Opinion PEDIATRIC NEWS • September 2007

LETTERS FROM MAINE

A Shot of Confidence

've written about it several times, and we have all experienced The inevitable erosion of technical skills starts

the month you leave your hospital-based, high-acuity residency programs and begin practicing outpatient primary care. You've been warned to "use it or lose it." You may try to stay sharp by taking some hands-on refresher courses, but the opportunities to use your technical skills are fewer and fewer with each month of disuse.

And, with less opportunity to experience success, one's confidence begins to dip to dysfunctional levels. Tackling a procedure with a serious debt of confidence is one of the best ways to ensure failure.

A few weeks ago when I was in a particularly dark valley of technical selfdoubt, I took a mini-inventory of my few remaining skills. Despite the fact that I can't remember whether I started an IV last year, I still have just a smidge of confidence that in an emergency I could use an old-fashioned butterfly needle. But, of course, their rigid design significantly shortens their life span. Surprisingly, I have just a shade more confidence of my

ability to do lumbar punctures. However, these little glimmers of confidence are just that, very tiny sparkles of light on a dark landscape of technical skill.

But, there are a few shining examples that I can be trusted with sharp instruments. Although I have infrequent opportunities to stick needles into blood vessels and other vital structures of varying size and visibility, I do a mess of injections. And, while administering immunizations may not sound like the most challenging technical skill, nonetheless it is a skill . . and at the risk of sounding pompous, I must say I'm pretty darn good at it.

It's not unusual for a parent to say, "He didn't even cry." Or for a preteen to ask, "Did you do it? That didn't hurt." From my admittedly biased and self-promoting perspective, when it comes to giving injections I feel I'm near the top of the heap.

Just do the math. In the course of an average day that includes six or eight health maintenance visits, I could be administering 25 or 30 immunizations. If I have been paying attention only half of the time, I must be learning something that can make the process more comfortable for my patients.

First of all, I'm fast and prepared. I have a little understanding with the nurses in our office. If the injection materials aren't drawn up and ready in the room when I'm ready to give the shot, they have to give the injection. I'm not sure whether this strategy qualifies as a carrot or a stick, but it works extremely well.

Next, I make sure the patient is in a situation where he or she will be well restrained. This requires an accurate assessment of the parent's mindset and ability to hold the child. Sometimes, despite my best coaching, some 150-pound adults can't seem to hold even one extremity of someone weighing only 25 pounds.

Although I do a ritualistic alcohol swipe, I don't and never have drawn back on the syringe before the injection. I have read that this maneuver increases the discomfort and doesn't minimize the risk of an untoward consequence. I try to distract the child by squeezing or gently pinching another portion of the target extremity. I give the most painful injection last, a strategy that has recently been shown to decrease the pain of the first vaccine (Pediatric News, "In Vaccine '1-2 Punch,' the Second Hurts More," June 2007, p. 13).

But most importantly, I try to be as matter-of-fact as I can be about the whole shot process. Unfortunately, many children arrive at their well-child visit in a high state of anxiety fueled by well-meaning parents and not-so-well-intentioned older siblings and schoolmates. Promises of gifts and trips for ice cream may have further inflamed the situation to a point that even a confident master technician like myself is going to fail to give a painless injection. In the words of my old lacrosse coach, "All you can do is give it your best shot."

DR. WILKOFF practices general pediatrics in a multispecialty group practice in Brunswick, Maine. Write to Dr. Wilkoff at our editorial offices (pdnews@elsevier.com).

Adverse overt	% of pediatric patients
Anormia (loss of appetite)	discontinuing (n=685) 2.6
Insormia Weight loss	16
Emailional lability Depression	1.0

Body System	Preferred Town	WIGHTH NA.	Placebo (n=218)
OSC Accod Acche Fever Intect Wrat	Abdeminal Pain (stomostractie)	14%	10%
	Accidental Injury	25	25
	Asthenio (fatigue) Enver	52	- 52
	Infection	46	2%
	Wiral Infection	2%	P%
Digestive System	Loss of Appetite	22%	2%
	Dantes	25	15.55
	Dyspapaia	2%	776
	Noutres Vocation	2% 2%	276
	re-mong		
Hernous System	Dozeness	2%	15
	Emotional Lability	2%	2%
	Impomnia	17%	2%
	Nervousness		
Metabolic/Nutritional	Weight Loss	4%	P%

Metabolic Notritional	Weight Loss	4%	Ph-
Table 2 Adverse Events : 75 kg/165 lbs Ressivi Placebo in a 267 Patier	no ADDERALL BR wi	th Higher Incidence	e Than
Eady System	Preferred Term	ADDERALL XR* (n=250)	Placabe (n=54)
General	Abdomissi Pain (storactache)	11%	2%
Digestive System	Loss of Appetite 1	38%	2%
Hervous System	Insomnia 1 Nervausness	12%	4% 6%
Metabalic/Nutritional	Weight Loss 1	9%	4%
Appears the same due to Close-related adverse en-	rounding eds.		

Budy System	Preferred York	ADDERALL XR* (8-791)	Placeto (n=64)
General	Acthesia Headache	20%	12%
Digestive System	Loss of Appetits Districts Dry Mouth Names	955 955 955 955	2% 2% 2% 2%
Hervous System	Agitation Anxiety Distincts Insorania	8% 8% 2% 27%	5% 5% 5% 13%
Cardievascular System	Tachycardio	8%	2%
Metabolic Votritional	Weight Loss	11%	2%
Uragenital System	Utinary Tract Infection	9%	P%