Chapter 10
Special Considerations in Pediatrics: "[A] child is not a little adult…"

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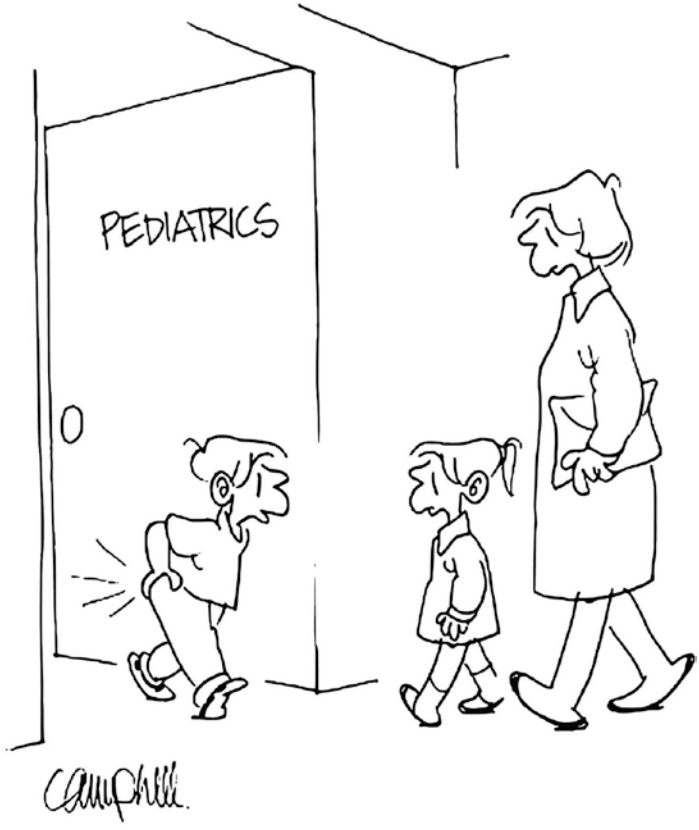


"Don't try to turn tail and run. That's just what they want."

A person's a person, no matter how small.

Dr. Seuss

Journal of proceedings and Addresses of the Annual Meeting. National Educational Association (US): 336, 1902.

Pediatrics is one of the primary care specialties. The pediatricians or family practitioners who include pediatric patients in their practice take on the responsibility of acting as a first contact for children and their families in the

event of illness. These physicians also provide follow-up care, regular physical exams, and ill child evaluations. The pediatrician has the satisfaction of following a child from birth through late adolescence, and is often the first adult outside of family members with whom the child establishes a social relationship. Participating in the physical and social development of the child is a very satisfying part of providing pediatric care.

Where the pediatricians' practices differ from those of adult medical specialists is in the special challenges and opportunities of caring for the newborn, infant, child, preadolescent, and adolescent. Most adults between the ages of 20 and 50 rarely visit their doctors' offices except for an acute illness, such as a fever or URI, a chronic symptom such as a cough or GI reflux, an injury, or the new onset of pain. The well-child visit, on the other hand, is an important part of maintaining a child's health, and includes immunizations, first year of life visits, physical exams to check for normal growth and development, and for school and sports participation.

You will learn in your clerkship how to examine a newborn baby, always a delight if you are not rushed, how to perform the elements of an age-related well-child visit, how to deal with common but potentially serious problems of the newborn and premature infant, and how to deal with common problems of the growing child and adolescent. A detailed discussion of the problems you will run into in a pediatric clerkship or residency is beyond the scope of this chapter. Rather, in this chapter we will try to give you some techniques on how to make the clerkship more fun, meaningful, and productive.

A special challenge for pediatricians is how to balance the medical needs of their patients against the desires and biases of those responsible for their care at home (for convenience we will call them the parents). In the first years of life, children are totally dependent on their parents for healthcare. During this period, the conversation in the medical office is between the doctor and the child's parents. As their patients grow and mature, pediatricians can spend time

speaking with the child. For the very young child, this will mostly be social conversation, or play.

In the case of the somewhat older child, you may question your patient directly to bring out signs and symptoms of disease. This will depend on the child's level of maturity and physical development. During the part of the consultation when you discuss how to approach treatment, if any is needed, very little of the conversation will include the very young child.

As your patients get older, they can contribute more information about symptoms and the course of any illness. If you are able to involve your patient in the beginning stages of the consultation, you will find they will cooperate more fully with the exam process. Although you might easily engage the older child during the socialization and exam process of the consultation, it is just as important to include the older child and adolescent in conversations concerning the diagnosis and any recommendations for treatment.

Wise pediatricians and parents recognize that an older child is competent to participate in at least some of that conversation, often showing insight into school and daily routines that influence treatment regimens. Older children might wish to raise concerns about healthcare routines that may not be compatible with their schedule or social life. While the parent may try to maintain control over the details of their child's treatment, with the older child, preadolescent, and adolescent, control of the treatment regimen falls increasingly into the child's hands. The doctor should therefore enlist their patient into any discussions about treatment options. Some children as young as 7 years can give information about their symptoms and also help in figuring out the best way to approach their treatment. Many adolescents can coordinate their own care, with little parental supervision.

Including the child in discussions and decision-making about any illness has an added benefit. This is an opportunity for your patient to have an adult interaction in a safe and controlled atmosphere. This will foster experience and

confidence in the ability to relate to an adult during a conversation about an important subject—in this case his or her health. Children can participate actively in their healthcare, and when included in the treatment plans, will engage and cooperate to a greater extent with the plan.

With the younger child, put your patient at ease by making the physical exam a sort of playtime. You will find this comes quite naturally. Describe everything before you do it. Gently advise your patient when something you are about to do will not feel good. Use words or expressions they will understand.

For example, when examining the very young child, say you are about to use the otoscope to see what new words they have learned today. Ask the child to blow out the flashlight you use to exam his throat. He will feel more in control. Do a simple magic trick, like taking a shiny coin out of their ear and giving it to them. Give them a picture book when they first get on the exam table. For the older child, if you or your assistant know a quick card trick or how to juggle, that will put them at their ease and make going to the doctor a playtime experience. Try to distract the child during any part of the exam that might cause discomfort, and especially when giving an injection. Giving neonates and infants 20% to 30% dextrose solution in a bottle has been shown to be effective in reducing pain [1]. See below for an excellent summary article on practices to reduce pain when giving a vaccination [2], and as a side note when placing an IV in children [3].

With the preteen, encourage your patient to enter into the conversation. In many cultures, children are encouraged to remain silent in the company of adults, and on these occasions, parents may answer for the child or interrupt a conversation between the doctor and the child. A good way to control the consult is to maintain a triangle of conversation, with the pediatrician at the apex and the parent and child slightly separated. That way you can turn to the person with whom you want to address a particular part of the conversation. If necessary, have the parent on one side of you, and

the child on the other. You may have to interrupt the parent with a slight wave of the hand or address the child by name. If this does not work, you just have to accept it and continue to try each time you see them in your office.

The parent may feel the doctor is not showing respect for the parent's authority, or that the child is not ready to take on responsibility for his or her health. Explain (but do not lecture) that by bringing their child into the conversation you will not only gain the child's confidence and trust, but a successful interaction is an opportunity to learn polite adult behavior, increase confidence, and demonstrate maturity. Most pediatricians will recruit the preteen and teen into the question and answer part of the exam, and the normally developing child will often eagerly participate. This is a good opportunity for the child to learn about turn-taking during a conversation. As with the adult patient, you should always show respect for both the parent and your patient by listening carefully, being attentive to their needs, and making certain all their questions are met.

Many parents may feel guilt or anxieties concerning the origins of their child's illness. They are reluctant to raise these fears but you, with some discretion, must address them in order to arrive at a practical course of treatment. Otherwise the parent might believe one possible source of the problem was not considered, and might be tempted to seek another doctor's diagnosis and opinion, thereby wasting time and money. Address all questions honestly. Parents need to know why their child is ill. This is one of the important goals of any medical consultation. If parents are distracted during the discussion of the treatment plan, ask them to repeat back to you any point they may find confusing. Repeat the plan. If you believe the child is old enough to understand, ask him or her to repeat the plan.

Before they leave your office, you, your patient, and parents should be in agreement as to what the problem is, what caused it, and how to deal with it. They should be able to "say back" to you the diagnosis, the treatment, and the plans for follow up. Be certain the treatment plan and your

impressions are written down. Some situations call for you to be discrete but always truthful.

Caring for the Teenager

We know of young adults in their 20s, lifelong patients of their pediatricians, who become quite upset when told they will be referred to an internist because of their age. On the other hand, some teens refuse to visit the same pediatrician as their younger siblings, finding a doctor's office that caters to infants and toddlers and decorated with cartoon characters too juvenile for their sensibilities.

The best doctor for teens is one who has a long-standing relationship with them. However, families move, doctors retire or relocate, or you may start a pediatric practice and decide not to treat teens. Adolescent medicine is a subspecialty of pediatrics dealing with the problems of teenagers.

To effectively communicate openly with a teen, you must practice the behaviors we discuss in Chap. 4. Teens will respond positively toward doctors who can talk openly with them in a safe and comfortable office environment and in an unhurried manner. Of particular importance to most teens is to find a pediatrician of the same sex. Some teens respond better to an older doctor, some to a younger doctor, some to a doctor in authoritarian dress and demeanor, and some to a doctor who eschews those trappings.

Teens are famous for their unpredictability, fickle behaviors, and nihilistic approach to any guideline or suggestion, and their opinions can change faster than their thumbs can beat out a message on their phones. Your most important job is to communicate well and focus your questions to the teen and not to the parent. At the end of the visit, you should ask your teen patient how it progressed. A shrug of the shoulders is an affirmative. If it did not go well there will be anything from no response to a stinging, in your face, review. Listen carefully. Acknowledge that you are now aware of their concerns. Do not be defensive.

Some teens may prefer to speak with the doctor without the parent in the room. The teen may state this desire spontaneously, or after a certain age (sometime after puberty) you can ask the parent and the teen, at the same time, if they would prefer to start the interview and exam with just you and your patient. Make certain you make it clear that you will call in the parent after the interview and exam. You can get a lot of information from the response of both. A same-sex chaperone during a physical exam with a teenager is always mandatory, even if the physician is of the same sex as the patient. This is an inconvenience, but just one misunderstanding can ruin a career.

A private exam is an opportunity for the child to discuss issues they believe will result in either increased tension or outright confrontation with their adult guardian or parent. Some parents balk at this, believing they have a right to be present and have been frozen out of an important conversation. Explain that the alternative to a parent not agreeing to their child's request for private time with the doctor is to not give their child the opportunity to discuss a bothersome health issue with an expert. After the private consultation, you can ask the teen if he or she would like to bring the adult into the conversation, if appropriate. You can ask the teen what they do not wish to discuss with the parent and why. As with guilt, it is the unanswered questions that engender the most anxiety.

Immunizations

After maintaining proper nutrition and hygiene, keeping a child's immunizations and medical records up to date is the single most important medical task a parent can accomplish to prevent serious illness. Yet some parents refuse to allow their children to receive the recommended vaccinations. It is beyond the scope of this chapter to discuss, in detail, immunization-hesitant parents, a group distinct from parents who are intransigent "anti-vaxxers." However, whether you

are a pediatrician, primary care practitioner, a subspecialist in surgery or internal medicine, or a researcher, because you are involved in healthcare you will probably get asked at some point in medical or social interactions your opinion of immunizations. Even in our own personal experience, we have close, older family members who refuse to receive influenza, pneumococcal, or pertussis booster vaccines. As a result, they are respectfully but forcefully asked to not visit any of our homes where there are infants or immunocompromised family members during the flu seasons. No amount of shaming, social isolation, or directly addressing their fixed, false beliefs will change their minds. Yet because we are respectful, we maintain a close family relationship, given the above constraints. The good news is the opinions of these older adults have not been passed on to their children.

As alluded to above, you will find hesitant parents who just want their fears addressed in a respectful and truthful manner. They are not "anti-vaxxers." They are aware of some of the false information being disseminated on the social networks and do not know what to believe. You are an expert source, and for those parents who are not suspicious of a "conspiracy," or that physicians have some sort of self-interest in recommending immunizations, or are not among those who are distrustful of any authority, you will find a receptive audience eager to obtain the best medical care for their children and willing to listen to what you have to say. We have referenced further resources on how to approach these families here [4, 5]. For a short history of the development of vaccines by year, see this article from the Children's Hospital of Philadelphia [6]. You will find a complete listing of recommended immunization schedules for infants, children, adults, as well as a catch-up immunization schedule here [7]. For a full discussion of the ethics specifically supporting the pediatrician's responsibility to inform parents of the overwhelming evidence supporting childhood vaccination, see this article by Chervenak, McCullough, and Brent in the *Journal of Pediatrics* [8]. The authors make a strong case that the child's primary

care physician, usually the pediatrician, has a strict legal obligation to report child neglect to local child health protective services in the event that parents, despite repeated attempts at counseling including the provision of accurate information, continue to deny childhood immunizations to their child. While strictly ruling out extreme measures, such as removal of the child from the home, the police powers of the state can be ethically applied to support immunization as a prerequisite for school attendance based on the concept of beneficence. This concept was discussed in an earlier chapter on professionalism.

An inexpensive way to obtain needed childhood immunizations is through a public health clinic. If you recommend a public health clinic to your patient, usually out of cost concerns, make certain you check your patient's immunization schedule at each follow-up visit. It has been our unfortunate experience to have asked a parent of a very ill child if his immunizations were up to date. The parents answered that they were, but as it turned out they were not and treatment for diphtheria was unfortunately delayed.

The Importance of Being Hopeful

(apologies to Oscar Wilde)

> *The miserable have no other medicine, but only hope.*
> —Claudio in *Measure for Measure*

In the previous chapter, we discussed the importance of hope in providing comfort to the patient nearing the end of life. We have included a discussion of the role of hope in this chapter on pediatric care because nowhere in life events does a devastating diagnosis create more shock and need for hope than when giving unexpected and potentially discouraging news to the family of a newborn or young child. Such a diagnosis can be shocking and can emotionally disable an adult. In today's world, as distinct from that of only three generations back, it is the nature of life to expect our children and grandchildren to outlive us as parents and

grandparents. Further, nowhere does a child's innocence and brilliant smile toward the future get more of a test than in a hospital ICU.

Carroll et al., in an article in *Pediatrics*, July 2018 [9], noted that not all unexpected news is bad news. They point out that our unconscious, predetermined attitudes toward a particular subject or patient will influence our behavior, including how we deliver unexpected news. These unconscious attitudes form our implicit biases. Usually used in the context of racial biases and how they affect the treatment of patients who look or act different than the treating physician, in the context of unexpected news, implicit biases include the physicians' attitudes toward patients with certain diagnoses. An obvious example is the following: On one occasion, shortly after we began caring for premature infants in a newly established NICU, the Chief Medical Officer of the hospital, an orthopedic surgeon, approached us. He opined that perhaps an NICU was not such a good idea, because "all the patients you treat will just end up with cerebral palsy," thus revealing several implicit biases. We addressed these biases, which he held perhaps because of patients he had treated or what he had observed many years previously. However, such misunderstandings and poor communication can result in real suffering.

Some biases are not so obvious. Many years ago, we cared for a 24-week premature baby born after a prolonged period of ruptured membranes marked by amnionitis. Meticulous nursing care and weeks in the NICU resulted in weaning the baby off oxygen, full nipple feedings, and readying the baby and family for discharge. As part of the routine protocol at the time, a CT scan prior to discharge revealed extensive damage to the brain white matter, periventricular leukomalacia. The nurses gave the news to the parents, who were at the bedside when the baby returned from the imaging suite. Although the family had been counseled concerning the outcome statistics of 24-week preemies, nevertheless the news was understandably upsetting. Naturally, the family was distraught.

We were paged stat to the bedside. We reassured the parents that their role had not changed one bit since before the baby went for the test. Their job, as is any parent's, was to raise the child to achieve the best possible outcome given the child's potential. While that potential might be diminished from what they had expected before complications affected the pregnancy, just as before the test, we did not have any idea of what that potential would be. Of course, the news was a disappointment, and as Carroll et al. point out, although the parents mourn for the loss of what they thought they had, they still loved what they did have.

How might this have been done in a manner to avoid a situation where the family is devastated and hope has been withdrawn? In the last chapter, we discussed how to foreshadow what you are about to say, a kind of verbal warning that what is to come is not going to be pleasant. But be careful how you frame what you are about to say. Your words will be remembered forever. Do not start with "I have some bad news…" or "I'm sorry but…" These statements reveal your implicit bias about the diagnosis. A child with spina bifida may not turn out to be bad news, but it can be unexpected if prenatal care was lacking. A child with cerebral palsy may not be a source of grief for what the child cannot do, but rather of great pleasure and accomplishment for what the child can do. A fetus with Trisomy 21 will result in different decisions for different families.

When we have to deliver news to a family that might not meet their expectations, it is important to consider our implicit bias, rehearse what we are about to say, make certain the news is given by the doctor and any other professional who has become close to the family, and in a quiet space. Frame the news, if appropriate, as unexpected. Listen to the parents' response. Do not be somber. Every baby is an opportunity for joy, except in rare cases. Offer hope, a plan, resources, and guidance. Make clear you and the medical system will not abandon the baby and the family.

Of course, some news is clearly bad. In these cases, you can offer comfort, guidance toward resources, and expertise as the problem progresses. Never try to predict the future. There is a great temptation to display your newly acquired knowledge, but you do not know to any degree of certainty what will happen in the next hours, days, weeks, years. And again, never let your families feel you are abandoning them.

Professionalism in Pediatrics

In an earlier chapter, we discussed the concept of professionalism. The principles we touched on span the spectrum of all medical specialties and subspecialties, including basic science and clinical research. However, in pediatrics there are certain issues requiring special expertise and they merit mention. A further in-depth discussion on how to teach and evaluate professionalism in general and in pediatrics in particular can be found here [10]. Previously we emphasized that professionalism is never a completed process. It is a continuing journey of improvement and education. As we spelled out, professionalism is a manner of becoming, and one is in the process of becoming throughout one's professional career.

The American Board of Pediatrics lists the following as principles of professionalism that can be measured and that the Pediatric trainee is expected to be able to practice as part of the core curriculum. The medical student is not expected to fully master these principles; however, it is important to know what they are—excellence, humanism, accountability, and altruism. The incorporation of these four principles can be demonstrated by the trainees' behavior and also measured by examining trainees' clinical competence, communication skills, and ethical understanding.

Since the recognition of pediatrics as a specialty within medicine, pediatricians have been advocates for the individual child and for all children. The recognition that children are not just "little adults" has been one of the founding

principles of both the American Pediatric Society and the American Academy of Pediatrics [11].

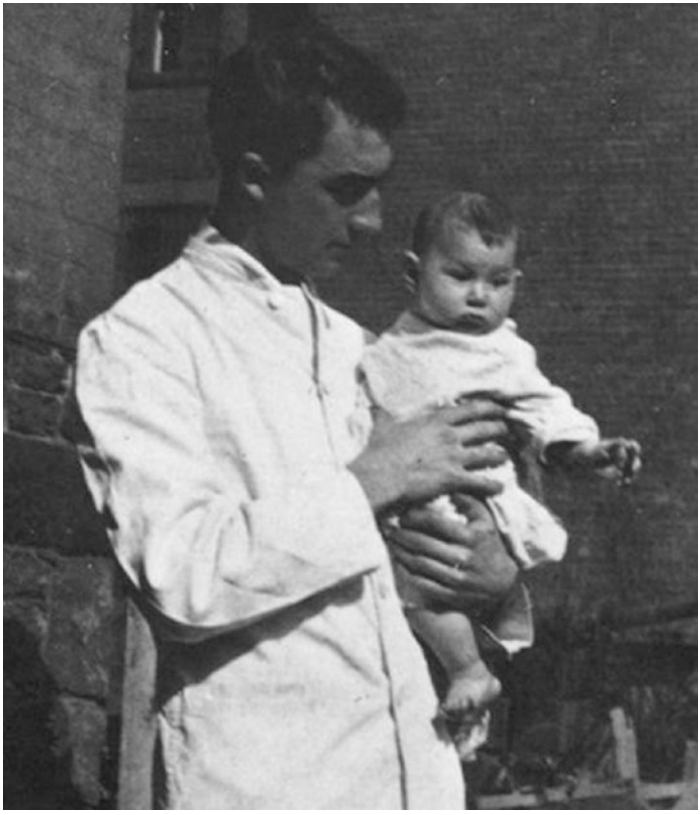
The pediatrician must care for the child in collaboration with the family. The special nature of this responsibility lies in those cases where the concept of beneficence applies to the child and may diverge from what one or the other of the parents believes is best for the child. A good example is when the parents are confirmed in their false belief that the risks of immunizations exceed the benefits that would accrue. Another example might be concerned with a family in transition, divorce, or economic inequities between the mother and father and where or if the child should receive medical care.

While compassion and empathy are essential values for any physician, a pediatrician must try to understand pain, fear, and the ability to trust from the child's point of view as well as from the point of view of his parents. The pediatrician must evaluate the child's ability to understand and communicate, and involve children in their care given the constraints of understanding and communication. This is also critical when it comes to informed consent and dialogue as to treatment.

We also wish to emphasize the values without which one cannot be a truly outstanding physician in any field. Patient well-being is the primary motivation of truly caring for your patient. "The patient comes first" is not just a shibboleth the authors learned in medical school 55 years ago; it is as true now as it was then. "Altruism and advocacy" are considered core values of professionalism by the American Board of Pediatrics. A prime example of the importance of both values is in the story of the Flint River water tragedy and Dr. Mona Hanna-Attisha's courage to save her community's children [12].

In our experience, those doctors who practice general pediatrics are committed to the idea that their patients' health is their first priority. Pediatricians are among the most accessible and dedicated of our colleagues. In the movies, the pediatrician is often portrayed as a kindly dedicated

physician. Our observation in working with our colleagues bears out that perception.



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William Carlos Williams
Physician Poet

William Carlos Williams was born on September 17, 1883, in Rutherford, New Jersey. He knew from an early age that he wanted to write and be a doctor. Williams studied medi-

cine at the University of Pennsylvania, where he met Ezra Pound, the poet, who mentored his writing and assisted with the publications of a collection of his poems, *The Tempers*, published in 1913. In 1910, Williams begun his pediatric practice in his hometown. He continued to publish, writing plays, poems, novels, and essays. He was a major writer in the modernist movement, helping to create a clear American voice. A heart attack in 1948, which was followed by a series of strokes, resulted in his retirement from medical practice, but he continued to write until his death on March 4, 1963. His awards include the National Book Award in 1950 and the Pulitzer Prize in 1963.

The Dead Baby
by *William Carlos Williams*
Sweep the house
under the feet of the curious
holiday seekers —
sweep under the table and the bed
the baby is dead —
The mother's eyes where she sits
by the window, unconsoled —
have purple bags under them
the father —
tall, wellspoken, pitiful
is the abler of these two —
Sweep the house clean
here is one who has gone up
(though problematically)
to heaven, blindly
by force of the facts —
a clean sweep
is one way of expressing it —
Hurry up! any minute
they will be bringing it
from the hospital —
a white model of our lives
a curiosity —
surrounded by fresh flowers

Issues Discussed in this Chapter

- Why pediatrics is different than other medical specialties.
- The role of the pediatrician.
- Older children can be encouraged to contribute to discussions about their illness and their management.
- A pediatrician must communicate effectively with both child and parent(s).
- The medical encounter can be an opportunity for a child to learn how to participate in adult style interactions.
- Some teenagers will prefer alone time with the doctor during the exam.
- Uses and pitfalls of digital communication.
- Talking about immunizations.
- Unexpected news and what not to say.

Study Guide

1. Describe how you determine when it is appropriate to interview a child, discuss an illness, and confer about treatment.
2. How do you calm a child to whom you have to give a shot?
3. How do you address the parent's concern that you respect their authority over their child while respecting the child's autonomy?
4. What is the essential information that parents must leave the office with?
5. What are some of the best behaviors to practice when communicating with a teenager?
6. What recommendations do you give parents who refuse to immunize their children?
7. Discuss conveying sad news to the parents of a newborn and how you would have managed the baby with periventricular leukomalacia.
8. What is meant by accountability when considering professionalism in pediatrics?

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11. Sir William Osler, known as the father of modern medicine, was also a founding member of the American Pediatric Society, an invitation only group of notable clinical pediatric researchers, and the fourth president of that institution. About 10% of his clinical papers, mostly when he was working in Canada, deal with childhood disease according to Tonse Raju writing in Pediatric Research in 1998. The American Academy of

Pediatrics, established in 1930, gave all pediatricians an organization to support their work to be a "beneficent influence on the life and health of those patients whom the pediatricians will reach" said Isaac A. Abt, in the first presidential address of the American Academy of Pediatrics on June 12, 1931.

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