Being the Voice for a Child

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My introduction comes by way of a half-legible note, written by a nurse, that lists patient information: 1-month-old girl with otitis media. No other symptoms. Admit for full ruleout sepsis, intravenous antibiotics.

She will be arriving to the eighth-floor — the pediatric wing — directly from the community pediatrician’s office. As the senior resident, it is my responsibility to greet and examine this patient, differentially diagnose her, and collaborate with the primary doctor.

This is a busy service with a lot

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of admissions. With the faculty attending doctors who are in-house most of the time, we may discuss management and contemplate some finer points of treatment. With the community doctors, who are sprinkled around the county in private practice offices, there is a not-so-subtle mantra of “just tell me what she has and what to do.” This usually does not cause a problem.

The patient arrives tucked comfortably in the crook of her mother’s arm. A nurse leads them to a room, and I watch them walk by, mother and daughter. I take passing notice of the baby, who does not appear critically ill. Reassured, I allow the nurses to settle the infant, obtain vitals, and take a brief history without my getting in the way.

When we talk, I find Mom is a pleasant woman. Her story is simple: she came to the doctor for a routine 1-month exam and was told to come to the hospital because her doctor noted an incidental ear infection. No fever. No irritability. Eating well, eliminating normally. Pregnancy and delivery unremarkable. Mom seems intelligent, interested, and appropriately concerned. As far as she is aware, the baby appears well.

Mom is certain: no fever. A fever in a 1-month-old infant would eliminate the budding dilemma of the situation, because a work-up for sepsis is widely accepted as the standard of care for such an infant.

I am beginning to wonder why this child was admitted, beginning to fall into the dread habit ubiquitous to medical professionals called “second guessing.” What was the pediatrician thinking, doing this lab test? Who in the world put the kid on this medicine?

I try to soothe my skepticism and proceed to the physical exam, hoping to find a frankly infected eardrum. This would at least anesthetize that nagging itch. I put the speculum in an ear and there is no salvation. What I see is unimpressive. I invite the in-house attending physician to examine the patient — normally, she would have little or no contact with a patient on a community physician’s service — and she shares my view that the ears look okay. I notice Mom in the corner of the room crying because her baby is squirming and uncomfortable with our mildly invasive exam.

A work-up to rule out sepsis requires a needle in the arm for a blood culture and cell count, a catheter in the urethra to collect a urine sample, and a needle in the back to do a lumbar puncture. We tidy up, and I tell Mom I will be right back. The in-house attending physician and I step outside where I voice my hesitation. I explain that I am not comfortable proceeding with the sepsis work-up on this seemingly well child.

There are frequent occasions when a patient is admitted to the hospital for reasons not entirely clear to me. This is usually due to miscommunication, so I call the community doctor’s office and am put in touch with the doctor on-call, who explains that he is not the doctor who examined the patient. I tell him my thoughts and he agrees to contact the examining doctor.

A few minutes later, he calls back. His colleague thinks the eardrum is red, he says politely, and she still wants to rule out sepsis. He continues, saying that a senior doctor at his pediatric firm once got “burned” when an infant with an ear infection died.

I recently won a tongue-in-cheek resident award called “Brass Balls.” It is half complimentary, a tribute to
speaking the mind, and half derogatory, an indictment of disrespecting authority. I straddle this line while explaining to the on-call physician that the planned course is against my concept of evidence-based medicine. I question this practice of anecdotal medicine. While I understand the desire to be extra-conservative after an adverse event, I do not feel it justifies imprudent choices that, most likely, do more harm than good. He remains polite and apologizes, saying his hands are tied. I thank him and hang up, reluctantly agreeing to perform the work-up.

Before returning to the patient’s room with the consent form in hand (I must explain the risks of lumbar puncture, which include bleeding, pain, and infection), I stop by the office of the in-house attending doctor and again voice my concern. We talk for nearly 10 minutes. I tell her that I believe this is morally wrong. An otherwise well child with maybe a red eardrum getting a sepsis work-up? There is nothing I have studied to justify this intervention.

The in-house attending doctor is sympathetic to my plight but not necessarily supportive. As a resident, she says, it is my role sometimes to simply do what the community doctor asks.

In training, residents often face the whims of faculty and community attending physicians whose management opinions counter their own. Digesting these opinions and proceeding with diagnostic and treatment is, in some form, part of the process of becoming a doctor. A metamorphosis must take place, however, before residency is completed, when a doctor changes from information gatherer and passive doer to practitioner and active advocate - a transition not defined by graduation from residency training but rather by a confidence in one’s skills and knowledge base.

There is also a part of becoming a pediatrician that differentiates itself in the world of medicine from the course taken by internists and surgeons. A doctor who chooses pediatrics must at some point choose when he or she becomes a child’s voice.

I walk to the patient’s room, where the baby girl is swaddled in wool blankets on the crib. I ask Mom if she knows why the baby has been admitted to the hospital. Because she has an ear infection, she says. I ask if she knows the plan, and she shakes her head. My normally fluid, routine explanation of procedures is checkered with pauses and hesitations. Immediately upon my mentioning the word “needle,” Mom begins to cry again. I get flustered, gently put my hand on her shoulder, and again explain that I will be right back.

During my months of training, I have become well versed in, and trusted to, the tasks of paperwork, general physical exams, and well-child care. During this time, I have also practiced the skills that allow me to treat children who are sick, under the close supervision of attending pediatricians. Usually, the interventions requested are benign - I administer the antibiotics, give the albuterol treatments, draw blood for an obscure test.

Sometimes, however, my opinion differs. Outside the patient’s room, I see the in-house attending. I have considered the ramifications, the potential fall-out. I will not stick that child, I tell her through a crack in my voice. I will not.

As a postscript, a compromise was ultimately reached whereby we drew blood and collected urine from this infant but withheld the lumbar puncture. She was watched for less than 24 hours, without antibiotics, as opposed to the original plan of 48 hours of observation with antibiotics. No adverse effects or continued illnesses have been reported.

I do not consider this a victory. I consider this a lesson — in how to properly represent my patients as a pediatrician.