

## *Personal view*

# Why irritated?

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The Editor, by asking me to write this article, reminded me of many of my past sins and alerted me to the danger that I would give the impression that my management of patients was always impeccable—and that would be very far from the truth. Someone once said that as one gets older, one makes all the old mistakes with ever increasing confidence. I would like to think that as one gets older one becomes more tolerant of man's foibles and feels less irritated by them—or at least conceals it. I believe that we should consider what irritates, why it irritates, and what we should do about it.

Infants and toddlers do not irritate, but the older preschool child (or his older sibling) may—because of his disruptive, unchecked rampaging round the room, his violent struggling when his mother is trying to give him three drops of polio vaccine, or his screaming and fighting when his mother tries to bare an arm for his diphtheria tetanus injection. Less often the child strongly resists the physical examination, and with great effort one represses an almost overwhelming urge to smack his bottom.

Why does all this irritate? Perhaps because of one's own impatient and intolerant personality, or because of pressure of work, fatigue, or an overdue mealtime. One forgets that the child, too, may be tired, hypoglycaemic, hungry, unwell, or that especially after an accident, he is afraid of the unknown. He may have had an unpleasant experience in hospital or at the hands of a doctor, with nothing more than a clumsy examination of his throat. His behaviour reflects management at home, lack of loving discipline, or threats that if he does not eat his dinner he will be taken to the doctor. In a 36 page chapter, entitled the Basis of Behaviour, and in chapters on individual behaviour problems, I tried to summarise the origins of children's behaviour.<sup>1</sup>

There is no easy way of dealing with the problem. One talks to the child and keeps on talking to him—and gets the mother to do the same—in order to distract him from his fears.<sup>2</sup> Where possible I talk to the child first—before eliciting the history. If that

fails, it is best to leave the child for a while to thaw out while one talks to the mother. If he does not want to lie down on the couch, one gets the mother to lie him down—and if necessary examines him in the kneeling position. If he is afraid of having his throat examined, he may press the tongue down himself—and one leaves the throat examination to the last.

Why does a mother irritate one? It is difficult to avoid feeling irritated when a mother or father says 'I don't believe in immunisation,' or excuses her failure to bring the boy for his second diphtheria, tetanus, pertussis vaccination until a year or two after the first, by saying that 'he's had a cold all the time' and expecting the doctor to believe it (because he looks stupid and gullible). When her 4½ year old is brought for his diphtheria tetanus polio booster, she warns him of his impending agony by saying 'Try to be brave—and I'll give you a sweetie.' She says that her 7 year old girl is 'very delicate—she's so sensitive, and I'm afraid that she's outgrowing her strength.' In front of a 10 year old girl she says 'She's always been a big disappointment to us, She's not nearly as clever as her brother.' After an hour's session with the doctor, during which she described innumerable symptoms suffered by her child, none of them suggesting disease, she goes away and complains that 'I've never been told a thing.' She had not liked to express her real fear—that her child has leukaemia, like a neighbour's child, and the doctor had failed to realise that she had not told him about her real fear.

In a busy accident and emergency department the hard pressed doctor, tired after a disturbed night, or a succession of severely ill children, finds it hard to be patient with an aggressive mother who demands to be seen out of turn, or be treated privately: she is going to Majorca tomorrow and wants to be sure that her boy's knee, grazed a week ago, has healed, so that he can swim there—or at least go through the motions, as they say. It is hard for the doctor to be kind and sympathetic to a mother with her child who has a 'non-accidental injury'—not realising that the

mother suffered in the same way as a child, with punitive non-loving parents, and that she has dreadful problems without a home of her own, with overcrowding, massive debts, a mentally subnormal older child who cries constantly, wets and soils, and will not sleep. She is battered by her alcoholic cohabitee, is worn out, anaemic, bored, and with absolutely no hope for the future. The next patient has trapped his finger, and his mother is aggressive, because she is in a panic and feels terrible guilt for allowing the accident to happen.

A grandmother may irritate too, when she accompanies her daughter, and will not let her give the history herself.

It is essential never to appear to criticise a mother for her child's difficult behaviour. She has done her best but has had conflicting advice from relatives, doctors, books and journals. It is important to let her talk; many a mother has complained that it is no use talking to her doctor, for he 'just won't listen.' But it is not enough just to listen: one has to try to allay her anxieties and worries.

When a mother has been irritated by another doctor, one has to use all one's tact to cope with the situation. Scores of mothers have expressed to me their irritation at being told that they are 'just overanxious, imagining things,' or 'fussing about nothing.' The mother may or may not be telling the truth, but one can say with certainty that it is dangerous in the extreme to discard a mother's fears if she is insistent that there is something wrong with her child. I told all my students never to use those words when speaking to a mother: a good mother *is* anxious about her child—especially if he is an only one.

It may be difficult for one to avoid feeling somewhat irritated by another doctor's treatment, and not to feel disturbed if a doctor seems to have

allowed medical etiquette, with regard to his colleagues, to override the interests of his patient, which should always be paramount. For instance, it can never be right for a consultant to operate on a child (for example, for tonsils), not because it is in the child's best interests, but because he wants to please the family doctor who recommended it or just to please the parents.

I feel disturbed when a family doctor or consultant refuses to allow a mother to obtain a second opinion. She has every right to, but it is a strange and irrational fact that when a second opinion is sought (or a test is repeated) the second one is accepted as correct. If a mother asks for one's opinion after consulting someone else, one has to give it—and one certainly has to express disagreement with a previous opinion if one feels that the treatment was potentially harmful or that the operation recommended was unnecessary.

One may feel irritated by a child, his parents, the granny, or his family doctor—and the mother may be irritated by the doctor. After a busy outpatient or child health clinic I have often felt irritated with myself—feeling that I may have appeared to criticise a mother when she was seeking advice, or have failed to deal adequately with her questions and anxieties, or have managed a resistant preschool child badly—and annoyed because I realise that with pressure of work I have forgotten to write down some important physical signs.

#### References

- <sup>1</sup> Illingworth RS. *The normal child*. 9th ed. London: Churchill Livingstone, 1987.
- <sup>2</sup> Illingworth CM. *The diagnosis and primary care of accidents and emergencies in children*. 2nd ed. Oxford: Blackwell, 1982.

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