PEDS REFLECTION PROJECTS AUGUST, 2012

Hi --, thanks for tackling that string of haiku (it's harder than it looks to write them!). You captured very well the two voices of reluctant patient and pressured medical student trying to complete an early morning check-up. The patient resents the intrusion, the apparently pointless repetition of a previously performed examination; the student knows this is his job, and worries that if he takes too long, "intern won't be pleased." I liked that you did not easily resolve this tension; but I wonder in an actual clinical encounter what you could do to reconcile patient and student, how you could bring their two worlds closer together? In any case, a really interesting issue to ponder, and one that obviously resonated with your classmates. Everyone's been there ☺ Dr. Shapiro

---

Nice, visually appealing healthy eating "plate." The diverse colors attract attention and the explanations are clear and succinct. An especially clever and creative section is the "Ten Tips" to encourage kids to eat fruits and vegetables. This chart provides an easily accessible and understandable guide to cultivating healthy eating habits.

On another level, I appreciated that you shared your frustration with patients and parents who don't seem to take their health seriously and don't seem engaged in making the effort to improve their eating habits. It was quite interesting when you contrasted these attitudes with prevailing cultural norms in Japan, which seem to stress and reward healthy practices. These feelings of frustration are so understandable, especially when you know that the future health of these young kids is on the line. It's also good to remember that, in this country anyway, food is a complicated entity influenced by family, culture, and socioeconomic status, as well as individual psychology. It is not irrelevant that we are immersed in a world where manufacturers of junk food have many more resources to advertise their products than do producers of fruits and vegetables. As I say, it's a complicated equation. Physicians often stress individual responsibility for their patients, and this of course is an important strand. But interventions that involve families and even whole communities have been shown to be effective and empowering as well.

Thank you for focusing our attention on this important issue; and thank you for being willing to express the aggravation that so many physicians feel. You helped to remind us that these feelings of helplessness and irritation should be a beginning point in patient care, not an ending point. Best, Dr. Shapiro

---

What a wonderful project, --. It was inspired of you to pair Dr. Seuss and the Peds experience, a perfect fit!. Your piece was not only funny, but very well-written. In addition, you offered a terrifically insightful introduction to hospital, doctors, procedures, tests, and the "not-so-good streets" that, if at all possible, should be avoided. What I liked most about the poem was that despite a few warnings about the variable nature of doctors ("red fish and blue fish") and the vulnerability of life ("sadly, bang-ups and hang-ups can happen"), it strikes an encouraging, optimistic note that believes in the resilience of your patient. If you can bring that empathy and that hope to your future patients, you are going to be one fine doctor. Best, Dr. Shapiro

---

Hi --, your project focused on a classic dilemma in medicine – the gap between the doctor/medical student's perspective and that of the patient. I'm so glad you helped us to reflect on this issue. When you encounter a rare or interesting diagnosis, it *is* exciting. If your heart doesn't start to beat faster when you see unusual pathology, you probably shouldn't be a doctor. But importantly, as you pointed out eloquently and sensitively, what is thrilling for you is usually terrifying and bewildering for the patient. I appreciated that you acknowledged that, in your enthusiasm, you momentarily lost sight of this distinction. Fortunately, you had a great attending role model who could "close the gap" and help the patient's mom understand her child's diagnosis. Medicine is a constant juggling of the voice of medicine and the voice of the real world. It is a great tribute to you that at such an early point in your training you realized how easy it is to allow the voice of medicine to predominate to the exclusion of the patient. Simply having this awareness makes it much more likely that you will continue to be enthusiastic about the intriguing twists and turns medicine presents while remaining sensitive to the devastation they can cause on a human level. Best, Dr. Shapiro

---

--, you presented a really interesting and well-researched project. I, and I suspect many of your classmates, learned something about the importance of phrasing sensitive questions in certain ways; and how such phrasing has empirically been shown to influence positive outcomes. As we discussed, and as you recognized, the ultimate success of all screening and all algorithms depends on establishing good rapport. If the teen feels judged or alienated, how you phrase the question won't help. But within a context of respectful, nonjudgmental interest and caring, language matters. HEADS screening can be a frustrating process, and your information provided concrete ways for improving the experience for both patients and doctors. Thank you. Dr. Shapiro

---

Dear --, I was moved by your reflections on life and death triggered by the terminally ill patient you cared for. I'm always surprised that medical training doesn't trigger more "big questions" about the meaning of life and death. One of the great potential gifts of this profession is that it can encourage practitioners to think about how they want to live – and how they want to die. In seeking answers to these questions, patients are our greatest teachers. Being a physician gives you the opportunity to live what the philosopher Robert Novick called "the examined life," i.e., a life that is self-aware and consciously chosen. I'm glad you took the time – not easy to find in third year! – to consider what the unpredictability and proximity of death might mean in your own life – to cherish the moment and temper strivings for the more superficial trappings of success. Thanks for such an eloquent statement from the heart. Dr. Shapiro

---

Dear --, thank you so much for having the courage to share this traumatizing experience. The core of what you shared was the misleading prognosis a neurologist provided to the parent of a severely impaired infant with a rare and terminal disease. Your description of the father's joy when he

mistakenly concluded there was significant reason to hope for a good outcome was truly heartbreaking. The tears you shed in my view were wholly appropriate and the correct professional response to a situation where iatrogenic unnecessary suffering created by the physician compounded already tragic circumstances.

As a third year medical student, you do not have the authority to challenge the specialist's presentation to the family, which puts you in a position of moral distress, classically defined as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action." I admired that you used the anguish you experienced to research best practices in delivering bad news, and in the process educated not only yourself but your classmates. In the process, you discovered the courage that is necessary to be an outstanding physician – to be brave enough to speak hard truths when every fiber of your being – and the patient's and family's – resists what must be spoken. Yet when you have learned this courage (which is infused with compassion), when you can look at suffering and death without turning away in horror, you'll find that this is a great gift you can give your patients. Your courage helps contain their fear; and while you cannot take away their suffering, your attitude of honesty and truth-telling will help them bear it.

I had great respect for your willingness to address this very difficult issue. I thought you did so with integrity, perceptiveness, and authenticity. I have every confidence that, when you find yourself sitting across the table from a father or husband or patient facing a similar devastating diagnosis, you will tell that person what they need to hear, not what they want to hear, and you will find a way to do so that makes them feel supported, cared for, and not abandoned. Best, Dr. Shapiro

---

--, I really liked the form of a dialogue that you used in this project. It made the interaction between you and the patient very immediate; I think we all could easily put ourselves in your shoes, and imagine that we were interviewing a patient who disclosed fear of a possible shooter at her school. You presented a really challenging dilemma – I'd never heard of something exactly like this arising in a medical setting. But I could easily imagine that it *could.* And we discovered that we weren't completely sure how to deal with it. How much better to find this out *prior* to its actual occurrence. As we discussed in class, in a situation of uncertainty, a good option is always to seek direction from CPS. A guiding principle should always be the safety and wellbeing of your patient, and taking proactive steps to ensure these things as much as is possible is part of the therapeutic contract.

Thank you for being sensitive to your patient's plight and for your thoughtfulness about the physician's responsibility in such a problematic situation. Best, Dr. Shapiro

---

--, what a creative idea to use the form of the chart note to celebrate the beauty and "perfection" of a healthy newborn. Before there was such (appropriate) tight security on Newborn Nursery, students from all services would sometimes drop by just to look at and even hold a baby to raise their spirits and remind them of all that is good in life. The listing of the patient's name, date, and time were completely precious. As you move through the vital signs and general appearance, you capture not just the "objective" infant but the struggles ("my untrained ears," "I try to complete my exam," "I don't know how to comfort you") and joy ("never cease to amaze me," "you make me feel special", "blowing by me like a breeze") of being a medical student examining this little being. Your Comments section is a

wonderful encapsulation of all that is miraculous and worthy of celebrating in new life. All in all, the "note" was a beautiful tribute to your patient and demonstrated your ability to connect and be moved by this "clinical encounter." Thank you, I think this project reminded everyone who heard it about the privilege of being in medicine. All best, Dr. Shapiro

---

Hi --, I really liked the way your Peds reflection project included both the voice of the infant and the voice of the medical student. I particularly appreciated how in presenting the perspective of this severely disabled, dying infant, you imagined her as responding to the med student's smiling. In these situations, we can't know what the child is experiencing. In my view, it is both humane and ethical to assume the importance of a human connection.

I thought that this theme of not knowing also reappeared later in the piece when you reflected on the absent mother. This is a phenomenon that does occur on Peds, and leaves staff wondering, "Where is the mom? Where are the parents?" It is natural to make a quick negative judgment. Yet I very much respected that you were willing to complicate your own thinking, to acknowledge how impossible it is to walk in that mother's footsteps, to understand all that informs her choices. I imagine how heartbreaking it would be to sit next to the bedside of that dying baby, and I ask myself if I too would not find reasons to be elsewhere? I hope not, but I can't know for sure. Neither could you, but in seeing both the baby's need for love and companionship (which you attempted to provide in a small way with your smiling eyes) as well as the factors that might have made it difficult for the mom to offer what her child needed, you are grasping the full heartbreaking tragedy. You are seeing clearly, and out of such seeing I believe comes compassion and humility, qualities much needed in clinical medicine.

Thanks for such a moving and thoughtful essay. Best, Dr. Shapiro

---

Very touching and sensitive reflection on what you can and cannot do for your patients. I was so moved by the way you fantasized having Peter Pan carry her home, safe and sound. What a wonderful, magical thought. You can't send her home, you can't take off her cast, but you can give her the bedpan and control her pain. You can hurt a little for her and hold her hand. These are the things you can offer her, and they are the things that distinguish between a merely competent physician and one who is also caring and compassionate.

Also appreciated the way you recognized that patients (i.e., people) can easily be reduced to "buzz words." Very true, and very dehumanizing.

You may not have felt you did "enough," but by "doing the best you could" in circumstances that are always less than idea, in my mind you fulfilled the requirements of a true healer. Best, Dr. Shapiro

---

This was an outstanding project, --. You refused to demonize or sanctify ANY of the players, including the patient, the medical team, or yourself. It was especially wonderful that you didn't elevate your patient to a pedestal of great beauty, extraordinary intelligence, delightful personality – the kinds of qualities that can make us think it is "worth it" to go the extra mile for someone "special", when in fact

we should *always* go the extra mile for every person. She was not a patient you were drawn to emotionally. She wasn't even medically interesting! This makes her like the majority of patients, not the exception, but the rule; and therefore how she is treated, what happens to her, becomes *hugely* important because of her ordinariness.

To me, your essay was a lot about the limitations of medicine. Your patient J had to deal with homelessness and all the attendant psychosocial consequences. In all likelihood, stabilizing her living conditions would probably do more for her health than all the statins and blood pressure medications in the world. Yet this is not something medicine can easily offer, despite the appropriate involvement of a social worker. This inevitably makes you (and likely the team too) helpless and frustrated. The causes of her diseases are more social than medical. What can you do? First, exactly as you did, you can avoid oversimplifying her situation ("If this kid cared about herself, she'd lose some weight"). This honors the enormous obstacles she faces. Secondly, although supportive resources these days are in short supply, you can investigate (with the help of a social worker) whether there are any programs available that might benefit your patient. Third, as we discussed in class, you can consider what steps you could take (no matter how small) to nudge society in a direction of great equity and social justice. Fourth, and in my view most important, you can treat your patient with respect and involve her in problem-solving her own challenging circumstances, finding the balance between avoiding oversimplification and giving into despair ("It's hopeless, she has too much going against her" – maybe so, but not up to you to decide).

--, as you expressed so eloquently, the world is an unfair place to live. But I think it is better to acknowledge that than pretend it isn't so. From that place of clear seeing, you will likely do more good. Thank you for such an insightful and powerful essay. I have deep respect for your willingness to "tell the truth" about this very troubling aspect of our society. Best, Dr. Shapiro

---

--, thank you for sharing such a complicated and troubling incident. I can only share my own perspective, but whether or not this child could cry/experience emotions to me was not the point. Rather, through understanding the moisture that was discharged from her eye (!) as a sign of feeling, you humanized a patient with whom it was otherwise challenging to connect. The residents' response of dismissive laughter was too simplistic. It took a fact-based approach where a heart-based approach was what was needed. Rather than laughter, it would have been a more meaningful teaching opportunity to discuss what the different views of this patient were, and what were "best practices" for ensuring that she was treated not as an object, but as a sentient being.

As we discussed after class, often "broken-heartedness" is frowned on as somehow unprofessional. In my view, it is quite the contrary, in fact broken-heartedness could be regarded as a sine qua non of true professionalism. Of course, if you are paralyzed by your own grief or sadness about a patient, then it has become all about you, and you are not functioning as a good doctor. But if we think of the patient's and family's suffering as 90 on a scale from 1-100, then it is not too much to hope that a doctor might dare to share a tiny bit of that suffering (maybe a 5!). It is a good thing when the doctor is moved by the patient's suffering, and it is also a professional thing. When you have learned to look at suffering clearly and feelingly, but without indulging excessively in your own emotions, you have become a great doctor.

Your humanism and patient-centeredness were very evident in your essay. I appreciated your prioritizing communication and connection with "difficult-to-reach" patients, who may suffer cognitive disabilities or be in PVS. (Less extreme examples might be an older patient who is hard of hearing, or

who “rambles,” or a patient with whom you do not share a common language). The easy route is to direct communication toward those who “communicate like you do.” The ethical choice is to seek connection with all patients, no matter what the challenges.

A wonderful story that provoked rich discussion. Best, Dr. Shapiro