PEDS REFLECTION SESSION 8/10/15

Dear --, thank you for your project on unaccompanied minors. It was moving (and uncomfortable – but in a good way) to be reminded of these desperate children fleeing drug-related gang violence, abuse, and hopelessness. Sometimes the study of medicine can become narrow – all about exams and evaluations – and it can be easy to forget the wider world. You reminded us that in important ways, the lives of doctors will inevitably intersect with the lives of these children as well as adults escaping unbearable circumstances. It is impossible to adequately care for patients unless you know something of their personal history, so that you can place their particular disease within the context of their life. You also challenged us to interrogate our own attitudes to who "deserves" care – because these children are here "illegally," does that ethically absolve us from caring for them? As you rightly pointed out, the answers are complex, and hard to discover. But to turn away from even acknowledging the existence of these kids is a morally bankrupt position. I very much liked your answer when you said that, although you could not solve all the problems or even answer all the questions, it was better to know their stories than not to know. I think this is a brave and admirable stance. I hope your classmates were paying attention. Best, Dr. Shapiro

---

Hi --, nice to run across you again in 3rd year! Thanks for sharing your thoughts about the messy intersection of business and medicine. Your presentation put to shame facile references to patient-centered medicine. I guess this goes with a great qualifier – "*if* it is economically feasible." While you saw clearly that it was "wrong" of the family to lie about their insurance status in order to obtain help for their sick child from UCIMC, at the same time you put the onus of responsibility squarely where, in my view, it belongs, i.e., on healthcare systems that force parents between truthfulness and the wellbeing of their children. I do think there was an "original sin" involved in this turn of events. Clearly, in their interactions with the outside hospital, the parents neither felt satisfied with the care they received, nor able to express this dissatisfaction/concern to the treating physician. If the original doctor had truly been practicing patient-centered medicine, he likely could have detected the parents' worries and explored them compassionately, acknowledging the limits of his knowledge and encouraging follow-up and even a second opinion. Such behavior does not "solve" the problem of treating uninsured or underinsured patients, but it would be a long way of anticipating and defusing such problems before they lead to such distressing consequences. This was an excellent ethical dilemma with no easy answers. Best, Dr. Shapiro

---

Dear --, thank you for your presentation about a case of suspected child abuse with resultant court proceedings and the mom being forbidden unsupervised contact with the infant. I really appreciated your questioning of the way the child protection system works. You showed a lot of concern for the infant, not only for his physical damage, but also for the emotional scars that will likely result from his

being separated from his mother (and even health consequences resulting from his inability to breastfeed). You also showed great empathy for the mom. Whether or not she intentionally, in a moment of extreme frustration, did do something to harm her baby, she is still a human being deserving compassion. You raised many good issues about the whole CPS process to which there are no perfect answers. We have mandated reporting because of how easy it was to overlook of rationalize child abuse in the past. Nevertheless, inevitably the system makes mistakes, and puts some families through needless suffering. Even when it is appropriate for a child to be removed from the home, this act in itself has many negative consequences for the child. In the end, it is weighing what is the lesser of two evils. Mandated reporting is designed to save the life of the child, rather than necessarily ensure the child's optimal psychosocial development. It is a step in the right direction, but we should not be complacent about how it functions, nor cease to seek for better options. Thank you for challenging conventional wisdom and reminding us that the way we do things can often be improved. Best, Dr. Shapiro

----

Hi --, thanks for your presentation about the diligence of the team in probing for a diagnosis to explain this little girl's symptoms. It was a sobering reminder that going with the easiest or most obvious answer is not always the same as finding the best answer. I also really appreciated your sharing that Peds was tough for you initially because you were not used to being around so many sick – sometimes very sick – children. Thank you for acknowledging this – I think this is true for many of your classmates as well. We are used to think of kids for the most part as happy and healthy, and it can be a shock to see them suffering and even facing disability and death.

Your haiku was beautiful. The haiku is a hard form to master, for precisely the reason that so many medical students try their hand at them for these sorts of assignments – they're SHORT! ☺. Your haiku showed real craft – the falling leaves seemed to refer both to the time of year, and to the child falling from health to sickness. The child's smiles were interrupted much as a leaf is unceremoniously severed from the tree. The last line referring to "blasts and shocking news" was a powerful play on words – the abnormal cells providing a "blast" that shocked (family and medical student as well).

Thank you for creating something so poignantly lovely from such a distressing diagnosis. Best, Dr. Shapiro

----

--, you presented a very interesting dilemma, which in my mind boiled down to how to persuade a mom to accept a g-tube that was in the best interests of her multiply disabled child. In my experience, these situations are often very frustrating for physicians because, from their point of view, the way to proceed is clear, and a lot of time seems to be expended (wasted?) in conversations with parents who seem stubborn, resistant, and uncooperative.

As your nuanced presentation brought out, there are a lot of factors to take into consideration. Specifically, if we try to enter the mind of the mom in an act of empathy, we can see she may be

plagued by guilt, shame, the stigma that might attach to the g-tube, her sense she has failed as a mother, and perhaps fear of her spouse's reaction. Under these circumstances, although it seems time-consuming, it is worthwhile to understand the mom's perspective, make sure that she does not feel judged by the medical community, and give her permission to ask for help (she seemed understandably overwhelmed, with 5 other children, a job, and no adult partner in the home).

You raised the possibility of neglect, and provided your classmates with excellent guidelines for determining whether neglect is indeed present (harm, pattern, severity, history of CPS involvement, willingness to accept help etc.). While it is true, as one of your classmates commented, that neglect is neglect as far as the child is concerned, the mother's motivation and intention do matter. If she wants to take good care of her baby, but doesn't know how, education might help. If she is motivated to be a good parent, but "can't do it all," there may be resources that can support her parenting. On the other hand, if she has "checked out," (which happens sometimes with parents of children with disabilities, when they have real difficulty bonding with their children) the prognosis may be less hopeful.

Situations like these arise *all the time* in clinical medicine, both inpatient and outpatient, simply because doctor and patient/parent are not yet on the same page. This should not be a cause for blame or exasperation, but rather understood simply as part of the process of building partnership between physician and family. It requires patience, nonjudgmentalness, and perseverance. In a surprising number of cases, the outcome is a positive one. I hope that will be true for this baby. Thanks for such a thoughtful and thought-provoking presentation. Dr. Shapiro

---

The case you presented was really sad, because as you intimated, it didn't sound as though the child's best interests were being considered either by parent or pediatrician. It certainly makes the pediatrician's task harder when parents are defensive and in denial. On the other hand, this reaction is very understandable and a good pediatrician does not get too rattled by this response and knows how to work with it. It is easy to say even to a resistant parent, "I know we both want what's best for X. It's scary to hear that there might be a problem. Let me give you some information to read and some things you can keep track of in X's behavior in the next couple of weeks. Why don't you come back then and we can talk more?" It sounded like a very uncomfortable situation, but if the doctor can remain calm and nondefensive, there's a greater likelihood that progress can be made.

Thanks for assembling important information about ASD for your classmates and parents. I particularly liked the way your pamphlet emphasized early intervention. A good intervention program when the young child's brain is especially plastic and receptive to repatterning can make a significant differences for these kids particularly with social skill development and communication, as your hand-out pointed out. The list of resources seemed quite comprehensive and useful, especially the way you noted the focus of each organization or agency.

Excellent work on a difficult topic! Dr. Shapiro

Dear --, your pamphlet on what a pneumothorax means and its implications for future lifestyle was fantastic. It is one of the best educational pamphlets created by a student (or a health agency!) I've ever seen. I loved the informal, slightly jocular tone ("how to get your life back," "So you're in a hospital room after the biggest scare of your life"). These and other phrases are designed to get the patient to identify, to say yes, and to want to read more. The way you put "you must be wondering…" on the front cover, with the answers on the inside, will also encourage the patient's curiosity to open the pamphlet. You provide good information illustrating what happens in a pneumothorax, but also keep the mood light with your slightly crude (☺) pencil drawings.

Asking questions that will really matter to a patient ("Will life ever be the same?" "How do I make sure it doesn't happen again?") is also a very clever device to ensure the patient keeps reading. Finally, after the patient has learned something about this condition, and feels more confident that their life isn't ruined, you provide signs indicating an emergency. This section delivers important information in a way that will educate but not terrify the patient.

The quiz at the end is really cute, and will give the patient a sense of competence and accomplishment. In the final section, your decision to personifying health ("my health is my friend") is also creative and makes paying attention to one's health seem like something nice you'd do for a buddy. Even your choice of type and your reliance on few words (but to-the-point) make it likely that a pre-teen or an adolescent would actually read this pamphlet, learn something, and feel reassured that their life isn't over. Extremely well done! You have a true flair for patient education. Dr. Shapiro

----

Dear --, --, --, and --, what an impressive way to start off the reflection session. Both the content and the process of the skit were fantastic. You chose an excellent and very challenging case, and role-played it to perfection. The father's belligerence and efforts to manipulate the encounter were both believable and discomfiting. You also role-modeled skillful responses on the part of the attending, i.e., by trying to engage the father in conversation, by acknowledging the tension and offering to return later, and by noting the common ground that both doctor and father cared about the child and wanted the best for him. The way you engaged your classmates was superb – this is a situation where there are no right answers, and the important thing is to brainstorm different approaches so that, when something similar arises in the future, you have lots of arrows in your quiver to choose from.

I was especially impressed by the important information you conveyed – the various ways of thinking about "difficult" parent behavior; as well as the empathy-based strategies for defusing such conflicts. You all did an excellent job of imagining – and helping your classmates to imagine – the father's perspective, his feelings of fear for his child, his possible guilt as a parent, his bewilderment at the nature of a teaching hospital, and his lack of trust/familiarity with the medical system. Such factors do not justify poor behavior, but they can explain it in part, and enhance our feelings of compassion toward this individual. When we are feeling kindly and compassionately toward another, and curious

to understand them better, there is less likelihood that the situation will escalate in a negative manner.

Your exercise highlighted skills of listening, paraphrasing, understanding another's perspective, and developing partnership with parents. It gave your classmates an opportunity to wrestle with a difficult, but not uncommon, clinical encounter; and showed how it could be handled in a way to diffuse tension and promote dialogue. Outstanding work! Dr. Shapiro