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Editorial

Paediatric Hospital Medicine: The Practice in Evolution

In the eyes of children, a visit to the hospital may already be a scary ordeal, let alone hospitalisation. The sense of vulnerability can never be greater, considering the little ones being exposed to strangers in uniforms, environments that bear no resemblance to their cosy home, and procedures that are meant to be helpful but yet inconveniently distressing. This is the time when tender loving care from parents and hospital staff would most eagerly be sought. Those looking after the hospitalised babies may recall the elegant words of Rabindranath Tagore, "If baby only wanted to, he could fly up to heaven this moment. It is not for nothing that he does not leave us. He loves to rest his head on mother's bosom, and cannot ever bear to lose sight of her..... It is not for nothing that he never wants to speak. The one thing he wants is to learn mother's words from mother's lips..... It is not for nothing he has chosen to shed tears. Though with the smile of his dear face he draws mother's yearning heart to him, yet his little cries over tiny troubles weave the double bond of pity and love."

In this issue of the *Journal*, two articles are related to the issue of hospitalisation. Kum et al reported on the opportunity to perform developmental surveillance in children hospitalised for neurological and non-neurological problems.¹ They found that up to 42.4% of the 113 hospitalised children aged 2 to 42 months had developmental difficulties, in areas of language, motor, social, emotional, play and self-help skills, in a low to moderate income country. Akyildiz and Zararsiz, on the other hand, explored the anxiety levels of parents whose children required intensive care management.² They found that whereas the anxiety levels were similar between fathers and mothers of children who were hospitalised for acute illnesses, mothers of children with chronic illnesses experienced a higher level of anxiety. These are but only two of the different facets of issues related to the broader topic of paediatric hospital medicine.

The changing landscape of paediatric hospital medicine has become evident, not only by impression of paediatric residents and seasoned paediatricians but also from weekly review of the disease and procedural codes for hospitalised children. For those practising paediatrics in hospital settings, it has become obvious that two distinct populations of hospitalised children have emerged. The first is represented by children, who are otherwise relatively healthy, admitted for acute illnesses involving primarily a single organ system. While the organ-based stratification of childhood illnesses epitomises the practice of a reductionist clinical approach, one cannot argue against the success of the hospital-based approach in managing common respiratory illnesses including bronchiolitis, croup, and pneumonia, gastrointestinal problems including acute gastritis and gastroenteritis, problems of the urinary tract including urinary tract infection and complications of reflux, and so on. Notwithstanding, achievements in preventive

medicine and advances in medical care have shifted the management of some of these acute illnesses from hospital- to community-based care.

On the other hand, the population of hospitalised children with chronic illnesses is growing. These chronic illnesses are characterised by involvement of multiple organ systems, complexity of the underlying illnesses or undiagnosed rare conditions, existence of co-morbidities and complications, and associated mental, behavioural and psychosocial issues. It is in these children with known complex and, at times, undiagnosed rare conditions, which are neither organ- nor disease-specific, that a truly holistic care and concerted efforts of a hospital-based dedicated paediatric team with the appropriate expertise is most required.

In UK, the Great Ormond Street Hospital for Children, London, appointed a Senior Consultant with more than two decades of experience in general paediatrics to support the development of a new team of general paediatricians in 2011.³ It is worth noting the involvements of this team in the 'multi-disciplinary team meetings for children and young adults with complex problems, to contribute general paediatric input and support liaison with local services' and the running of complex care clinics to provide 'a comprehensive family centered overview of the child's or young person's needs, assist with the co-ordination of their care and liaise with all specialists involved in the child's or young person's care to help optimise their care and limit the number of hospital visits required'³ In US, The American Board of Medical Specialties officially recognised subspecialty certification for Paediatric Hospital Medicine in October 2016. Quoting from its press release,⁴ "This subspecialty certification will recognise the training that goes into preparing to care for children hospitalised with more complex conditions."

There is no doubt that the practice of paediatric hospital medicine is evolving, and which would continue to evolve given the increasing complexity of patients to be taken care of in the general paediatric ward setting. While one would not cast much doubt on the adequacy of training and the clinical competence of trained residents in the hospital management of acute, uncomplicated commonly encountered paediatric illnesses, one would beg to ask the question of the adequacy of a similar set of skills in providing complex care of children with conditions that span across different

subspecialties, require special health care needs, and have multiple comorbidities that require concurrent management.

It is intuitive that an extended depth of knowledge in particular areas of clinical paediatrics and an expanded set of skills are required to cater for this increasingly complex patient population. Barrett et al recently highlighted some of the more in-depth clinical and non-clinical components.⁵ The clinical ones would include, amongst others, expertise in the management of children requiring special health needs and technology support, palliative care, performance of certain invasive procedures and technical skills such as insertion of central lines, ultrasonography, and chest tube placement; while non-clinical ones would include the contributions to formulating and implementing changes to improve the health care system through training and research in quality improvement, risk management, patient safety, evidence-based practice, and health information systems.

Hospital care presents not only a challenge to children, their parents and families, but also to providers of paediatric health care. As we are cognizant of the evolution and changes of the practice of hospital paediatric medicine, it is timely for us to strategise the grooming of the next generation of paediatricians to cater to the increasingly complex needs.

YF Cheung
Chief Editor

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