

# The Med-Peds Perspective

The Official Publication of the National Med-Peds Residents' Association

## NMPRA National Meeting A Success!

Rohini Harvey MD, NMPRA Secretary

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The October National Med-Peds Residents Association (NMPRA) National Meeting was a success! More than 70 people braved torrential rain and delayed airline flights to make the Columbus Day weekend meeting held in conjunction with the American Academy of Pediatrics (AAP) National Conference and Exhibition. Held at the Grillfish restaurant in



*The NMPRA Board at Grillfish (from left to right): Petra Lehning, Allen Friedland, Rohini Harvey, Scott Oberhoff, Emery Chang, Ranya Sweis, Ken Remy, David Kaelber, Heather Toth*

Dupont Circle, attendees included at-tendings, residents and future med-peds

residents from all over the country. The guests dined on expertly prepared food while socializing with fellow residents from other hospitals. The NMPRA board spoke

about the state of NMPRA and other med-peds organizations including the Med-Peds Program Directors' Association and the AAP Med-Peds section. Winners of the NMPRA resident case

presentation competition, Drs. Wael el Mallah  
Continued page 2

- *Dr. Andy Kavanaugh-Black talks about his fast-paced career as a med-peds hospitalist. See page 4.*
- *Does the job hunt have you mystified? Learn from Dr. Allen Friedland, NMPRA advisor, how to prepare your CV. See page 6.*

### Inside this issue:

NMPRA National Meeting	1
Northeast Regional Meeting	1
Money Matters: IRAs	3
Exploring Your Future: Med-Peds Hospitalist	4
Thoughts From One Rainy Night In The ED	5
Create the Med-Peds CV Of Your Life	6
Case Presentation: Juvenile Huntington's Disease	9
First Do No Harm	10

## Northeast Regional Med-Peds Conference

Ritu Sharma MD

Save the date! The Northeast Regional Med-Peds Conference will be held on Saturday April 22nd, 2006 at UMDNJ–New Jersey Medical School in Newark, New Jersey. Topics of Discussion will include:

**Saturday April 22, 2006**  
**UMDNJ– New Jersey**  
**Medical School**  
**Newark, NJ**

1. Transitional Care: The Unique Role of the Med-Peds Physician

2. Humanism in Medicine: A Discussion by winners of the Arnold P Gold Humanism in Medicine Award  
Continued page 2

## National Meeting, Continued

and Rupesh Raina presented their outstanding submissions. Perhaps the highlight of the night, though, was the moving story told by Dr. Tracy Conrad, program director of the Tulane University med-peds program who braved Hurricane Katrina with his hospitalized patients, and by Dr. Anjali Niyogi, Tulane resident, who described her efforts to provide medical care after the storm with few provisions.



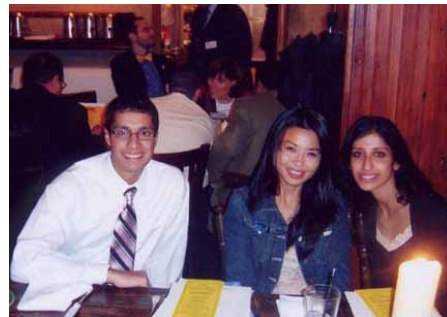
*NMPRA National Meeting attendees kicking back at Grillfish restaurant in Dupont Circle, Washington DC.*



## Northeast Conference, Continued

3. Cultural Competency : Dealing with a multicultural patient population
4. Genetics: A perfect fit for Med-Peds
5. Tuberculosis: A spectrum of presentations in all ages
6. Surviving Childhood Cancers: The lifelong followup
7. There will also be panel discussions on Med-Peds related topics for students, residents and faculty.

Registration and CME Information to follow. Please contact [medpedskonference2006@gmail.com](mailto:medpedskonference2006@gmail.com) with questions.



## **Money Matters: IRAs**

**Emery H. Chang, NMPRA Travel Advisor**

I am now 30 years old and still in training. Meanwhile, many of my friends have been working full-time for 8 or more years, putting us residents close to a decade behind in income and retirement planning. Sure, you think, we'll make up for that with our higher-than-average incomes when we finally finish. However, I think that we could be missing a valuable opportunity – the Roth IRA (Individual Retirement Account).

### **What is an IRA?**

These accounts are usually at banks, insurance companies or stock brokers. You can make annual contributions to them and the money in these accounts can be used to buy investments such as bonds, stocks, and mutual funds. For some accounts, you can earn interest. If needed, the assets can be transferred from one institution from another. There are two basic types: the traditional IRA and the Roth IRA. The main difference between the two are where your contribution comes from. With the traditional IRA, your contributions are pre-income tax but you pay taxes with you withdraw your funds. With Roth IRAs your contributions are post-income tax and your earnings are tax-free when you withdraw. More later on the other differences. Note, you can have both types of IRAs

### **First, Where Do I Get the Money?**

Ah, probably the hardest part. If you don't start the habit now, it's just going to be harder and more costly to do it later. Automatic deposits of \$50-100 from each paycheck can add up quickly and you're likely not going to miss it. My rule for my moonlighting money is that at least half of what I earned must go back to paying off extra on my loans or go towards savings. Also, cutting out your daily \$4 latte can save almost \$1,500 each year – YIKES!



### **What Makes Roth's Cool?**

Since you paid income tax on the money you contribute, all the earnings from the Roth are federal tax-free. You can withdraw your contributions at any time without penalty or taxation. Your earnings generally are for your retirement and can be taken out after the age of 59 ½. However, they can also be withdrawn without penalty for things such as your first-home purchase, higher education, major medical expenses, disability, and unemployment. So the Roth IRA can serve as a safety net. For 2005 to 2007, you can contribute up to \$4,000 per year.

### **Why Not Do a Traditional IRA?**

The IRA can be great and has different characteristics. There are no income limits, so once we become attendings we won't be locked out like a Roth IRA. You can deduct your contributions from your federal income taxes when you make a deposit to a traditional IRA, which can lower your Adjusted Gross Income. You pay taxes on the earnings when you withdraw out of your IRA (e.g. when you retire). The IRA can still serve as a limited safety net so you can withdraw earnings without penalty for your first-home purchase, higher education, and a limited amount of major medical expenses. You cannot, however, withdraw your original contributions without penalty.

### **Why can't I do Roth IRAs later?**

If you cross the income limits of \$95,000/\$150,000 (single/joint) Adjusted Gross Income, you no longer contribute to a Roth IRA; what's in there is what you have. So when you reach the average attending's salary, you can only do a traditional IRA.

Regardless of what you do, we should all start making plans for our retirement. The earlier we start, the more our money can build on itself, hopefully making our retirements more comfortable. Good luck!

As always, NMPRA and myself are not financial experts and you should consult your tax and finance professionals before investing.

## Exploring Your Future: Med-Peds Hospitalist

Rohini Harvey MD, NMPRA Secretary

I spoke with Dr. Andy Kavanaugh-Black, med-peds hospitalist, in the midst of my final NICU rotation last month. During that time my pager was set to take the NICU codes, but I also received code blue announcements. The words code blue always prompt me to jump up, but that month I was forced to stay in the NICU and deal with its own emergencies, and despite my urges, let others cover the emergencies on the other inpatient floors.

Dr. Kavanaugh-Black, though, has a different perspective. A graduate of the Rush University med-peds program, Kavanaugh-Black projects contagious enthusiasm for his chosen career path, one that seamlessly melds internal medicine and pediatrics. Within hours or even minutes he can see patients that cover the spectrum of ages.

He works at both a small community hospital in an underserved neighborhood of southwest Chicago and at a university-oriented hospital with an internal medicine residency program. In these facilities he is the pediatrician on call for deliveries, the one to resuscitate and stabilize the baby before the neonatologist arrives. He may be present at deliveries for 500 gram preemies or term infants. He often must intubate, start lines and administer medications before a NICU team arrives. On the pediatric floors he assumes responsibility for patient care, arriving at diagnoses, and ordering tests. He attends pediatric codes, especially in the ER, and is skilled in pediatric resuscitation and intubation. He feels comfortable with the anterior pediatric airway and pediatric central line access, often more than the adult-trained emergency physicians. If a physician in the emergency department has a question on diagnosing a rash, interpreting an EKG, or admitting a child, he may be consulted.

On the adult side, Dr. Kavanaugh-Black provides hospital care like any other general internist. Because he does not have to set aside time to take care of ambulatory patients, he also goes to codes, or provides intensive care when needed. He has to be comfortable with critical care medicine since the sickest patients often remain under the care of the hospitalist in the intensive care unit. If needed in this setting he can call in specialists, for example, to insert an internal pacemaker. Dr. Kavanaugh-Black notes that most med-peds residents train at large academic hospitals where specialists abound, and are not accustomed to community hospitals where general internists coordinate critical care medicine.



Unlike my NICU experience, where I focused on our infants, and let other residents manage the adults, Dr. Kavanaugh-Black is on medicine and pediatrics at the same time. His secret to managing delivery codes on top of code blues, with inpatient care in the middle is known to any busy resident: he must triage his patients. Neonates generally come first, especially since he may be the only one in the hospital

capable of caring for these patients. Also, they usually need help right away- the first few minutes are so vital and have a long-lasting impact on the infant's survival. Because it may take time to stabilize an infant he can rely on telephone triage to care for his other patients until he is free. He may give orders over the phone for labs, call anesthesia for intubation, or ask for a cardiology consult. There is backup available!

There is more than just the intensity and acuity that attracted Dr. Kavanaugh-Black to the field. As a hospitalist he has the luxury of time to be with patients and their families, a perk that is scarce in the outpatient setting. He likes that he can spend thirty minutes or one hour in a family meeting and will be compensated for his time. This is crucial time for counseling, educating and making sure that patients understand what is happening to them during their sometimes overwhelming hospital stay.

The hospitalist field is friendly not only to patients, but to their physicians as well. Dr. Kavanaugh-Black works for a corporation, a multidisciplinary group of physicians from diverse fields including neonatology, pediatric intensive care, internal medicine, pediatrics and of course, med-peds. He works in twelve or twenty-four hour shifts, and can schedule a few shifts in a row if he wants time off later to spend with family, travel or pursue other interests. When he is out of the hospital, he is not on call and does not carry a pager.

A hospitalist's time at work, though, is spent taking care of sick, challenging patients, and in Dr. Kavanaugh-Black's case, sometimes critically ill adults and children. I asked him if hospitalists should be required to complete a fellowship in the field. He thought that it was an interesting concept. He felt very well-trained by his residency program, but did need to learn new skills on the job. He may have benefited from training specialized to his field, but after all,

## Med-Peds Hospitalist, Continued

he still considers himself a general internist and pediatrician. Every one of the procedures that he does is available for certification to generalists. However, he did not come out of residency being at ease with many of the skills and procedures he has acquired on the job. For intubations, as an example, he called the anesthesiologist for backup until he felt comfortable doing them on his own. Now that he is no longer a resident, it is no big mystery to him: attendings keep learning after they have finished their residencies, no matter what the field. Though he did not need subspecialty training to learn chest tubes and intubations, he did need to seek out opportunities to perfect these skills in residency and beyond.

I have heard others comment that hospitalists, because of their focus in an area where residents spend much of their time, and attendings or primary care physicians, very little in comparison, are simply advanced residents. I asked Dr. Kavanaugh-Black what he thought of this idea. He disagreed. Med-peds residents are perhaps uniquely positioned to enter the field because of the time we spend taking care of intensive care and other hospitalized patients. Why not concentrate on these particular patients after residency as well? He was also clear to point out that unlike a resident, he takes full responsibility for his decisions instead of conferring with an attending. Other than consultants, there is no one else to rely on; he is in charge.

## Thoughts From One Rainy Night In The ED

Kenneth E. Remy MD, NMPRA President Elect

It was an extremely busy, rainy Thursday night in the adult emergency room. Rule out heart attacks, acute diarrhea, stroke, and the closing time inebriated filled the halls. Patients complaining that their sore throat and red eyes at 1 am had to wait 3 hours before seeing a physician. Tired and aware of my position in a service business, I put on my happy face to offer an apology for waiting before placing my stethoscope to hear the barely audible "lub dub" above the screaming psychotics. And then my evening changed.

*"Dr. Remy there is an 87 year old woman with shortness of breath in room 6. Her pulse ox is 85%. She came from home and her children live in Philadelphia."*

I entered the room and saw an elderly lady working at breathing. I put oxygen on her and her ribs stopped tugging for air. She told me that she didn't want anything more than oxygen and no aggressive treatments. It was then that my pediatric charm on adult patients was turned on with a smile...

*"So you're 87 years young, aren't you supposed to be on a hot date instead of here in the hospital?"* I asked. She looked at me inquisitively. I looked down at her information.

*"Oh no, I can't take care of a Phillies fan, well, I guess I can make an exception."* She smiled again, breathing more comfortably.

***The ER began to calm down around 2:00 and with my patients all tucked in I returned to visit my sickest patient. She was still alone, sick and in need of my attention.***

*"You remind me of my grandson"* she responded. *"He runs his own business in Pennsylvania."*

I continued my history taking and completed my examination. She didn't look good. I discussed her with my attending and put in for an ICU bed although the wait for a bed at 1:30 am was probably going to be some time. The ER began to calm down around 2:00, and with my patients all tucked in for admission or discharge, I returned to visit my sickest patient. She was still alone, sick, and in need of my attention.

*"How are you doing? Are you still short of breath?"* I questioned.

She nodded. I turned up the oxygen to 4 liters. She looked better.

*"So where did you live before Cleveland?"* I asked because I genuinely was curious.

*"I'm from South Philadelphia..."*

I interrupted her as only doctors can do. *"South Philadelphia...ever hear of Jefferson hospital?"*

She nodded *"I was born there, that's where my husband worked before he moved us to Cleveland. He was a doctor too."* Are you kidding me? I thought in my mind.

*"I graduated from Jefferson a few years ago."* I heard my name overhead and got up to leave.

*"Can you come back soon, Doctor?"* She said as she looked up at me with almost puppy dog eyes the way that a 2 year old looks up at you after being scolded.

*Continued page 11*

## Create the Med-Peds Curriculum Vitae (CV) Of Your Life: Your First CV for Your First Job

Allen Friedland, MD, FACP, FAAP

NMPRA Non-Resident Advisor

Immediate Past President Med-Peds Program Director's Association  
Program Director, Christiana Care Health System Med-Peds

The term curriculum vitae means "course of life" in Latin. I have reviewed many cover letters, CV's and resumes and I have been struck by how commonly we forget to market ourselves better. In my mind there are two general problems I see in reviewing many of your documents. The problems are related to structure (including layout) and function (including message). I wish to point out several items in both of these areas to make your first impression count with a potential employer who may or may not be a physician.

When you apply for your first job, it is important that you get up front the names, correct titles and mailing addresses for the person(s) to receive your personal information. This is really critical in large settings or hospitals where snail mail occurs if the full address is not included. Usually this requires a phone call even if you think the information is clear in an advertisement. Never make this first mistake; never have a short fuse or be other than extremely courteous to the person on the other end of the phone. You never know how important that first person receiving your phone call is to the employer.

*Sincerity and integrity can be felt through your cover letter and CV. Make it real and reflect your core values.*

Now let us discuss what to send; cover letter and curriculum vitae. I will discuss these in outline form.

### Item: Cover letter

- A. Function: The cover letter is the equivalent of meeting someone for the first time. Think of what attracts you to something the first time you lay eyes on it.
1. State how you found out about the job opportunity (employers like to know how their word got out).
  2. Convey intent and focus specific to job (requires homework to get specifics).
  3. State some of your best attributes and aspirations.
  4. State that you are available to interview and create the opportunity to open a dialogue to learn more about job opportunity (beyond the basics of the job opportunity).
  5. Basic Med-Peds information. (You may need to tailor it differently if the information is being sent to a physician or not.) NMPRA has a brochure about Med-Peds that can be downloaded from the website <http://www.medpeds.org/pamphlet.htm> to send to potential employers (make sure you print it out professionally). Also, the American Academy of Pediatrics, Med-Peds section has almost completed a trileaflet brochure to send to potential employers. Both of these may help eliminate some concerns about what to include in the cover letter about med-peds training.
- B. Structure:
1. Never use a form letter
  2. Date the letter appropriately
  3. Use appropriate salutation at beginning and have ample space for your signature at the end
  4. Must contain your correct contact information in event that cover letter is separated from CV.
  5. Must contain in the content of the cover letter that your CV is enclosed (in case cover letter is separated from CV)
  6. Use a clear style font at 10-12 pt font with equal margins
  7. Paper clip (never staple) to curriculum vitae (always include CV with cover letter).
  8. When you use bulleted phrases, they must be written with parallel construction (proper New York City English is not acceptable here although I am expert at it).

## Your First CV For Your First Job, Continued

9. Do not indent the first word of paragraph and do not justify right
10. Length should be one page

### Item: Curriculum Vitae

- A. Function: Resumes are usually shorter documents summarizing career highlights while CV is more exhaustive. When you come out of residency the resume should equal the CV.
1. To create an organized time line of medical and non medical activities
  2. To create an atmosphere where your CV relates to the job opportunity.
  3. To account for all gaps in time from college through residency. The time-line created should lead to only a few questions about where you were during certain times.
- B. Structure:
1. Number pages on bottom and have name on top of all pages.
  2. **Personal information:** legal name, home address, phone number, citizenship (optional), place of birth (optional), e-mail address. You never want to give a contact number or fax number that you do not check often or have little chance of answering when a call comes.
  3. **Education:** residency, graduate school, medical school, college. I believe it should be organized from most recent to oldest. Use something like, Combined Internal Medicine-Pediatrics; a four year integrated combined residency (soon you may be able to say accredited).
  4. **Work experience:** moonlighting experiences or other experiences that may or may not be related to medicine. You should show degree of involvement, e.g. moonlighting urgent care on average 16 hours per month
  5. **Honors and Awards:** please include scholarships to school or travel grants to conferences. No high school awards here anymore!!
  6. **Committees and Memberships:** again involvement is key. e.g. med-peds curriculum committee; meet 4 times per year; redesigned ambulatory and peds inpatient block rotations.
  7. **Certification and Licensure:**
    - a. There is no reason to include license number and no reason to include scores of exams unless they were great
    - b. "Board eligible" though it is used frequently is not accepted terminology by the boards lately. Just list when you are scheduled to take the boards and which specialty.
  8. **Presentations:** national, regional, intramural with each as a separate category. This is the area that most of you need to develop. You probably all have lots of intramural or local presentations. In this area, I feel that substantial presentations where a handout and references are provided and the audience is the residency class or med-peds group can be included in this first CV. That is why it is critical to keep up your CV from internship.
  9. **Research Activities:** papers not written yet but with IRB-approved protocol. Include involvement with activity
  10. **Personal Extracurricular Activities**
  11. **Memberships:** It is more important to show involvement (participated in annual meeting) than to list all eponyms (AMA, ACP, NMPRA, AAP, etc.) indicating that you are members of everything but do nothing

## Your First CV For Your First Job, Continued

### 12. Bibliography:

- a. Publications-Journals
    1. Published articles
    2. "In press": accepted but not printed yet
    3. "Submitted"
    4. "In preparation"
  - b. Publications-Abstracts, Editorials, Book Chapters
13. Do I clump or split activities? It depends on the activity and involvement. For example, you are part of the American College of Physicians (ACP) and are involved with the planning committee for the annual state meeting and are considered a "key contact" for your state legislature but have not done anything for this position; in this instance clump under ACP. Remember "filler" can be detected and will be detected if not now, during the interview, so do not do it.
  14. Have a visually oriented person (radiology friend) review the look of your CV. Place it on bond paper with the same color as the cover letter and envelope. I personally use large envelopes so that the pages do not get folded and are kept straight.

*Keep the CV alive and ongoing. I have seen too many missed opportunities by residents because they forgot what they did.*

Reminder: Keep the CV alive and ongoing. I have seen too many missed opportunities by residents to place items in their CV because they forgot what they did. Start this process in internship. By starting early will allow you to figure out what areas need more experience.

Bottom line: Sincerity and integrity can be felt through your cover letter and CV. Make it real and reflect your core values. Make your first impression count and do not lose points on presentation and style!! Good luck on your first cover letter and CV.

A good reference: The Physician's Resume and Cover Letter Workbook: Letter Writing Exercise Young Physicians Section, AMA at <http://www.ama-assn.org/ama/priv/category/11909.html> will be invaluable to review. As well, the ACP has resources (need to be a member) but the AAP has minimal resources.





## Case Presentation: Juvenile Huntington's Disease

Stacey Walker MD, Geisinger Medical Center

**Presenting Problem:** Mr. S.H. is a 33 year-old man who presented to the clinic as a new patient for evaluation of possible adult attention deficit hyperactivity disorder (ADHD). His wife stated that her husband of 15 years had problems with hyperactivity, inappropriate behavior and memory difficulty. The patient's mother said that Mr. S.H. was evaluated during school for these difficulties but treatment was not implemented due to his stepfather's refusal. The wife stated that the patient had abnormal movements since high school, predating their relationship. The movements prompted a visit to a neurologist in the past and the patient was treated with Celexa for depression without improvement. The patient and his wife noted that the movements have increased over the past few years and that they are now interfering with daily living. The patient had to quit his job as a tow lift driver and general worker due to poor coordination and clumsy walking. Finding living quarters and employment was difficult due to the impression that the patient was using drugs. At the time of evaluation the patient did not have medical insurance.

**Clinical course:** Mr. S.H. and his wife completed surveys for ADHD symptoms and they were markedly positive with regards to inattention, memory difficulty and task completion. The patient was started on Strattera 40mg daily with samples from the clinic. On follow-up the ADHD symptoms were not improved and thus the Strattera was increased to 60mg daily. Once the patient obtained medical insurance work-up was initiated for his movement disorder by obtaining liver function tests, ceruloplasmin, copper level, iron level, lead level, TSH, anti-streptolysin O, anti-strep Dnase B, EEG and MRI. The results of all these studies were negative for Wilson's disease, hyperthyroidism, lead or iron intoxication, Sydenham's chorea, seizures and intrinsic brain malformation. A 24-hour Urine collection for copper was ordered to definitively rule-out Wilson's disease and a neurology consult was placed. Urinary copper excretion was within normal limits. Prior to neurology evaluation a Huntington's PCR and a CBC were sent to evaluate for neuroanthracosis and Huntington's disease. The neurology recommendations were to check heavy metal panel, TSH, Free T3, Free T4, ceruloplasmin, iron, ferritin, TIBC and autoimmune work up with ESR, SSA, SSB, ANA, ANCA and Anti-thyroglobulin Ab. The impression from neurology was that the patient had a psychiatric disturbance causing the movements. All of the studies neurology had ordered were within normal limits. Genetic testing returned and was markedly positive for Huntington's Disease (HD) gene.

A meeting was held with Mr. S. H. and his wife where the full work-up and differential diagnoses were discussed. The final diagnosis was discussed with the patient and his wife. The main concern of the patient was the testing of their children, ages 9 & 12. The patient complained of worsening of the movements with the higher dosage of Strattera so the dose was decreased. The patient was started on Haldol to attempt to control the movements. The Haldol was slowly increased to a total of 4 mg twice a day with no improvement of the chorea and increasing daytime somnolence. The patient was referred to physical and occupational therapy due to concerns over slurring of speech and loss of balance with increasing falls. Their home was evaluated to make it safe for the patient and Mr. S. H. is currently undergoing speech therapy to help with speech and swallowing problems. The patient was also referred to a Huntington's specialist who discontinued the Haldol, and started the patient on Lexapro for his increasing depression and Namenda for mental clarity. The patient and his family are happy with his current level of function.

**Discussion:** This patient had long standing ADHD symptoms and motor tics, which delayed recognition of his disease. The patient had no known family history of Huntington's Disease although his biological father had some mental instability. The biological father abandoned the patient shortly after birth and had no further contact with him so it is unknown whether he was afflicted. Although Mr. S. H.'s diagnosis was not made until adulthood, his history revealed symptoms suggestive of juvenile onset HD (JHD). JHD represents approximately 10% of all HD cases. They typically present with more atypical mood and behavior disturbances and with stiffness or rigidity rather than chorea. It is not uncommon for children with JHD to have difficulty at school with writing, learning and increasing clumsiness in physical education classes. Children who present with JHD in their late teens may develop chorea similar to adult onset HD. Seizures have also been noted in one-third of JHD patients. Similar to adult onset HD, JHD patients have wide variability in presentations thus any case of HD with an onset before the age of 20 is considered to be the juvenile form.

This patient and his wife have two children who are at risk for HD. The children each have a 50% chance of inheriting the HD gene from their father. However, paternal anticipation of the trinucleotide repeat tends to correlate with earlier disease onset and puts the children at higher risk for JHD. It has also been noted that with longer chains of the trinucleotide CAG repeat that the disease progresses more rapidly. Often, death from juvenile HD occurs within 10 years of onset, as opposed to 10-25 years in adult-onset HD. Physicians need to be aware of the difference in presentation between JHD and typical HD, and the importance of genetic counseling for these patients.

## First Do No Harm And Other Ethical Thoughts

Ken Remy MD, NMPRA President-Elect

Through my explorations of various ethical issues and dilemmas facing physicians today I have come to the conclusion that every action of the physician's pen has ethical implications. Surprisingly, these actions usually are executed with little thought to these implications. For instance, many would suggest that the most important aspect in the physician-patient relationship is communication. In this communication there is a trust that the patient will keep the physician accurately informed of any symptoms, complications, or response to treatment, and that the physician will keep the patient informed of all testing, diagnoses, and treatment regimens. For the most part, this equilibrium occurs with major items such as an elective surgery, blood transfusion, or anesthesia. However, especially in the hospital there is a disconnect for the more minor things.

In viewing many physician interactions over the past few years as both a medical student and resident I have routinely witnessed medicine practiced from computer screen to computer screen with a breakdown in the physician-patient interaction. For example, a house officer will often order a complete blood count and urinalysis to locate an etiology for dysuria and increased urinary frequency. Inasmuch, once these results are received the house officer will immediately begin Bactrim, Cipro, or Macrobid without informing the patient that he/she has a urinary tract infection and that these treatment options might be prudent. The specific side effects to these medicines are rarely discussed. Although it may appear minutia for a physician to inform the patient and then receive consent, the ethical implication of neglecting this important interaction is epic. The physician is responsible to a code of beneficence, to first do no harm. Not explaining treatment regimens is counter to this beneficence principle because it disrupts the balance of the physician-patient equilibrium and results in lost autonomy for the patient. It is unclear whether this conundrum results from physicians neglecting to describe adverse side effects to antibiotics within the hospital because they feel a sense of pro-patria or paternalism that they know what is best for the patient. Perhaps some physicians believe that patients by entering the hospital and offering general consent to services are rendering the physician trustworthy and responsible to his/her care without need for discussions on each aspect of care. It is also unclear whether the rigors of the daily routine make it difficult for doctors to engage full discussions.

Nonetheless, patients in the hospital are scared, anxious, and vulnerable in a hospital gown and bed that exposes their utmost intimacies. They need reassurance. They deserve to know how their bodies will be manipulated so that their minds can comprehend. Thus, it is paramount for the clinician to keep the patient informed of every diagnosis, treatment regimen, and procedure. Without explanation, the clinician enters a slippery slope because patients and their families are lost in the medical jargon. They cannot make informed decisions about their loved ones when they do not understand exactly what is happening unless a learned friend, who has gained their respect and trust can keep them abreast every step in their path towards health or more importantly to a peaceful passing. In my mind, the greatest skill of the physician is not using the stethoscope, not keeping a steady hand prior to making an incision, but relaxing the facial muscles and taking the time to openly engage in a dialogue. To first do from the heart guided by the mind and with the instrument of the voice.

Ultimately a day may arrive when malpractice or managed care will drive the art of healing out of medicine and in will enter robotic-like replacements. What will set apart the healer from the computerized body mechanic will not be technical skill but instead the ability to communicate and engage with empathy in the human experience. I fear that without this, the trust in the physician-patient relationship will be relinquished... and on this day will be the demise of medicine.



## Thoughts From One Rainy Night In The ED, Continued

I quickly returned after writing my narcotic script for a person with a "really sore throat."

"Bet you could use a Pat's cheese steak right now?" I said as I entered the room. She smiled.

"I have called your son and let him know that you're here and are going to be admitted." She smiled again and then grabbed my hand as to say thank you. She didn't let go and I moved to sit at her bedside. It would be another half hour before her bed was ready upstairs.

We talked about my times in Philadelphia and how my heart was tickled there as well. She talked about her husband and how they met in Philadelphia at a park that I was very familiar with. As she was telling me about her life, she began to come in and out of consciousness. I pushed the call button for the nurse and asked for my attending to come in. And then, without another moment, she passed.

I didn't get up to shock her or put a tube down her throat. I didn't request fifteen strangers to run into her room and tear her covers off in efforts to bring her back. She was gone; gone to where she wanted to go, at least from what she had told me. I squeezed her hand and then let go, folding her hands one over the other and said a short prayer bringing her to the Jesus that we both believed in.

I got up and called her son and let him know.

*I didn't request fifteen strangers to run into her room and tear her covers off in efforts to bring her back. She was gone; gone to where she wanted to go.*

It was 3 am now and I was ready to sign out. Ready to go home and ponder how some days I want to be the mechanic with the human body as substrate. But today I let my heart be the artist with medicine as the canvas and human touch as the healer.

I don't know why amid drunken people, diarrhea, and chest pain she came. Maybe she knew that I had felt empty inside earlier that day and needed to be touched.

And three days later I have been called that my grandmother is in the hospital. Although I don't think that she will pass at 85 years old, I don't know. I know that my family is there with her and my heart as well.

In this all I am left with only a few thoughts: In life there seems to be days filled with nothingness. There are times in residency without the view of a light at the end of the tunnel.

But some days, not every day, there are little sprinkles of fairy dust from secret angels, bringing our hearts to dance in the moonlight when we thought they were sleeping in the darkness. And when I'm tired and dreading the touch of water on my skin after my short slumber, this is what gets me up in the morning...this is what refreshes those naïve blue eyes that could take on the world only two years ago after finally graduating from medical school.



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***The Med-Peds Perspective***

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