BEYOND THE WHITE COAT

Committed

It is such a common scenario. It might be 4:45 p.m. in a rural, two-doctor office, or 9:30 a.m. Saturday during rounds in the nursery, or 11:55 a.m. in a teaching hospital. You are waiting on just one more lab result before you can finish that last patient encounter of the day, but you are also running late for your daughter's soccer game. Do you stay and finish up, or sign the problem out to your partner who is on call?

I was taught there are three "coms" that characterize ideal physicians: They are competent, compassionate, and committed to their patients above all else. Those three characteristics are reflected in the mirror each morning. Your reputation is built on them. Your patient trusts you because of them. But you don't want to disappoint your daughter, either. "So," says the little voice in my head, "just how committed are you?"

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Dr. James Gordon reflects on this in the American Medical Association Virtual Mentor column "Sharing the Pain" (Virtual Mentor 2007;9:508-10).

"In the old days, anyone who wanted to go into medicine had to be prepared for a life of exhaustion. Before laws and regulations prohibited one-in-two call, we were rapidly conditioned to accept the idea that the life of a doctor was not only one of service, but a kind of servitude. … In the first year of residency, the fledgling doctor learns never to leave work for anyone else at the end of the day."

Dr. Michael B. Edmond reflects on how this has changed for today's newer physicians in "Taylorized Medicine" (Ann. Intern. Med. 2010;153:845-6).

"The marked changes in the way we conduct our business in teaching hospitals have been driven by advances in technology that have improved the process of care. … But the biggest changes have been driven by the rules of the ACGME on resident work hours and their rigid enforcement.

"Every resident now has an invisible but heavy stopwatch sitting on their shoulder, ticking loudly, constantly reminding them that their task list still has many unchecked items as time slips away."

Dr. Edmond claims that in the past, "part of the maturation process for young physicians was coming to terms with the daily unpredictability and lack of control associated with caring for acutely ill inpatients."

Dr. Gordon claims that in his era, "regardless whether you had been up all night, you did not leave loose ends for your colleagues." He goes on to claim that, "in the end, most of us embraced the pain, which made us a fraternity."

But what I see is that Generation X and Y physicians have developed a different solution with a different work-life balance. These newer doctors don't and won't work the long and particularly the unpredictable hours that the prior generation did. They don't have a spouse who runs the household. They have kids at day-care who need to be picked up on time. Many prefer working 0.8 full-time equivalent (FTE). So they have adopted a different work ethic. They recognize that unpredictable events sometimes – even routinely – make it necessary to sign out work to the on-call colleague. The new fraternity is committed to relieving last night's on-call person, and expecting the same when it is their turn. Work flow is organized to hand off tasks to ensure that the patients' needs are always paramount. The technological tools for carrying out these handoffs aren't working smoothly – yet.

There are advantages to this new paradigm. It reduces the House of God attitudes I saw in medical school, and that will benefit patients. It will also benefit physicians as we balance our professional and personal lives.

Personally, I'm comfortable being cared for by a doctor from the older generation, whose commitment was evident in his long hours. Of course, that assumes that those excessive hours haven't spawned burnout, substance abuse, or divorce – all of which would negatively impact my care. I have the expertise and wealth to afford such a doctor, if I could find one who isn't too busy. But Henry Ford reminds me that the horse and buggy aren't the way of the future. ■

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SUBSPECIALIST CONSULT

Initiation of Gynecologic Care in Healthy Young Women

It is important for pediatricians to recommend that their female patients seek gynecologic care by age 18 years at the latest. However, there is a role for gynecologic care as early as age 14 or 15 years in this patient population if a teenager is sexually active, is considering becoming sexually active, or has problems with her menstrual period.

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Make it a policy to take the gynecologic history with the patient without the parent being present, starting at the age of 14 years or earlier, on an individualized basis. Asking the parent to leave the room as a part of routine practice makes this discussion far easier.

Start your consultation by asking specific questions about the girl's menstrual period. Oftentimes, their periods are irregular, painful, or heavier/longer than they think is normal. If this is the case, it is appropriate to refer your patient to a gynecologist. Also refer your patient if she expresses an interest in seeing a gynecologist for any reason.

Ask about boyfriends, sexual activity, and birth control. Often, girls do not want their parents to know about their sexual activity. I recommend you tell parents that you routinely recommend referral to a gynecologist at a certain age to address menstrual issues. This is an easy way to bring up the subject without making the patient or parent feel uncomfortable.

As a general pediatrician, you can manage this type of patient if you feel comfortable with discussion and management of problematic periods, birth control, and sexual activity. You also should be comfortable with counseling your patients on sexually transmitted disease (STD) prevention and other preventive tools, such as the human papillomavirus (HPV) vaccine.

I want pediatricians to routinely discuss the HPV vaccine with their patients and parents. The HPV vaccine is ideally given to young women before they are sexually active, as early as age 9 years. By the time most girls see a gynecologist for the first time, they are already sexually active and have already been exposed to HPV.

Pediatricians can help by encouraging parents to vaccinate their 9- to 13-year-olds. This discussion also should be taking place with parents of boys.

I realize that there is a wide range in how pediatricians practice. Some feel completely comfortable with gynecologic care in this age group and will perform gynecologic exams, STD testing, and prescribe birth control if necessary. Others might have the discussion and then refer if an exam or prescription for birth control is required. Others may not even feel comfortable having the discussion. So I think gynecologic referral of a patient in this age group is based on the comfort level of the pediatrician.

If you do refer to a gynecologist, you can help prepare a girl by letting her know what to expect. For example, if a girl is being sent for evaluation of vaginal discharge, the patient needs to understand that she is going to have an internal examination with a speculum. I have seen several young women for evaluation of this problem who were surprised that I had to examine them. Discharge cannot be appropriately evaluated simply by talking to the patient. So you can alleviate a lot of anxiety by explaining the exam to the patient ahead of time.

On the other hand, not every young woman needs to be examined during her first gynecologist visit. If her initial appointment is a discussion regarding menstrual cycles or birth control, I often just take a history to establish rapport with the patient. I often want to do this in private, without a parent, so that I can comfortably ask questions about personal issues such as sexual activity. It is very helpful if you can prepare the parent ahead of time that this private discussion will need to take place.

Several physician organizations provide recommendations and other guidance for management of these patients. The American Academy of Pediatrics provides relevant resources for pediatricians. For example, in September 2010, it published a Clinical Report on Gynecologic Examination for Adolescents in the Pediatric Office Setting (http://aappolicy.aappublications.org/cgi/content/full/pediatrics;126/3/583).

You also might consider consulting with colleagues, including an ob.gyn. or a pediatrician who is fellowship trained in adolescent pediatrics. ■

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