

**PEDS REFLECTIVE SESSION MAY 18 2015**

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Hi -- (I apologize for the name mix-up at the reflection session). Your "succulent garden" project was very creative and well-conceptualized. It provided a great illustration of how a good metaphor engages interest and opens up new possibilities. The discussion your project generated showed how eagerly your classmates began to work within the metaphor, identifying the soft "fuzzies" of infants, the flowering "bloom" of puberty, and the "prickles" of the adolescent. The way you "decorated" your succulents with string to indicate the "ties that bind" between parents and kids and added the tell-tale body piercing of the "crazy, scary" teens you saw on Psych enhanced the points you were making, and helped the succulents "come alive" for us (I doubt we'll ever be able to look at a cactus garden in quite the same way again!). I also liked the way you emphasized the importance of prioritizing mental health issues in Pediatrics. As you pointed out, mind and body are inextricably intertwined, and sensitivity to the emotional dimension of health is so essential in kids and teens to their overall healing. Finally, I really appreciated that, although you are going into Ob-Gyn, you were open to your Peds experience and recognized how much it could teach you about families that you could apply in your chosen specialty. Thanks for a very cool and thought-provoking project. Best, Dr. Shapiro

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Dear -- (sorry for the name mix-up at the reflection session!), you told a sad story of how easy it is for parents and medical team to end up on opposite sides of an issue. Your main point, I believe, was that children of a certain age who have not yet reached legal majority should have the right to have input in decisions regarding their own healthcare – and this is a very important observation. Pediatric oncologists in particular have reflected on the ethics of this question, particularly in terms of chemo trials and end of life choices. I believe that the trend is to involve older children who have capacity in decisions that affect their very lives. Often, parents actually welcome their child's participation in these very tough choices.

When doctors and parents disagree, sometimes legal recourse is the only solution, but it should rarely be the first option. Ideally, you want frank discussion among child, parents, and doctors to determine the best course of action. In this case, as you imagined, the parents were likely suspicious of doctors who had "missed" the original appendicitis and thus especially fearful that their son could be medicated inappropriately and become addicted (an especially prevalent parental fear during the teen years). It is always so much easier to anticipate difficulty and attempt to head it off than to correct it when things have already started to unravel. Of course, you and the team did not want your patient to suffer with the NG tube a moment longer than necessary. But a quick phone call to the parents to discuss the plan and allay their fears might have avoided a lot of misery down the road for all concerned.

I felt your narrative showed great compassion and empathy for your patient, and concern to respect his autonomy. This of course is always your first priority. Often it can be achieved by taking the time to bring everyone on board. Best, Dr. Shapiro

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Dear -- and --, great role-play! --, you made a very convincing recalcitrant teen, and -- you were an admirably persistent and caring medical student (I'm sure recapitulating your actual self 😊). The response of your classmates confirmed that you chose a topic – the HEADSS exam – that really resonated. Everyone struggles with the awkwardness of some of these questions. You both made the excellent point that, difficult as the HEADSS exam can be, it is also be an opportunity to provide both education and a sympathetic, listening ear about sensitive topics for which the teen may have no other outlet.

One of the best things you did as “medical student,” --, was simply hang in. No matter how uncommunicative and withholding your patient was, you acted “as if” she were a lovely conversationalist; and as a result, you managed to learn a surprising amount of information.

In observing many HEADSS interviews, I've learned that the more it can be a “conversation” rather than an “interrogation” the more easily it flows. Making a few personal disclosures (“I like math too”) and asking non-HEADSS question to show genuine interest (“What position do you play in soccer?”) can help make the interaction less artificial. Sometimes acknowledging the “process” can help as well: “I'm going to be asking a bunch of questions, it can feel a bit uncomfortable, but they'll help me to get to know you a bit better so I can take the best possible care of you.” As other students noted, emphasizing confidentiality (within appropriate limits) and normalizing the awkwardness can go a long way toward a successful – although never completely simple! – interaction.

Thanks for helping us all think about how best to ask questions that make not only the patient, but also the medical student, uncomfortable. As we discussed, by confronting your own discomfort, as you did so well, you gradually increase your skills and your comfort level. I appreciate your being willing to demonstrate the process. Best, Dr. Shapiro

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Dear --, thank you for drawing our attention to one of the most difficult aspects of Peds – the suffering of innocent children. As you point out, we tend to think of a child's birth as a joyous thing. But when an infant is burdened with congenital disabilities, as you rightly observed, it represents a different experience for patients. To be sure, it is not an experience without joy or reward, but it does involve working through grief and loss as well. Your awareness that some kids are not dealt a fair hand is hard for all of us to face – and yet they and their parents have to live with that unfairness every day. The task of health professionals is not to pity these kids and families nor to transform them into “super-heroes,” but simply to recognize and respect their human struggles and resilience. I really appreciate the empathy you showed for this kid and mom. Best, Dr. Shapiro

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What a creative and thoughtful project, -- and --. A collage of a child's picture, combining fantasy, imagination, and possibility, constructed from a myriad of images of various kids with various medical conditions was inspiring and provocative. It sent a beautiful message that kids are more than their diagnoses, and that doctors, while utilizing the knowledge they have available, should always leave room for possibility and hope.

--, I admired your openness that you were not looking forward to your Peds rotation; yet how receptive you remained to the experience and how much you got out of it. It was obvious that you

actively sought out learning opportunities and became absorbed in discovering as much as possible from each patient encounter. This is the sign of a committed lifelong learner as well as someone who is not too quick to judge what is and what is not going to be valuable to them.

--, you were eloquent about admiring the often almost unfathomable devotion and self-sacrifice of many parents of kids with disabilities. You were equally eloquent about not judging other parents' limitations and struggles in the face of kids with challenging medical issues. I agree that often kids with severe challenges surprise their doctors – and this should be cause for both humility and rejoicing. It is also true, as we discussed, that the parents' perspective is often different from that of their doctors. Ideally, this can be seen as a good thing for both parties, so long as the parents' hopes are not wildly unrealistic nor the physician's prognostications rigidly disheartening. Each perspective may expand the other, and in this scenario, the child will benefit. Thanks for such a lovely and inspiring piece of work.

Best, Dr. Shapiro

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Dear --, thanks for your interesting presentation about the importance of the HEADSS interview. Your example illustrated very well just how important this interaction between an adolescent and the physician (or medical student) can be. I was impressed that you were able to help your patient open up and admit his use of marijuana. It also sounded as though you framed excellent questions that generated useful details and actively tested your hypotheses (e.g., kid being influenced by bad peers vs. kid being the initiator of the drug use; problems at home vs. good home life). I also liked how you “hung in” with your patient when he started to cry, and tried to help him sort through his confusion. As you helped us all see, the HEADSS exam is not simply a checklist to be answered or a list of questions to be completed. It is an opportunity to interact with your patient in a very personal way. Done properly, as you demonstrated, it can lay groundwork for a trusting relationship. Excellent work! Best, Dr. Shapiro

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Dear --, how lovely to see you again. Congratulations on making it through 3<sup>rd</sup> year! Amazing how time flies when you're having fun 😊

I ADORED your project. It was a beautiful and touching example of a physician thinking outside the box, not only to solve a problem (how to adequately assess potential exercise-related hypoglycemia in a kid) but to connect with a likely frightened and confused child. The image of the three of you running up and down hospital stairs (you slightly behind to catch the kid in case he keeled over) seemed very moving to me. It made me think how often doctors (appropriately) send off their patients for labs, tests, procedures. The doctors write the order, then the patient goes – alone. Of course this makes sense and is how the system works. But how wonderful was it that in this case the physician *joined with* his little patient to share the evaluation experience. How wonderful that the physician mustered this level of dedication and commitment. And then of course the idea was just plain fun! The whole anecdote was a great reminder to be creative in medicine, to be present for your patients as much as possible, and to try to make things that are scary and overwhelming interesting

and enjoyable. Very acutely observed on your part. You saw right to the heart of the matter! Thank you! Dr. Shapiro

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--, you used the word “appalling” in describing an incident in which the neuro service suggested outpatient evaluation of a kid because of lack of insurance – and you were right to do so. When kids suffer disease and disability, all doctors should have to think about is how best to help them – not how much it will cost. As I noted in class, to me the “hero” of your story was the attending who refused to go along with this plan, and was at least able to get an MRI in hospital. As you know, there are many examples of doctors working around the system to get the best possible care for their patients. Yet it is frustrating and demoralizing to have to figure out individual solutions to what are systemic problems. No matter how hard individual physicians try, they are often acutely aware that indeed their patient is not receiving optimal treatment only because they do not have optimal insurance. We should have a more equitable system of healthcare, but right now we don’t. That means you will find yourself working in a system that is not always fair or just. Somehow you must do the best you can within its limitations, as your attending modeled so well; and do whatever you think is right on the county, state, or even national level to ensure that access to good healthcare is a right, not a commodity. I really appreciate your reflecting with such empathy on this troubling issue. You are right to be concerned. Best, Dr. Shapiro p.s. All blessings and good wishes to your wife as she proceeds through her pregnancy. It is scary but also miraculous to bring new life into the world.

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--, you presented one of the most heartbreaking scenarios in pediatric inpatient medicine: kids with serious illness and/or disabilities whose parents are rarely if ever there for them. What I especially appreciated in your reflection was that, although you felt deeply the emotional needs of the children in these situations,, you pulled back from hasty judgment of the absent parents. Indeed, as you pointed out, it is very hard to know what motivates other people. They may be single parents, working two jobs, and caring for other children at home. They may not have the psychological resources to accept their child’s medical condition, and have not yet figured out a way to be emotionally present for their kid. They may be exhausted, physically, psychologically, spiritually, by the demands of caring for their child, and see the hospital as a kind of respite care. None of these explanations (or others) necessarily justifies their behavior, but they help remind us that the parents too are struggling. It is important to identify such situations as carefully and dispassionately as possible, in order to marshal whatever available resources can be brought to bear to support these families. Indeed, it does take a village to raise children, and when that child is disabled or seriously ill, that need is even more acute. Best, Dr. Shapiro

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Hi --, it was so lovely to see you again. It’s hard to believe it’s the end of third year! What a long road you’ve traveled, and how close you are to the end (at least of this phase!).

Thanks for such a thoughtful and educational project. You are absolutely right that many parents are reluctant to put their kids diagnosed with ADHD on meds; and at least want to try behavioral approaches as a first line of defense. Pediatricians need to be prepared to guide parents in terms of

effective behavioral interventions, and your poster was an excellent summary of useful methods (minimizing distractions, limiting choices, providing schedules, charts, checklists, and structure, reinforcing positive behavior, establishing attainable goals, etc.). I thought your observation very insightful that these are good guidelines for *everyone*; and this realization underscored my favorite part of your poster: the quote “I am not my ADHD.” Although diagnoses are necessary and helpful in medicine, anytime we label others, we risk reducing them to that label. Every kid (and person) deserves to be seen “whole” while being supported in ways that maximize strengths and capabilities and soften difficulties.

The video clips were not only adorable but also showed how exhausting hyperactivity can be; and how focus and concentration have an essential role to play in life. In my view, ADHD is likely overdiagnosed and overtreated; and there are concerns that the diagnosis can be misused as a method of social control that intersects alarmingly with race and class. Yet it is also a real problem that requires serious and rigorous intervention, including at times pharmacological approaches. Your presentation helped us to think outside the box about what kids and parents need. Best, Dr. Shapiro

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--, you shared such a heartbreaking story. As a mother and grandmother, I cannot imagine the devastation of watching your child die from a fatal genetic condition. Where do the parents find the strength? Somehow, for the most part they do. I especially appreciated your speaking from your own very painful experience with the death of your cousins. It is easy to judge parents who do not handle this inconceivable situation “perfectly” (whatever that might mean). With parents that I’ve talked with who are facing the likely death of their child, I’ve been struck by their commitment to preserving normalcy and simple joys for the child as long as possible. They don’t think in terms of the future, but rather in terms of good days or even good moments. It takes such grace and grit, but these parents are not super-heroes, they are only ordinary people placed in extraordinary circumstances, and trying their best to navigate. ). Whatever it takes to keep going is whatever it takes.

I also thought your care to avoid the “commingling” of the family’s story and your own showed great sensitivity. There is no doubt that there is a right time and place for personal disclosure. In fact, because thankfully the death of one’s child is rare, parents can feel very isolated and alone, as if no one understands (because of course most people don’t). In these circumstances, it can be helpful to share a personal experience, which will have the effect of moving you closer to the family. This can be a very good thing, if done wisely. However, as you realized, there is a risk of shifting the focus from the suffering of the family to the suffering of the doctor, and this is NOT appropriate. In engaging in self-disclosure, you want to take the time to be sure that your openness will truly benefit the family.

You were thoughtful and generous in your presentation. It made us ponder something many of us would probably rather avoid, and to do so without resorting to platitudes or easy answers. This was a real gift to your classmates and all of us listening. Best, Dr. Shapiro