PEDS REFLECTION SESSION DECEMBER 2014

--, thank you for starting us off with a patient situation that had so much to teach us: 1) How to handle situations where patients are waiting a long time 2) How to broach sensitive topics such as proper diet and bottle use 3) How to defuse an angry patient/parent.

First, let me say how impressed I was that you recognized the elephant in the room - your patient's dentition and his consumption of large quantities of soda and sugary drinks through a bottle – and that you didn't ignore it, which would have been the easier and more efficient course. I also respected that you called in first the resident, then the attending, as the father's frustration and impatience increased. Being sensitive to the patient's/parent's concerns and asking for help are two ways to proceed that are always a good idea.

In terms of patient waiting, as we discussed, it is easy to try to "skate over" uncomfortable feelings in others, especially when we feel it's not our fault ("hey, I'm saving lives, take a breath"). But it's better to acknowledge and apologize the wait – not because you've done anything wrong, but so the patient knows you understand their perspective and are sorry for the inconvenience to them. The idea that emerged from the discussion your project generated of the physician personally popping her head in the door to say, "I haven't forgotten you," is an especially good one.

As we also discussed, helping parents to see there is a better way to feed their kid is a delicate art. No parent wants to be told they are not doing a good job of caring for their kid. The ideas from the group discussion were both sensitive and creative: find common ground, reinforce whatever the parent is doing right, empathize with how tough it is to raise a child. Another good idea was to invite the parents to share what they know about sodas, bottles etc. This is a great way to assess parents' knowledge base, as well as where the problem lies (is it lack of education? Is it convenience or pacifying a cranky kid?) A nice thing to do is to ask permission, even though of course parents are there to get your advice ("Would it be okay if we talk a little about what to give baby to drink?"). The overall idea is to make the parents feel safe and show that you respect them and are not judging them as parents (although you obviously are discriminating between healthy and unhealthy forms of nutrition for their child).

Finally, how do you respond to an angry patient or parent? First, of course, is to make sure you and others are safe. If you feel the chance of physical harm to yourself or others is very low, then you can proceed. It is not acceptable to have patients cursing at doctors or medical students or (as happens more often) staff, but setting this boundary is not always the best place to start. Instead, think about acknowledging the patient's anger (this is not the same as saying they *deserve* or are right to be angry). You can employ de-escalating strategies, such as asking the parent to sit down (if they've stood up), and sit down yourself while asking them to tell you more about why they're so mad. Surprisingly, after a minute or two, many people will start to "wind down." Without anything to "push against," their anger starts to dissipate. Tell them you understand their perspective; that is very important to most people, i.e., to be understood. Remember, you have a lot of power and they have

very little (which is why people often yell and threaten, because they feel so helpless). When you are willing to listen, it restores some of the power balance. You can always escalate if the patient/parent does not calm down (leave the room, call security etc.). You can always terminate from the practice a patient who is intractably belligerent or aggressive or a danger to staff. But these outcomes rarely are necessary if the situation is handled carefully.

I was also so pleased to hear that your resident took the time to review what had happened with you, and recognized the many pressures and stresses that can make people behave in ways that are not their "best selves." Understanding bad behavior does not excuse it, and in your situation, after everyone had hopefully calmed down and worked out the problems, it would have been possible to let the dad know that it is not okay to shout or use profanity with medical students or staff – or doctors. Ideally, at that point, he might even have agreed with you ☺

Thank you for contributing such a thoughtful reflection to our session. Best, Dr. Shapiro

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Dear --, you handled yourself SO well in an overwhelming and unexpected situation. Sixteen year old with abdominal pain – throw in a quick HEADSS exam, and what could be simpler? As you discovered, clinical medicine is full of unexpected twists and turns. I was very impressed at how much sensitive information you learned from your patient – you must have developed very good rapport very quickly for her to trust you with so much of her story. You did an amazing job of being nonjudgmental in tough circumstances. I know that you struggled with not being able to spend all the time that you would have liked in counseling her more thoroughly. But you did so much right in the time you had – recognizing the severity of her cutting behavior, evaluating her emotional state/depression, assessing her resources and support system, reaching out to her grandmother, and providing her with support services she could access by phone. In working with teens, there are 3 (maybe 4) sources of potential support and guidance: 1) family 2) school 3) doctor/medical system and (up to a point) 4) friends/peers, and it's important to assess each. Bullying, isolation, depression are things no kid should have to face alone.

I so respect that as a third year student, you gave this patient so much, and brought into play your previous suicide hotline training. I am sure that this young woman benefitted from your attention, your concern, and your caring. Ultimately, what I think you conveyed to her is that she mattered; and this may have been an extremely important message for her to hear. Did you do everything possible? No, but often that is simply not possible (otherwise, you would only have a handful of patients to care for!). With a little luck, what you did was enough. Best, Dr. Shapiro

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-- and --, your adorable gingerbread house was a great metaphor for both of your experiences (plus of course seasonally appropriate!). --, I know how embarrassing it can be when we tear up in a "professional" setting. I wish this were not the case. Tears are often the most appropriate and compassionate response to much of what we see in medicine. They are not a sign of weakness or lack

of control, but compassion for the suffering in the world that cannot always be fixed. Thank you for expressing what all of us, listening to the story you told, were undoubtedly feeling.

In terms of the issue itself that you raised – the incommensurability that exists sometimes between the devastating nature of disease and what we can offer as help – brain cancer vs. gingerbread house – I commend you for your insight and nuance. Sometimes modern medicine is a miracle. Sometimes the gap between what we want to do and what we can do is large. Still, I believe that doing what we can makes all the difference, not only from an abstract ethical perspective, but to patients and families (and ourselves). Sometimes all you can do is give a hug or throw a party, and these things can seem very small in the face of devastating illness. They are – but they are not nothing, and they can make a surprising difference to the way patients and families experience their disease, because they feel that they are not alone, that others care. In this way, what are small things become big things.

Ashton, I loved the genuineness with which you expressed your capacity for liking "every single Peds patient" (under 10 ☺). As Dr. X intimated, not everyone finds every kid likeable – so in fact there is something within you that allows you not to be exasperated, annoyed, or frustrated by kids whether nasty or nice. This nonjudgmental accepting quality is a wonderful gift to give any patient, big or small. You are also right that kids are always innocent, so you don't have to get involved in thinking whether someone's suffering is "deserved" (because brought on themselves) or not. It makes taking care of kids, as you expressed it, so "straightforward." Here's a radical thought – maybe we would save ourselves a lot of time and stress by just setting aside that question for *all* our patients. The more we delve into people's lives, the harder it seems to me to untangle all the threads that have led them to where they are. That is not to say that patients bear no responsibility for their own choices, but just that all the factors that influence our choices are complex.

Thank you for sharing your thoughts, both through your project and throughout the discussion. You contributed many very perceptive and thoughtful ideas. Best, Dr. Shapiro

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First, thank you so much for staying to present your project. I would have completely understood if you had elected to leave immediately. My thoughts and prayers are with your fiancé, and hopefully he is already on his way to a quick and complete recovery.

Your project was wonderful. Focusing on "Cheeto fingers" (how soon before it becomes a diagnostic code? ☺) allowed you to raise important issues about diet, culture, and parenting. You also provided a good education to your classmates about how these spicy junk foods can contribute to all sorts of gastric and intestinal symptoms. As we discussed with --'s patient, understandably parents can be very touchy when doctors start intervening with advice about their kids' diets. As we discussed, it is important with any "counseling," that the physician makes the parents feel safe and respected, and elicits their thoughts and concerns before giving advice.

You added an essential cultural element by reminding us that eating habits are strongly influenced by cultural background and customs. I thought you made a great distinction between "healthy" spices

that might be part of a traditional Mexican diet and the spicy taste of "hot" Cheetos, so that parents would not conclude the doctor was telling them their child couldn't partake of culturally important foods. As I mentioned in class, when talking about food, it is important not only to think about culture but also about class, and how larger socioeconomic forces are brought to bear on working class people that encourage consumption of cheap, nutritionally empty foods.

Another especially insightful point was the comparison to addiction, and the information that chemicals added to these foods act in similar ways on the brain to other addictive drugs. That could make a powerful metaphor in explaining to parents why it is so hard to "wean" a kid from these foods. Finally, the quotes you brought in from actual kids trying to "kick" the Cheeto habit were so powerful. Sharing these with parents might help them understand just how problematic these seemingly harmless snacks can be.

Again, hope all goes very well with your fiance's recovery. Best, Dr. Shapiro

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Hi --, thank you for focusing our attention on the growing problem of parents who refuse childhood vaccinations. Your poster was eye-catching and readable. It showed happy healthy kids and associated them with vaccination. The approach you used was to both educate and point out the negative consequences of NOT vaccinating. Fear, in moderation, can be a good motivator; and I suspect that the content of your poster would certainly catch parents' attention. As we discussed in class, sometimes education can shift a parent in the direction of immunization if their belief system is not too rigid. With some parents, as came up in class, it is possible to negotiate a "stretched out" immunization schedule. Still other parents are "true believers" and for them very regrettably evidence, research, and expert opinion is not persuasive. Nevertheless, even with these parents it is important to remain in dialogue. While some pediatricians will "fire" families who do not vaccinate, this simply forces them to seek out alternative practitioners. In my view, it is better to keep lines of communication open so that it is possible to periodically revisit the issue. As Dr. X pointed out, sadly sometimes it takes a disease outbreak to attract these parents' attention and get them to rethink their position. Thanks again for bringing this important topic into our discussion. Best, Dr. Shapiro

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--, thank you for sharing what had to be the most unusual chief complaint I've heard in 10 years of these session (dog bite on penis). Aside from the novelty, your presentation raised many issues worth contemplating: 1) the importance of privacy for patients, especially teens, in discussing sensitive issues 2) the value of being able, in your excellent formulation, "to think on your feet," to move in a completely unexpected direction when new information emerges 3) the difficulty of directly addressing potentially embarrassing subjects (for both patient and doctor!) with both directness and nonjudgmentalness. In all these areas, I thought you acquitted yourself excellently. You protected your patient's confidentiality (after an appropriate consultation with your resident). Despite feeling you are not much of an improviser, you managed a very successful pivot that addressed several aspects of this unexpected problem. Finally, you managed to establish good rapport with an

adolescent male (is there anything harder?!) so that he was able to share sensitive medical information; and you succeeded in avoiding conveying shock either verbally or nonverbally. Clinical medicine is full of surprises, some hilarious, some tragic, and everything in between. The ability to respond to all of them with respect, kindness, and careful investigation, as you did, is what makes an outstanding doctor. Best, Dr. Shapiro

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Thanks so much both for your project on circumcision and for your classroom comments, which were strikingly sophisticated and well-formulated. Your analysis of how to approach parents about modifying their child's diet was extremely insightful and compassionate, and demonstrated your deep understanding of the interpersonal dynamics necessary to avoid creating defensiveness and anger.

The information you presented on circumcision perspectives around the world was notable for its comprehensiveness and the way in which you framed an apparently simple decision – to circumcise or not to circumcise – in such a way that brought its various familial, cultural, religious, and national dimensions to the fore. In the face of varying – although often, as you highlighted so well, strongly held – opinions, it is important not to let the physician's personal biases drive parental choices. I thought your concluding point that medicine tends toward conservatism in its practice is well worth recognizing. It seems to me caution is likely justified to some degree prior to introducing change; yet, as you emphasized, what makes physicians scientists rather than "true believers" is their willingness to shift their views when confronted by evidence. Much food for thought in this presentation. Thank you for both educating and implicitly challenging us all. Best, Dr. Shapiro

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Hi --, first kudos to your boyfriend and his admirable adeptness with the Rubik's cube. A flower, really?! Your sketch of the young patient with absence seizures was really poignant. You captured so well that unfocused gaze off into the distance. Looking at your drawing, it made me wonder in a very existential, non-neurological way, where *is* she? You went on to make excellent points about how Peds provides a unique opportunity to integrate cute little things, like flower Rubik's cubes, animal badges, and stickers as ways of reducing the anxiety and fear of an encounter with a physician. I also completely agreed that even very sick kids can exhibit an awe-inspiring joy and resilience. It is a privilege to be part of that, and it certainly helps us put our own problems in perspective. Finally, you commented on how wonderful to see parents who literally lived in the hospital while their daughter was being evaluated. As I know you know, often this is impossible for parents, for financial, other childcare, or sometimes even emotional reasons. But in the face of serious illness, we all want to be part of a "team," and ideally that team should include the parents. I'm glad you experienced an example of this! Best, Dr. Shapiro

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Hi --, how nice to see you and to see how far you've come since our litmed days! I don't know if what you wrote was a poem or an essay, but it was very beautifully written, very poetic. I appreciated your

courage in addressing the issue of child abuse, it is the "dark side" of Peds, the realization that adult human beings can inflict terrible harm on innocents. I loved – and respected – that you acknowledged how hard it was to allow yourself to connect with this little one, and how you wouldn't have wanted it any other way. I also appreciated your honesty in expressing your wish that everything would go well for him, even when you knew it might not. Would he be placed in the "perfect" foster home? Would he be reunited with abusive parents? It was extremely insightful of you to recognize that medicine is a profession where (I think in part because of how much suffering you witness) you want certainty and guarantees of positive outcomes. How wonderful this would be! (not only in medicine but in life!). You are actually raising a profound philosophical issue – how do we go forward when we recognize that sometimes (often) there is a gap between what we can do and what we would want to do? My personal answer is that doing what we can matters, not only to us, but to patients and families. It may not be what they want (which is always restitution to "how things were") but the caring and witnessing that is always within the power of healthcare professionals means a great deal to them. As for the rest, as you so beautifully wrote, we must trust "the magic of the universe." Thank you for your eloquence, sensitivity, and insights. We all benefitted from them. Dr. Shapiro

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Dear --, it was really lovely to see you in full 3rd year mode. A long way from litmed, right? ☺

Thank you for your project on breaking bad news. You are so right that it is very challenging to do this well, even when culture and language differences are not in play, as they were in the case you described. We all know that there are certain practices that can ease the experience for patients and families (having a support person present, doing more listening than telling, allowing time for patient to assimilate tough information, acknowledging the emotional blow, showing a way forward etc.) but we also know these things don't always happen. Working through an interpreter is less than ideal because it introduces a stranger to an already difficult encounter. Yet sometimes it is necessary, and then patient/family have to be reassured that you are committed to staying the course until their questions have been answered and their concerns have been addressed.

You mentioned that the resident was "harsh," and that so often happens. As we discussed, physicians can make two types of errors – being so soft and sweet that, at the end of the conversation, it's easy for the patient and family to deny (or truly not understand) the bad news; and being so honest and delivering "just the facts" that the patient/family feels there is no caring. In both cases, the problem is often that the physician herself is acutely uncomfortable with telling the patient they cannot "fix things." Thus they excessively protect the patient (type 1) or themselves (type 2). It is only by learning how to be present with the suffering of another with compassion but without personal dissolution that the physician can "contain" the anguish that the bad news will bring.

Thanks so much for bringing this issue to our awareness. Over the course of your career, unfortunately all of you will have to deliver bad news more often than you'd like. It is important to

begin finding your way to doing this hardest of medical tasks in a way that is honest and also supports the patient. It is possible! Best, Dr. Shapiro

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--, you showed great courage in sharing this devastating story. Most of us don't like to admit that babies can just die and all the miracles of modern medicine sometimes can't save them. When it does happen, we definitely shy away from talking about it. But whether or not we talk about it, it's still there. I think one of the great things the healthcare system as a whole can do is to be able to support families in these most tragic moments.

I was impressed by so many aspects of your story – how the team worked so hard to save this kid; how the attending "kneeled down" beside the parents when he had to tell them their precious baby was gone; how members of the team came up to hug the parents; and how a resident took a few minutes to talk about the event with you. You mentioned that this was the first patient death you had experienced – what a tremendously hard way to start.

I once heard a physician colleague share this story about what happened when she lost her first patient: Like you, she was a third year medical student. She had gotten to know and like the patient, so when she passed away, the student was completely overcome. But she thought it was unprofessional to say anything or show her emotions, so she simply tried to carry on. But she couldn't. Her attending saw her as she came out of a utility closest, red-eyed and sniffling from sadness and confusion and loss. When he asked he what was wrong, she broke down completely, expecting to be chastised for being a wuss. Instead the attending put an arm around her shoulder and said, "Thank you for sharing. Losing a patient is always hard. But remember, you don't have to carry their coffin alone."

Thank you for allowing us to carry that little coffin with you. Dr. Shapiro