PEDS REFLECTION SESSION MAY 2014

Dear --, --, and --, thanks for a really artistic project on immunizations and kids' fear. I was really intrigued by the approach you took – rather than attempt to minimize the scariness, you enlarged it, and represented it through disturbing and truly frightening distortions of archetypal figures, whether friendly animals (hippos, bees, and peacocks), comicbook villains (rotating virus man, the Wicked Witch, the Mummy) and classic heroes (policemen, the Tin Man, the Ninja). The result not routine. Kids seeing these illustrations might be scared out of their skin! But on the other hand, the narrative and pictures are almost like a fairy tale (which can be pretty scary if you think about it), which function to adapt children to scary things in real life precisely because they read about children like themselves triumphing over more horrible, evil things. The little pink money is anxious, afraid, wants to run away, has nightmares (like many fairy tale protagonists), but in the end – guess what?! – he survives. So I commend your creativity (really great drawing, btw), and am intrigued to think that it might actually have the paradoxical effect of actually *reassuring* kids. Regardless, tremendous inventive and engaging.

Also, as you suggested, even if this approach did not help reduce kids' injection phobia, it will certainly help you remember the different ages and names of the smorgasbord of immunizations offered. You are absolutely correct that embedding facts in narrative and images improves retention, sometimes dramatically. You likely improved everyone's SHELF performance through this project ☺ Best, Dr. Shapiro

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--, thanks for your succinct, to-the-point, and clever parent education hand-out "Stop, drop, and roll." It took a nonjudgmental, slightly humorous approach to a common phenomenon which definitely puts babies at risk for mild to serious injury. As your classmates remarked, it is easy to read (simple, but evocative language), contains engaging visuals (adorable rolling baby; a kid "dropping" out of bed – less scary than a baby) , and effectively communicates the message of keeping an eye on them once they have learned to roll. It's like the best educational tools – simple, straightforward, and draws the reader in rather than pushes them away. Thoughtful and creative. Thank you, Dr. Shapiro

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Hi --, thanks for this project. The picture and caption "Pitfalls of the Pediatric Physical Exam," shows in a humorous way that the pitfalls are many and omnipresent! You also made a great point that many students feel about the difficulty of communicating with kids – and of course infants and toddlers are worse! Peds patients often (but of course not always) can be the epitome of "poor historians." But for that very reason they also present intriguing opportunities for thinking outside the box. You did a great job of sharing some creative ways that more experienced attending handled this challenge. As you summed it up so well, it is all about "learning how to ask." You also reminded us that when the verbal is an unreliable source of information, the nonverbal is doubly important, and that with kids this source of information can be especially valuable. As I mentioned, it would be lovely if even a portion of the patience, creativity, and kindness that are seen in the care of pediatric patients could be extended to adult medicine as well! Thank you for this excellent examination of one of the most confusing aspects of assessing and evaluating peds patients. Dr. Shapiro

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Hi --, as I shared in class, I was very sorry to hear of your mom's passing. You obviously loved her very much and, while I'm sure you are glad to have had her as long as you did, it was not nearly long enough. I think it was also very helpful to your classmates to see how you had channeled some of your grief into action that could benefit other children and young adults who similarly faced the devastating loss of a parent or sibling to cancer. I regretted that we did not have more time to view your slides, as they were very informative. The point made about how many of these children suffer PTSD as a result of these experiences was really eye-opening (although very understandable). The mentoring video was very moving and also hopeful in that it showed that a helping hand extended at the right moment can make a meaningful difference for kids facing this heartbreaking experience. --, I commend you for having the courage to share with us on a personal level. It helped us all move a little closer to something many of us would prefer to avoid – the untimely death of a parent. But your project was filled with the surest antidote to our helplessness in the face of death - the wise insight that we best heal ourselves by helping others. Thank you so much, Dr. Shapiro

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-- and --, great and (sadly) timely topic – childhood obesity; and great roleplay of a patient encounter. The skit itself modeled important motivational interviewing skills – getting the patient to identify his own intervention through open-ended questioning; reinforcing patient ideas; encouraging patient awareness of his weight issue. It was also an excellent approach to make weight reduction a family affair; and to be sensitive and respectful of the way cultural/familial issues (such as the types of food consumed) intersected with the goal of weight loss. The entire interview was respectful, supportive, and patient-centered. --, you also helped us see how careful disclosure of personal issues can result in increased patient trust. When the patient can no longer avoid intervention by claiming "You just don't understand me," you can move on to the next step of taking the next step. --, you similarly disclosed that you understood the patient because you'd faced similar issues of being "overfed" in your own family. As we discussed in class, physician disclosure always has to be done wisely for the best interests of the patient, but it can help level the power differential between doctor and patient and reassure the patient that you don't inhabit entirely different worlds. Finally, I really appreciated your recognition that obesity is a complex, multifactorial problem that has deep roots in social and economic factors, and cannot easily be solved merely between one doctor and one patient. Excellent work all around. Best, Dr. Shapiro

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--, I absolutely LOVED your reflection project. It was simple, yet elegant – monitor the emotions of patients and parents for a couple of weeks. You came up with a carefully calibrated list – worry, relief, joy, tears, sadness, frustration, rejoicing – and your classmates added others – happiness, fear, anger, impatience. This was an important project because Peds can be a swirling cauldron of emotion, but too often these are overlooked in the interests of focusing on the medical issues of the patients. Yet emotions ignored can become emotions on the loose, and we've all seen what can happen when angry, frightened parents are unattended to. The more we pay attention to and learn from parents' and kids' emotions (as well as our own emotions!), the more familiar and comfortable we become with the "emotional landscape" and can effectively calibrate our own responses to defuse the situation, support the parents, join the celebration etc. This awareness guarantees that patients will

be taken care of on all levels – physical, emotional, spiritual. You got it exactly right at the end of your essay when you wrote that "often we do not have answers to the questions they ask," but we can always listen and demonstrate caring. In fact, this sort of presence can exert a therapeutic influence, on the emotions and spirit, and even occasionally on the physical body. In any case, being able to work with patients' and parents' emotions will make overall management easier and infinitely more rewarding. This was a really innovative and worthwhile project, thank you! Dr. Shapiro

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Dear --, thanks so much for your project highlighting the plight of parents who have suffered a miscarriage or had a fetal demise due to extreme prematurity. Despite changes in the attitudes of health care professionals in the direction of more understanding and support, these parents can often still very much alone and isolated. In such instances, there is plenty of helplessness to go around and people in the health care professions in particular tend to avoid situations that provoke these feelings. You showed your classmates that helplessness and sorrow can partially be sublimated through action directed toward comforting and supporting others. The image of these little bodies being laid to rest with their little knitted caps was extremely touching. This gesture also suggested how a concrete action such as the caps can help restore humanity to little beings sometimes perceived as less than human. This was a thought-provoking and moving project. Thank you, Dr. Shapiro

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Hi --, you developed a very compelling visual project. The fact that the patient was reduced to a silhouette of organs and medical record number was an effective way of suggesting how easily patients are reduced to their EMR. The juxtaposition and relative sizes of the ear and the stethoscope suggested the relative importance of active listening vs. all the technical tools at the physician's disposal. The fact that you burned away (rather than simply cut) the confidential speech bubble of the patient for me underlined the sacrosanct nature of such communications.

The story you shared about your 16 yo who admitted to suicidal ideation during her HEADSS exam was a wonderful example of the importance of not treating this exam in a formulaic, checklist way, but really listening and probing beneath the surface. I thought you did an excellent job with this patient, especially the practical step of providing a suicide hotline since the patient seemed so isolated and mistrustful both of her own family members and school personnel. You seemed to use the perfect blend of bonding (just "two girls" chatting) and non-threatening investigation of the potentially life-threatening issue that emerged. The encounter was an important illustration that no technology can take the place of a sincere and respectful concern for the patient. Thank you for helping us all see this so clearly. Best, Dr. Shapiro

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Dear --, sorry you could not join us today, but thank you for sharing your clever stick-figure comic strip. You portrayed with the right amount of humor and empathy how medical personnel - including yourself and myself! - can be quick to judge a parent's behavior and to label that parent as "crazy" (or "difficult" or "demanding") because we don't know the rest of the story. What you did so well was to fill in the missing pieces by – gasp! – actually talking to the mom. You showed how an apparently "crazy" mom was simply at the end of her rope, juggling a sick baby and kids, sick herself, without transportation to the hospital, fearful that her baby is not being adequately treated. Importantly,

understanding some of the factors that contribute to someone else's behavior does not necessarily mean we have to agree with that behavior (and in this case you still do not), but having this additional knowledge will help us to be less reflexively judgmental. Holding judgment in abeyance in turn will make it possible to develop a positive relationship with mom (as you obviously did), which in its own right will be essential to ensuring the best possible care of the patient. Very thoughtful and insightful work, --. Dr. Shapiro

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Dear --, I commend you for such an honest and uncompromising essay about "losing empathy." This is a complex but crucial topic, and in my view it receives insufficient attention in medical education. For this reason, I was particularly glad that you helped us to focus on it during the Peds reflection session.

Please understand that below I am simply sharing my thoughts and observations with you. As we discussed in class, there are really no right or wrong answers to the questions you're asking, but it is important to ask the questions because you will have to answer them for yourself.

First, you had every right to be proud of the way you obtained a good history, performed a thorough physical exam, and identified the correct diagnosis and appropriate treatment. These are all significant accomplishments, as you and your resident both recognized.

What worried you was when you saw the parents' panic at the possibility of cardiac involvement. You judge yourself harshly because you realized you seemed to be emotionally "cold, heartless perhaps." You say that you "did not feel anything" when you contemplated the implications for your adorable little patient; or when you saw the parents' anxiety and fear. This is followed by a lot of "shoulds" about what you expected yourself to feel – "worry, pain, sadness, empathy."

-- offer an alternative interpretation. In fact, you were able to see that the parents were visibly shaken when they learned about the cardiac work-up. You wouldn't have noticed this if you were not sensitive to their emotional reaction. You were also able to see that your resident was "beautifully consoling" and supportive of the parents. Again, you wouldn't have noticed the resident's emotional skill if you did not have your own emotional intelligence. Finally, you admit that you "cared" about your patient.

Given all these data, I wonder if you wouldn't have done a similarly excellent job if you'd been standing in the resident's shoes. What might you have drawn on to be, in your own way, "beautifully consoling"? Maybe you would use your imaginative capacity to understand the parents' reaction and to recognize that they needed comforting. Maybe you would translate your "caring" for the patient to reassure her parents that you intended to take the best possible care of her and do everything in your power to advance her recovery. Maybe you would have contemplated your own personal history that apparently has involved being around a fair amount of illness and suffering to help guide you how to respond to the parents. Perhaps you would just have listened to them carefully looking for clues as to how, as their child's doctor, you could best help them. But I'm pretty confident you would have found a way to give them what they needed from you at that moment.

Another point is that we can't force ourselves to feel one way or another. There are no "shoulds" about feeling. But awareness of feeling – or the absence of feeling – is important. If, for example, you are feeling emotionally devastated by the serious diagnosis of a favorite patient, this may be an

indication that you need to rein in your own fear and despair when talking to the parents. If you "feel nothing" then you may want to make an extra effort, not to "fake" warmth, but to show your sincere "caring" in ways that reassure parents you are committed to their kid. You don't have to be a warm-fuzzy type to be a good, respectful, and caring doctor. You don't have to wear your heart on your sleeve. This does not mean you are heartless, but only that you need to learn not to be afraid to demonstrate your caring in ways congruent both with your personality and the needs of your patient.

Finally, not only the nature but the timing of feelings is beyond our control. It appeared to you that you "felt nothing" when you watched the interaction between resident and parents. This may be because, as -- suggested, you didn't have an active role in that situation. It may also be that you weren't too worried about the patient and had trouble imagining why the parents were so upset. However, it may also be that you disconnected (temporarily) from your feelings because you were afraid of feeling too much. You mentioned in class that you've had a lot of personal experience with family members' illnesses. When this happens to us relatively young in life, we don't always know exactly how to process so much intense and frightening emotion. It's easier to shut them down; and to continue to shut them down in situations where we fear they may get out of control. Yet sometime later we might be watching a movie, and we will start thinking about that kid and her frightened, helpless parents, and suddenly we will start feeling sad ourselves. What's important is to be able to become familiar and comfortable with our own and patient and family's emotions, so we can learn to enlist them in the service of patients' wellbeing.

--, the above is just food for thought. You may disagree entirely and you may well be right. This topic interests me greatly, and I'd be happy to discuss it with you further at any point if you'd like. All best, Dr. Shapiro

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--, thank you for contributing these two poems for your Peds reflection project. They are both lovely, although very different. I particularly liked "Endless Possibilities," which ironically is a poem about loss (although not only about loss). The child patient loses his ability to walk, although not his ability to live in the present and every day awake to hope. The medical student narrator has acquired great knowledge but in exchange has sacrificed her belief in "endless possibilities." As we know, coping is more often a process than an event. With so much uncertainty, it makes sense that the patient and even his mom would still hope. It may even been unclear from a medical perspective the extent to which he can recover some function. In these circumstances, a certain amount of hope is not misplaced. Even if tragically the kid who "loves to run" ends up a paraplegic, it will take some time for him to accept that he will not walk again. The doctors may accept it more quickly in part because, in addition to the science, they have less skin in the game. The main point to remember is that when such discrepancies exist, it is important not to make patient and family wrong for being on a different time schedule, while at the same time telling them the truth honestly as you see it. This way both doctor and patient can learn to coexist.

In the second poem, I loved the line when looking at babies, "their being is a mystery." Indeed, they are "endless possibilities," to borrow a phrase from an excellent poem I read somewhere ☺. The poem then moves in a beautifully philosophical direction, asserting that our differences are small, our commonalities large, and that indeed it is through the uniformity of baby faces that we are reminded of the "collectiveness of being" that unites all of us discrete, formed, apparently separate adults.