessive release of hormones (thyrotoxicosis, gigantism, insulinoma)
Developmental disorders	Genetic diseases, inborn errors of metabolism, chromosomal disorders, congenital malformations
Neoplasms	Benign or malignant
Allergic, hypersensitivity, or autoimmune disorders	Allergic diathesis, atopy, bronchial asthma, post-infectious disorders, collagen vascular or connective tissue disorders, etc.
Degenerative disorders	Atherosclerosis, progeria, and degenerative disorders of central nervous system
Psychogenic and psychosomatic disorders	Breath-holding spells, nocturnal enuresis, recurrent abdominal pain, anxiety, conversion reaction, conduct disorders, behaviour disorders, depression, autism spectrum disorders, attention deficit hyperactivity disorder, substance abuse etc.

It is essential to make a complete diagnosis including the *primary condition and likely cause, associated complications* like intercurrent infections and *concomitant disorders*. For example; protein-calorie malnutrition, marasmic type, faulty feeding and weaning practices, recurrent diarrhoea, hypothermia, nutritional anaemia, zinc deficiency, primary pulmonary complex and scabies.

Rational management

The purpose of making a correct diagnosis is to institute rational therapy and provide prognostic guidelines to the family. It is preferable to use a single most appropriate therapeutic agent, which should be administered in an optimal dose through the most convenient route, instead of instituting a "shot gun" therapy with half a dozen drugs. It is desirable to use familiar drugs, which have withstood the test of time. The newer drugs or procedures are not necessarily better. The discomfort and pain of the patient must be relieved by appropriate and safe medicines with due regard to their comfort and wellbeing.

We must provide global care to the child rather than mere cure against a disease process. According to Hippocrates, "A good physician treats the disease, the great physician treats the patient who has the disease". Complete and comprehensive advice regarding diet, personal hygiene and immunizations should be given to all children irrespective of the underlying disease process. Medical systems should not be fragmented into watertight compartments and instead all systems including complementary and alternative systems (CAS) should be exploited and harnessed to provide relief[6]. The government of India has introduced the concept of AYUSH by providing a kit to primary health care providers, which contains **A**yurvedic, **U**nani, **S**iddha and **H**omeopathic medicines, apart from medicines belonging to the modern or Allopathic system. There are a large number of therapeutic modalities to provide relief and healing, suggesting thereby that none is foolproof and nobody knows the ultimate truth (*Box 3*).

However, it is illogical to treat a patient simultaneously with homeopathic as well as allopathic medicines because one system is supposed to express the disease and the other tries to suppress it. The physician must establish a rapport with the child and his parents to provide them emotional support and win their confidence.

Box 3. Various therapeutic modalities

- Drugs from Allopathic or indigenous system, i.e. Ayurveda, Unani, Siddha and Homeopathy (AYUSH)
- Life sustaining technologies
- Surgical procedures to repair or replace defective body organs
- Physical therapy
- Psychotherapy
- Acupressure and acupuncture
- Hypnotherapy
- Magnetic therapy
- Yoga
- Naturopathy and nutrition
- Reiki
- Tai-Chi
- Qigong
- Music therapy
- Aroma therapy
- Salt therapy
- Gemology
- Visualization
- Art of living and life style changes
- Meditation
- Prayer

**No system of medical care is foolproof, harness, integrate and exploit virtues of all systems (AYUSH concept). Nobody knows the ultimate truth!*

The paediatrician who is likely to exhibit evidences of hurry, worry, and indecision is unlikely to inspire confidence in his patients. The skillful physician knows when to sedate with drugs, when to soothe with words, when to treat aggressively for cure, palliatively for symptomatic relief and consolingly for comfort. What we don't say and what we do say, how we say it and when we say it, makes all the difference between helping and not helping our patients. These attributes and skills cannot be learnt from books but by emulating the example of one's model teachers, which are of course a dwindling tribe in the modern commercialized society.

The patients and attendants have emotional feelings and one should avoid saying "nothing can be done" (because something can always be done), "there is nothing wrong" (even when it is a functional disorder), "don't worry", "it is all right" etc. The *world needs caring and concerned physicians, and not merely curing and commercial robots that lack compassion and deny healing virtues of human touch.* Identify the major worries and fears of the child and his parents.

Relieve their anxiety, reassure them and restore their confidence so that the will to fight is never dulled or extinguished. Nevertheless, we should be honest and pragmatic towards our patients. There is hardly any place for use of injections in ambulatory paediatric practice except for the administration of vaccines and treatment of anaphylactic reaction.

The news regarding the incurable or serious disease in a child should preferably be disclosed to both parents simultaneously by the consultant with due concern, sympathy and compassion. The dialogue should be unhurried and parents should be encouraged to express their feelings, fears and concerns by asking questions. It has been rightly said by Bernie Siegel "Our power to heal people and their lives seems to have diminished as dramatically as our power to cure diseases has increased by the technology boom". In the maze of scientific advances, we seem to have lost the human dimension. There is a need to resurrect the art of medicine. *There is no doubt that we should make sincere efforts not only to become knowledgeable and skillful physicians but we should strive to evolve as effective healers and above all good human beings.* These virtues of physicians are extolled in Charak Samhita "…Thou shalt behave and act without arrogance and with undistracted mind, humility and constant reflection, thou shalt pray for the welfare of all creatures…" When you look at your patients with a smiling, kind and caring eyes, the act of looking becomes a prayer, a meditation and a way of healing.

Sir Robert Hutchison has beautifully summed up the principles of rational management of diseases and art of medicine in the following quote:

"From inability to let well alone, from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, science before art and cleverness before commonsense, treating patients as cases, from making the cure of the disease more grievous than endurance of the same, good Lord deliver us"

—Sir Robert Hutchison

In order to avoid therapeutic misadventures, there are five messages or pearls of wisdom encapsulated in the above quote.

1. Many diseases are self-limiting and they recover spontaneously without any drugs. Nature, time and patience are the three great physicians.
2. We should not be enamoured and fascinated or carried away to use newer drugs which have not withstood the test of time and we should remember the well-known dictum that "old is gold".
3. Art of medicine should not be sacrificed at the altar of technology.
4. Patients should not be viewed as systems or organs but in their totality—body, mind, heart, soul and society. A good physician treats the disease; the great physician treats the patient who has the disease.
5. Medicines should be used only when indicated and they should not cause more harm to the patient than the disease itself for which they are prescribed.

We must use those medicines, which have withstood the test of time with an assured efficacy and safety track record. It is important to remember that no medicine is entirely safe and it has been cynically summed up by Oliver Wendell Holmes, *"If the whole Materia Medica as being used now, could be sunk to the bottom of the sea, it would be better for all the mankind – but all the worse for the fishes."*

Communication skills and ethical considerations

We should provide ethical and holistic care to our patients with due competence, consideration and compassion. Communication is indeed the key to strengthen the doctor-patient and the doctor-parent relationship. Physician must keep in mind that the patient is his honoured client and he should relieve the anxiety of parents and instill confidence in them towards him during the interview. However, he should not behave like an enthusiastic salesman by dramatizing the illness of the child. We should not judge, belittle or argue with our patients or their attendants. Most parental complaints or litigations against doctors originate due to lack of communication or because of abrasive, cold or callous attitude of the doctor or health care professionals rather than due to lack of knowledge, skills or faulty technical management of the patient[7]. It is an amazing fact that most parents are grateful even when we are unable to save the life of their child, especially if one showed concern, care and compassion, and parents and relatives were made to perceive that whatever was humanly possible was done for the care of their child[8,9]. The virtues and benefits of good-doctor patient communication are listed in the *Box 4*.

Box 4: Benefits of good doctor-patient /parent communication

- Better confidence, trust and faith of the physician
- Reduced anxiety and greater satisfaction of patients and parents/ attendants
- Provision of global care rather than mere cure
- Better compliance of therapeutic options
- Better health outcomes
- Reduced risk of malpractice litigation

Physicians are both morally and legally accountable to society. There is an age old faith, trust and respect towards physicians in the Indian culture. Charaka best sums up the legendary bond of faith between the doctor and patient, *"No other gift is greater than the gift of life. The patient may doubt his relatives, his sons and even his parents, but he has full faith in his physician. He gives himself up in the doctor's hand and has no misgivings about him. Therefore, it is the physician's duty to look after him as his own."*

There is increasing commercialization and a gradual decline of human values at all levels of our society and doctors are not demigods. The common correlates and types of unethical medical practices are listed in the *Box 5*.

The declining image of the medical profession needs a moral boost and regeneration by awakening the inner conscience and a thorough process of soul searching in the light of existent social realities. The continuing process of erosion of the doctor-patient relationship and trust due to insensitive and commercialized attitude of some physicians and over demanding attitude of educated and well informed internet-savvy parents, need to be checked against further disintegration. It is desirable that all medical and nursing colleges in the country should initiate regular education programmes in the field of social and behavioural sciences, art of communication and medical ethics for graduate and postgraduate medical and nursing students[10,11]. There is a need to establish Ethics and Grievances Committees in all hospitals and they should serve as watchdogs to monitor and maintain the sanctity of all ethical decisions and quality of medical care.

Box 5: Common correlates and types of unethical practices

- Change in social values and passion to become "rich overnight".
- Doctors are competing with each other to create revenue for the corporate hospital by fair or foul means.
- Exorbitant cost of medical education in the private sector and urgency to earn fast to pay back the loan.
- Unnecessary diagnostic studies for the lure of "cuts" or because the laboratory is owned by the physician.
- "Kickbacks" for referrals.
- Superfluous medical procedures like phototherapy, endoscopies and biopsies.
- Needless hospital admissions and delay in discharge.
- Unnecessary medical therapies, surgical procedures or surgical operations.
- Issuing false medical or disability certificates.
- Receiving courtesies, favors and gifts from manufacturers and suppliers of equipment and pharmaceutical companies.
- Fraud in research by plagiarization and "quantum Jugglery".
- Overt or covert sexual liberties or misconduct towards patients or their attendants.
- Self-promotion through advertisement.

Prognosis

"*Parents (and attendants) have emotional feelings. Never say, "Nothing can be done", because something can always be done. Never give a hopeless prognosis in order to avoid neglect and sustain the will to fight. Nevertheless be pragmatic and honest"*

—Meharban Singh

Most parents and attendants are worried and concerned about the outcome of the disease. They commonly ask, "Will the child become alright?" and "How soon he is likely to recover"? The outcome depends upon the nature and severity of disease process and the type of the host or victim, which is afflicted with the disease. The disease with an acute and sudden onset is likely to have either a dramatic recovery or a deadly outcome. Most diseases are self-limiting and they recover on supportive management without any medications. Faith, will power, positive thinking and sound genetic constitution are great healers. To augment the process of healing, the patient must have faith in his doctor and the doctor must have

faith in himself and his medicines. Infants below 3 months and children having protein-energy malnutrition and immunodeficiency state are likely to have poor outcomes.

The parents should be handled with due compassion and told about the likely outcome of the disease and possible side effects of the medications. They should be given explanations about the expected course of the disease. For example, viral infections are usually self-limiting and likely to take 3–5 days for recovery, acute onset of vomiting may be followed by diarrhoea after 24 hours, and a child with typhoid fever is likely take 4–5 days to settle even after start of specific antimicrobial therapy. The physician must establish a rapport with the child and his/her parents to provide them emotional support and win their faith, trust and confidence.

When a child is suffering from a chronic or incurable disease or an affliction with a lifelong disability, the parents are likely to respond with disbelief, anger and shock. The news about a disabling or deadly disease should preferably be given to both the parents simultaneously with due concern, compassion and empathy. The facts should be explained in a simple language without any medical jargon. The physician should allow the parents to ventilate their feelings and concerns and try to answer their queries in an honest and unambiguous manner. Physician should be pragmatic but not pessimistic. It is important to remain positive and hopeful, which is a great healing force. Hope is the greatest healer and we should give a guarded but not a hopeless prognosis. It is important to remember that nature is supreme and miracles do happen.

We should be careful and diplomatic in conveying the nature of the disease without hurting parental feelings. Instead of bluntly saying, "Your child is mentally retarded", it is better to say that the child is rather "slow" or having "developmental delay". In Indian society, giving a spiritual context to parents of "special children" is useful to buffer their anxiety and feeling of hopelessness. For example, we can say "God has chosen you to provide care and comfort to this special child because you are so compassionate, caring and sensitive human being." The family should be encouraged to join Self Help Association of Parents to share their mutual concerns and difficulties, and ensure effective utilization of available specialized services.

End-of-life issues

During their career, physicians are likely to face several "end-of-life" situations. Despite all the technological advances, medicine can never achieve immortality! It is as natural to die as to be born. When faced with a critically sick or dying child, the physician should allow the parents to express their feelings and concerns and try to answer their queries in an honest and unambiguous manner. In this situation, we should follow the well-known dictum—"Talk less and listen more." The coping of death of a child in the hospital is a painful and challenging experience for everybody concerned with the care of the child.

Death deflates our ego and teaches us humility and provides strength to handle the greatest reality of life with equanimity, composure and confidence. During the care of critically sick children in the intensive care unit, it is important to show due concern, care and compassion to the parents/attendants, and keep them duly informed about the condition of their child. It is important that the physician should not only provide state-of-the-art care to the child but also make the parents and attendants perceive that whatever was humanely possible, it was done for their child. The family should be emotionally and spiritually prepared before declaration of death. The news of death should be conveyed with utmost compassion but in no unmistakable terms that the child has died despite our best intents and efforts. When a child is conscious and dying, the parents should be at his bedside holding his hand and talking with him to allay his fears and provide him emotional support, for his journey to the unknown.

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