Incompetent

William N. Marshall, Jr., MD

From the Department of Pediatrics, University Medical Center, Tucson, Ariz
The author declares that he has no conflict of interest.
Address correspondence to William N. Marshall, Jr., MD, Department of Pediatrics, University Medical Center, 1501 N Campbell Ave, PO Box 245073, Tucson, AZ 85724-5073 (e-mail: marshall@peds.arizona.edu).

Received for publication March 30, 2013; accepted May 15, 2013.
ACADEMIC PEDIATRICS 2013;13:290–291

ON WEDNESDAY MORNING, the residents have teaching sessions and the pediatric faculty attendings see the patients in clinic. On one of these mornings, I was one of the attending physicians in clinic. I didn't recognize the name of the patient I was about to see, so I quickly reviewed the electronic chart before entering the room. It was 8-year-old Jacob's second visit to our clinic; he had been first seen in our clinic nearly 2 months earlier for a well-child visit. The family had moved from the Northwest, and Jacob was a generally healthy boy who was on stimulant medication for attention-deficit/hyperactivity disorder (ADHD).

I knocked, entered the room, and shook hands with and introduced myself to Jacob's mother. When I offered my hand to Jacob, he was too busy to respond; he was arguing with his mother, trying to pull his little brother away from his chair, then jumping up onto the exam table. I sat down, but before I could begin the interview, Jacob's mother stated, "We're here for a mood stabilizer."

I started to describe what I had learned from the chart and ask about things like his new school. Jacob's mother was frustrated: "It's all in the psychiatry notes from our prior home; I signed to have them sent at our first visit. He's only gotten worse. You need to prescribe a mood stabilizer." Meanwhile, Jacob continued talking, sometimes shouting, moving about the room, looking inside his mother's purse, trying to pull his little brother off his mother's lap, tearing the paper off the exam table, and attempting to take my stethoscope from around my neck. Jacob just laughed and turned away when I asked him about school.

I could feel tension and frustration in the room. But I remained calm and reflected to myself that, by doing so, I would be able to decrease the level of stress in the room and perform a better history and physical exam (for many years, I had taught interview skills for crisis situations to medical students and residents). I had not seen the out-of-state pediatric and psychiatry records, so I entered my password and opened the electronic medical record to review them. They weren't on the main chart screen, so I looked at the other screens, but to no avail. I told Jacob's mother I couldn't find them; she insisted they must be there.

"Why don't you tell me more about your understanding of the psychiatric assessment and plans from before?" I tried again to say something that might be helpful or productive.

She looked at me angrily. "You are incompetent. I am not impressed with anyone in this clinic. He needs a mood stabilizer and all you do is look at the computer screen. You don't even make eye contact. You are incompetent."

I had been frustrated with this encounter, but now I was angry. I was board certified; I had treated many children with similar problems and with good results. Maybe this mother was incompetent or had her own mental health issues; her child was certainly out of control.

But I also felt guilty about spending the time looking at the computer. Although I knew I had gone into the room and tried to establish eye contact and build a relationship, the search for records became my focus, and I found myself clicking from one screen to another. In this situation, it feels like the computer is the focus, not the patient or family. Author and internist Abraham Verghese[1] has written that our medical trainees have become more and more distant from the real patients and more focused on the screen–the iPatient. Maybe I was doing the same thing.

I was starting to doubt my own competence. Was I being a little too conservative about starting additional medications for ADHD that didn't seem to be responding to psychostimulants? Like most pediatricians, I probably hadn't studied enough about mood stabilizers and was more comfortable with psychostimulants. Perhaps this was the time to try something different.

I remained calm despite my rushing feelings and tried to renew the conversation, but then I suddenly felt a push that made me lose my balance, collide with the desk, and almost fall off the wheeled office chair. It was a jolt from Jacob who, perhaps feeling ignored, had thundered into my chair from across the room.

Jacob's mother reacted quickly by enveloping him in a whole-body hug while he screamed, and she loudly told him to calm down; his little brother and I, in opposite

William Marshall, MD, is professor of clinical pediatrics at the University of Arizona College of Medicine. Recently published essay topics include challenges to practice at the Arizona–Mexico border and care of a severely disabled newborn.

corners of the room, just observed quietly. Jacob continued to scream, but his mother again turned to me and shouted, "Now you see. This is what he is like. He needs to be on a mood stabilizer. I want to talk to someone here and file a complaint."

I told her I would go and talk to our social worker and return with some medication options and information about behavioral health specialists for Jacob. I didn't add that I desperately needed a break.

When I left the room, the staff outside was looking at me, wondering what had been going on in that room. I first talked with our clinic manager, who confirmed that we hadn't received Jacob's prior records. Next, I found our clinic social worker and asked her to meet with the family and me in a few minutes to review some options for continuing care. I took some time to review Jacob's methylphenidate dose and found that it was probably too small for his weight. I took some deep breaths and reentered the room.

The atmosphere was better. I spoke without interruption, Jacob seemed calm, and his mother listened to my plan for an increased dose of the methylphenidate and an appointment with either a child psychiatrist or one of our clinic's behavioral pediatricians. We would try again to obtain the old records. I asked Jacob about what he thought he might be when he grew up, and instead of constant motion and attempts to distract us, he looked at me straight in the eye and said, "I want to take care of animals." We talked happily for a few minutes about his favorite animals. The social worker arrived, and I left to write the prescription.

Thinking about the visit reinforced some lessons for me. Although I teach preclinical students about handling challenging patient encounters, I am often humbled when I have to be the clinician on the spot. It takes emotional energy and the risks of psychic—and at times physical—injury. It is far easier teaching the principles using standardized patient scenarios with their reassuring but unreal predictability.

Over a century ago, William Osler[2] taught medical students that imperturbability was an essential component of a doctor's persona, and I returned to this principle now, as I have often before in my career. Although my inner self was experiencing a range of feelings from anger to self-doubt to compassion, I think in the end I mostly succeeded in helping this family.

Finally, I realized the power of taking extra time with patients. I could have decided to cut things short and just write a prescription for a mood stabilizer, simply tell the mother we had to wait for the old records, or just send the family off to the patient representative to complain about me and the clinic. My assessment of the child, if only based on the initial moments in the room, may have included parenting problems, an out-of-control child, severe aggression, ADHD, disruptive mood dysregulation, possible autism, and likely bipolar disorder. Any or all of these diagnoses may still be appropriate—or not: a brief glimpse into a child's behavior and a parent's reactions are not enough.

When I finished the clinic at noon, I was exhausted but relieved. With the help of the clinic staff, I had assisted Jacob and his family to navigate a system where continuity of care, accessibility of family-centered services, and availability of medical records are imperfect. I didn't prescribe a mood stabilizer and I wasn't sure he needed one, but I had identified some possible steps to improve his life at home and at school. I had relearned what I teach trainees: engage the family, not the computer screen. I felt competent.

REFERENCES

1. Verghese A. Culture shock: patient as icon, icon as patient. *N Engl J Med*. 2008;359:2748–2751.
2. Osler W. Aequanimitas. Available at: http://www.medicalarchives.jhmi.edu/osler/aequessay.htm.