PEDIATRICS REFLECTION PROJECTS NOVEMBER, 2011

Dear --, how nice to see you again after all this time. And what a terrific poem/letter you contributed. I remember you to be an outstanding writer, and you did not disappoint. What great acerbic wit, permeated by an enormous humanity. I loved the idea of squeezing your little patients into the "well baby box." Ah, those interminable checklists. When your patient becomes a checklist, you know you're in trouble.

Although I completely agree with you that in general, pediatricians are wonderful docs, nevertheless you did a fantastic job of delineating a certain condescending, patronizing attitude that can sometimes creep into doctors' interactions with parents. Suddenly, somehow, because the doctor has the white coat and the degree, he or she is now the authority, the one to "tell, instruct, explain" all to the poor, inadequate parent. Of course, the doctor *does* have important knowledge to share; but sometimes this can be done in a way that demeans the parent. You captured this dynamic extremely well.

You also displayed great insight in realizing that illness is not a value-neutral experience; and that it is easy for patients (and parents of sick kids) to feel guilty, shamed, inadequate, and "at fault" because they are sick. Think about the language we use: "Patient *failed* chemo trial." Ouch. The idea that the cleanliness, purity, and health of the doctor can be "contaminated" by the unsavory ill patient is one that has received great attention in the philosophy of medicine. Your sophisticated awareness of this phenomenon, and the way you symbolized it through the doctor's starched coat, clean hands, and physical distance were impressive.

It is always a pleasure to encounter strong writing that embodies important truths about the human risks of medical practice. This is exactly what you contributed to our session.

Thank you! Best of luck for the rest of this year, Dr. Shapiro

---

Dear -- and --, welcome to the United States. I hope your experience here has been a positive one. Thank you for educating the group about some of the differences between the Norwegian and the American health care systems. As medical students, it is easy to get caught up in the daily issues of rotations, rounds, evaluations, and shelf exams, and to forget the larger context in which the practice of medicine occurs. You called our attention to some of the inherent inequities of healthcare in this country, and showed that there can be other models that better promote social justice. You were also honest about the limitations of a universal healthcare system, such as exploitation of free care, long wait times, and perhaps most challenging of all, runaway costs. But hearing about an alternative approach I hope reminded our students that how healthcare is ultimately configured in this country is in part their responsibility and deserves some thought and commitment. Thanks for sharing your perspective. Best regards, Dr. Shapiro

---

--, thanks for being the first “guinea pig” at the Peds reflection session; and thanks for creating these evocative haiku. They were funny (“why no mute button?”), reflective (“suspended reality”), and vulnerable (“what do I do now?”) In six short narratives, you provided a wonderful overview of the pediatric experience with all its joys, challenges, and frustrations. This tells me you were paying close attention during your rotation, not only to the developmental milestones and the medicine, but to the context and process of peds. You described what you saw with insight and empathy. This was a very well-conceptualized and well-executed project. Best, Dr. Shapiro

---

--, this was such a poignant, tragic tale. I particularly liked the way you delved into the different perspectives of medical student, child, and grandmother, yet united them with (varying versions of) hope. Doctors often use the adage, hope for the best, prepare for the worst. It is a hard line to walk – you do not want to destroy hope in patients and families, but you also want to help prepare them for realistic outcomes. You captured with sensitivity the little girl’s inability to look past Halloween and her longing to return to her premalignancy life as well as the grandmother’s faith and resolve. This told me you had really tried to imagine what this devastating news meant to their world, and in doing so had been able to move closer to their felt experience. This type of clinical empathy takes courage, but also enables you to truly understand, and therefore help, your patients. Thank you also for acknowledging that you didn’t always know how to explain the likely implications of what was happening, or how to adequately prepare the family for “how much her life is going to change.” In fact, by *not* facilely trying to “solve the problem,” but rather listening deeply to where patient and family were, I think you took the most important first step toward helping them adapt to their situation. An excellent piece of work. Best, Dr. Shapiro

---

--, you really expressed well the purpose of this reflection session, which is to change the ground rules for how physicians interact about the emotional challenges of clinical practice. These should not be undiscussable or unacknowledged topics. As you said so eloquently, “Medical students sit around and feel bad about these things, and then they laugh it off.” That’s what too many doctors do too. Part of good coping should be transparency and openness with colleagues, learning that others are in your boat, and sometimes even discovering more healing and helpful ways of approaching these tough issues.

I so appreciated your sharing a positive role model with the group (and your enactment was pretty funny too, it sounded from the comments that you nailed this particular attending’s quirks :-)). Bottom-line, you described a physician who is not afraid to bring his humanity into the newborn nursery, who treats both babies and parents as patients,

and recognizes the human dimension of medical care. No wonder he is beloved by patients and valued by students.

Finally, I really appreciated the title of your essay, embodying the thought that "If it's not in the chart, it didn't happen." I see many residents who seem to think that, documented in the chart is the sine qua non of effective patient care. Of course, it should go without saying that charting is important, both for good care and for liability reasons. Still, Charting stuff doesn't always make that stuff real. It becomes real when the physician and patient and family decide, in dialogue, to make it so. Thanks for an excellent project, Dr. Shapiro

---

--, first I hope your brother and his wife have very happy, healthy children. Your project was creative and clever, especially choosing to speak from the unborn child's perspective to caution prospective parents about prenatal risks and dangers. Your use of humor to discuss difficult subjects (Down syndrome, FAS, other birth defects) helped the group to consider the negative outcomes of poor prenatal care, and how important it is to address prevention during pregnancy. The distinctive, wisecracking voice of the baby reminded us that the arrival of new life is (usually) a joyous occasion, despite the risks, and one well worth celebrating. I suspect this little guy is really going to like his Uncle X, and hopefully they will bond around their shared dry wit. Thanks for a funny project that also got us thinking! Dr. Shapiro

---

--, it was great to run into you on Peds! I enjoyed your project, and the teeter-totter was a particularly good way of illustrating the point you wanted to make. Thanks for highlighting a topic receiving increasing attention, football-related concussions. As you noted, these may be particularly serious for high-school age brains. But beyond the specific content, your presentation caused us to think about the various societal, peer-group, and family pressures that can enter the exam room along with the patient. Football is a popular, high status sport, and patients (and perhaps families as well) are eager for the physician to greenlight them back on the field. As your attending skillfully recognized, simply "forbidding" play will likely result in the non-return of the patient and noncompliance with this instruction. Rather, as you demonstrated, it's about educating and negotiating within the interaction in a way that of course does not compromise good patient care. Patients and families are resistant to hearing that an activity they love can have severe, lifelong consequences. Helping them really hear this message can only be achieved when you understand how much football means to them. Once patient and family trust that you "get it," they will be more likely to seriously consider what you have to say. It's more complicated than "telling," but it's also more effective. Best, Dr. Shapiro

---

Your essay was well-crafted, cleverly written, and effectively involved your audience in the developing drama of this toddler's hospitalization and course. By its conclusion, everyone was actively guessing the explanation. Was this mother exhibiting Munchausen's-by-proxy, or was she just, as you wondered, a "concerned parent"? Of course, without more information, we couldn't decide, but the discrepancy between the child's multiple symptoms and persistent lack of findings was troubling. Your project did point out how persistent parental concern can trigger a hospitalization and drive a work-up, neither of which may be necessary. It is natural for parents to be vigilant, even a bit obsessive, about their children's health. In this case, however, the worry seems extreme. I would have wanted to discover whether this parental behavior was part of a pattern; whether the child had a history of previous hospitalizations; and what was the assessment of the child's regular pediatrician. The most telling question I thought was that asked by the perspicacious medical student (!). Will the child be safe? In my view, more attention should have been focused in this direction, and less on simply achieving the discharge. Your concerns (perhaps unlike the mother's) were well-placed, and showed a future physician dedicated to the welfare of his little patient. Best, Dr. Shapiro

---

Hi -- and --. You came up with a very cute little poem for your ped reflection project. You did an excellent job of imagining the clinical encounter from the kid's perspective – all the waiting, the seemingly endless questions, the poking and prodding, and the apparently infinite magic of stickers :-). The poem was clever, and also insightful. Thanks for your participation. Dr. Shapiro

---

--, you put together a wonderfully designed educational booklet for kids and parents that covered all the key peds topics – how to deal with injections, how to deal with a kid's fear of going to the doctor, how parents can cope with a crying kid. The illustrations were great. Thanks for this excellent effort. Dr. Shapiro

---

--, you wrote a very touching letter in the voice of an abused 5 month old. It showed how sometimes the hospital and its staff are the only place of refuge, the only caring people that a child encounters. The hospital provides safety and the staff provides love.

The particular story you related was terribly tragic. It is almost unbelievable that a convicted child abuser would have custody of another child. And the violence captured on the video-cam is horrifying. There is simply no way to understand how a human being can behave in this manner toward an innocent child – his own child. Yet child abuse is a reality; and pediatricians and emergency medicine physicians in particular are on the front lines for recognizing and intervening with these kids.

Your poem said it so well – these kids often cannot speak for themselves, and the medical community must function as their protector. These situations are usually very complicated; and the physician can only play a limited role in changing things. But what they can do, they must do. This is not only a legal issue, but a moral one as well. Your poem makes this clear that you were willing to step up to the full extent possible to serve the interests of this child. Thank you for having the courage to tackle this very difficult and painful issue. Best, Dr. Shapiro

---

--, your thoughtful essay captured well the many joys of general pediatrics; as well as how true continuity of care can be beneficial for the patient and satisfying for the practitioner. You also raised excellent questions about quality of life in severely disabled children (the MRCP issue); and whether parents can be truly informed about what life will be like for that child far down the road. I spent 10 years working in an early intervention program with parents of kids with Down syndrome, cp, and a variety of other problems. At that age, all the kids were adorable, as you saw with your patient X, but "down the road" is inevitably filled with larger challenges. Yet the interesting thing is how often the parents, along with the kids, seem to grow into those challenges. As your fellow's anecdote attests, this is not always the case. There is no right answer to the dilemma of how aggressively to treat extremely premature infants. The physician's responsibility is to try to help parents imagine themselves and their child into that future, so they are able to make the best choice possible for who they are (and who they think they – and their child - might become). Thanks for making us all think. Best, Dr. Shapiro