Letters From Maine

Reflecting on Education

BY WILLIAM G. WILKOFF, M.D.

If you have a minute—and I suggest that you not invest much more than a minute—turn to the commentary section in the back of the December 2005 issue of Pediatrics.

There you will find an article by a physical therapist, Margaret M. Plack, Ed.D., and a physician, Dr. Larrie Greenberg, titled "The Reflective Practitioner: Reaching for Excellence in Practice" (Pediatrics 2005;116:1546-52). It's pretty heavy stuff, full of words like "constitutive" and "contextualize."

One sentence is 74 words long. One reference, they say, compares "good evidence to a DNA double helix." Now there's an analogy that's guaranteed to clarify. It turns out that there are so many definitions of reflection that another pair of researchers felt the need to subject them to metaanalysis.

Don't worry, though, because I've done the heavy lifting for you. For some reason, as yet undetermined, I read the whole damn article and learned that "reflection is more than just stopping to think and act based on what we already know." It turns out that, while you and I have been in the trenches promoting health, waging war against disease, and trying to stay out of the lawyers' crosshairs, someone slipped another cornerstone into the foundation of medical education. It's called reflection, and it's sitting right next to that other newcomer, evidence-based decision making.

Now, I may be oversimplifying what Dr. Plack and Dr. Greenberg have to say, but it sounds as though all of us at every level of pediatric training and practice should be taking the time to think about what we've been doing, why we've been doing it, and whether it makes sense to keep doing it. It's hard to argue with their rationale, but there is that bothersome little piece about *the time*.

Stimulated by my plunge into the cold and deep waters of educational erudition, a few nights ago I found myself feet up, favorite locally brewed beverage within reach, considering how I would reinvent medical education. Who knows, I may have been reflecting. I even may have been epiphanating. Whatever you choose to call my condition, it's clear I shouldn't have been operating heavy machinery or seeing patients.

So here are my thoughts. I would mandate that all college students considering a career in medicine major in one of the humanities. History, art, music, religion—you get the picture. My decision to major in art history is one I have never regretted.

During the summer, these premeds must have a real job, preferably one in which they must interact with or serve the public, or work shoulder to shoulder with people who haven't and aren't planning to go to college. I am continually disappointed to learn how many young physicians don't really understand the everyday microeconomic challenges faced by their patients. I am also troubled by how many physicians don't have a clue about basic rules of customer service that could be learned by working for any successful shopkeeper or restaurateur.

Once these future physicians are in medical school, I would encourage them to shadow a wide variety of doctors from many specialties. As often as possible, these visits should include sharing an evening meal in the physicians' homes so that the student could get a more multidimensional picture of a physician's life. These glimpses can be valuable aids in both career modeling and pitfall avoidance.

After postgraduate training has begun, I would encourage new physicians to see as many patients as they can. Hidden in the commentary on reflection was at least one kernel of truth: "Experience is at the core of learning in medical education." We can ask a student to read, discuss, and reflect on a single case of scarlet fever until the cows come home, but that student is going to be a much more effective clinician once he or she has had the opportunity to see so many scarlatiniform rashes that the sight diagnosis becomes second nature.

Freed from the diagnostic fumbling that comes with inexperience, students can spend their time and energy exploring the nuances of how individual patients deal with disease. Familiarity with the commonplace makes sorting out the unusual much easier, but experience means seeing 15 patients with scarlet fever, looking at 2,000 tympanic membranes, and listening to a dozen depressed teenagers tell their stories.

The problem is that we're back to that troubling piece about time. Sufficient time for physicians in training to see enough patients is in short supply these days, particularly if we have decided that it is important to protect them from sleep deprivation. Fatigue or experience? Now there's a dilemma worthy of some deep reflection. ■

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Letters

Dr. Smith to the Rescue

I am a pediatrician in a rural area, and a few days after I read Dr. Laurie J. Smith's advice, a 9-year-old girl with known peanut allergy walked in with a swollen face and itchy skin ("Be Aggressive With Suspected Peanut Allergy," November 2005, p. 34).

The girl had been at school building gingerbread houses when the symptoms started. Her wonderful mother had an EpiPen Jr. device with her when they arrived at my office. Within minutes, the medicine was administered, even though the mother told me that her daughter had been given Benadryl and was not having respiratory symptoms.

I thank Dr. Smith for her wonderful advice. I was able to confidently treat this young lady. I mailed a copy of the PEDIATRIC NEWS article to the mother; she was so grateful.

Patricia Sabatini, M.D.
Canon City, Colo.

Dr. Smith replies:

Although most acute reactions to peanut ingestion are not fatal, the potential always exists, and presently we have no tests to determine who is at risk for a severe reaction.

A child who had only mild cutaneous symptoms upon peanut ingestion has about a 75% chance of having more severe symptoms, including respiratory or cardiovascular symptoms, on subsequent exposure. Because of this, if you see a child within a range of minutes to 2-3 hours of ingestion, and there are only skin symptoms, it is still very appropriate to administer epinephrine. Dr. Sabatini's treatment was totally appropriate.

If you see a child 6-8 hours or later after a peanut ingestion, and the vital signs are stable with only skin symptoms, it is reasonable to withhold epinephrine at this time because most severe, life-threatening symptoms would have occurred earlier.

Don't X-Ray Children Unnecessarily

A recent article summarized the results of a study in which a multivariate analysis was used to determine significant predictors of clinically relevant chest x-rays in children with asthma ("Relevance of X-Rays Tied to O_2 Saturation," November 2005, p. 36).

While the information presented may be interesting, it misses a much more important issue: Should we be obtaining routine chest x-rays in pediatric patients with exacerbations of asthma? In the vast majority of cases, the results of these chest x-rays do not influence the management of the asthma exacerbation. Even if pneumonia is suspected as a comorbid condition, or as an exacerbating factor, the diagnosis should be made clinically, and treatment should be offered only if a treatable etiology (such as *Mycoplasma pneumoniae* or another atypical bacterial pathogen) is suspected. Chest roentgenography should be considered if patients fail to respond to therapy, or if an etiology other than asthma is suspected, and even then, only if the results of the x-ray are going to help direct therapy.

Let's stop the unnecessary irradiation of children.

Michael J. Verive, M.D.
Chicago, Ill.

Families and Anxiety

I am convinced that the article about anxiety disorders and families, and the research on which it was based, have it backward ("Teens' Anxiety Disorders Can Burden Families," October 2005, p. 28).

It seems to make much more sense to say that family anxiety places a huge burden on a child. Children do not become anxious in a vacuum. Children are the carriers of family anxiety. If a family has an anxious child manifesting symptoms, the family needs to switch its focus to itself. And those who are in the best position for this shift in focus, and who need to carry this work for the family, are the parents.

This is not to lay blame, but if psychiatry wants to help youngsters and families, I believe it has to start in the right place. The child with the symptoms (the identified patient) will probably show quick and significant improvement once the focus is off of him and once everyone in the family owns his own piece of the problem, starting with the parents.

I am a psychiatric nurse-practitioner and a Bowen Family Systems Theory coach. BFST deals with anxiety as it jumps from one to another within families and how it goes from generation to generation.

A coach helps parents identify their issues and resolve them at their level. Coaches also help parents look back into their own families for anxiety patterns. Guaranteed, everyone will relax and the "anxious" child who is "burdening" everyone will have space to do his own work.

How can we lay this huge responsibility on a child? How can we say, "You're making everyone nervous," and then expect him to grow calm? How can we hold a child responsible for an entire family? Look first to the family and "give the kid a break!"

M. Cybil Britton
Severna Park, Md.

Can't Nap? No Coffee? Try Coughing

I agree with Dr. Rebecca Smith-Coggins's recommendations, but when I'm driving home after a delivery at 3 a.m., a highway parking place (for a nap) or a fast-food resource (for coffee) is not available ("Don't Drive Drowsy: Nap, Coffee Help," The Rest of Your Life, August 2005, p. 58).

I would submit that one is often aware of the risk of falling asleep at the wheel. That is the time to start coughing. The increased intrathoracic pressure is transiently transmitted to the superior vena cava and cerebral venules and capillaries, perhaps leading to a brief increase in oxygen availability. This will buy a lucid moment and a little time to avoid a disaster. I've coughed my way home many times. Downside: none.

Leonard M. Roberts, M.D.
New York

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