Relative Comfort

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ACADEMIC PEDIATRICS 2018;18:601–602

AFTER ROTATING IN and out of the adult emergency department (ED) for more than a year, I felt comfortable surrounded by the bustling physicians, endless charts, and flashing monitors. The pediatric ED had seemed unfamiliar on my first day, but I was eager to get started. I picked up one of the cold metal charts staring back at me, unaware that this patient would teach me a simple, yet valuable, lesson that might prove useful for the rest of my life.

Lily was her name; she was a 10-year-old girl with lower right quadrant abdominal pain that had a textbook-quality description to it. She came to the ED with her 2 sisters, mom, and dad, who all pitched in when describing the events of the night. From discussions and lectures in medical school, I remembered this condition was easily worked up with focused laboratory tests and imaging. However, in these teaching cases I had never considered the patient's pain or anxiety for longer than a few seconds, if at all. Unfortunately, that pain and surrounding emotion was likely the very impetus for the ED visit.

As I approached Lily's room, the giant purple "4" on the door confirmed her location, and I felt brightened by the miniature giraffes on the wall ushering me inside. However, the bright colors and animals seemed dulled once inside the closet-sized room crowded with anxious faces.

Lily's pain started as diffuse but localized to the lower right quadrant after a few hours, accompanied by nausea, fever, and loss of appetite. From the beginning, the little girl's history and examination seemed straightforward, even to my limited medical-student understanding of pathology. Her family had many questions, such as why she felt so nauseated, why she had a fever, and whether she just needed to have a bowel movement to feel better. Because Lily had seemed perfectly healthy just hours before, her parents couldn't grasp how she could become so ill so suddenly. They explained that the family had been sprawled about the living room watching a Disney movie, when suddenly her belly started aching. The pain increased over several hours, until it became almost paralyzing while we talked—she lay motionless, curled on her side. I explained to Lily and her family that we were going to do some ultrasound imaging to see if we could determine the cause of the pain. Minutes later, she was wheeled down to the sonographer, and the ultrasound confirmed an inflamed and elongated appendix. I watched my attending physician stroll back into the room and confidently explain that Lily would be admitted and scheduled for surgery in the morning. He left to see his next patient.

The parents locked eyes with dismay, as if they were trying to decipher an impossible riddle. Although the air seemed heavy with questions, none were asked, and I left the room as well. While the paperwork was completed, the family awaited their journey to a hospital room a few floors above the ED and with even more electronic screens and sounds.

Leaving the room, I thought to myself, "We did our job, found the problem, and came to a solution … yet the family still looked shocked and confused. Why weren't they ecstatic and thankful that we were such amazing health care providers?" After all, in our medical school caselectures, we were always thrilled when we reached a definitive conclusion with such efficiency. Wanting to turn the family's bewildered faces into accepting ones, I decided to step back into their cramped room. I simply asked, "How are things going?" in an attempt to reach common ground, as if I were catching up with an old friend from high school. At that moment the floodgates opened, and I instantly turned from a medical student into a friend whose job was to simply listen. The parents explained they were shocked that their little girl was about to have a part of her intestine removed. They had assumed she had gas pains from eating pizza earlier that evening, and now she was going to have surgery? Without interrupting, I listened until the room seemed to have exhausted its frustration and worry. I then paused, validated their fears, and thoroughly explained, "Appendicitis is commonly seen here, and although this is all very foreign to you, the physicians and surgeons taking care of Lily are some of the very best; so I want you to know, you're in good hands." The parents then breathed a sigh and the huddled sisters seemed at ease. Yet, I don't think it was the magic

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of my words that quelled the anxiety that filled room just moments prior. I think my listening calmed the family, not my pep talk.

As a student, I am presented daily with fictionalized patient scenarios in some form. Typically, I jump straight to thinking about the disease, its pathophysiology, and treatment, followed by a swift transition to thinking about other tasks to keep up with a busy schedule. The hypothetic patients discussed during the first few years of medical education don't have much real-world context. Quite frankly, I don't think they always need to, especially if the swift pace of education is to be sustained. In contrast, the patients in the hospitals and clinics where I will spend my career have plenty of real-world context, with emotions, friends, siblings, and parents who are scared and confused, and will be looking to me as a physician for answers and sometimes, more importantly, comfort. After reflecting on the "appendicitis in room 4," I realized it wasn't just appendicitis. It was a girl who came home from school, ate her favorite pizza, and enjoyed a movie with her sisters, only to be told shortly afterwards that she needed to undergo emergency surgery the next morning while her friends began another routine school day. The family was worried because they had no experience with surgery and knew nothing about the hospital or its machines that constantly hummed and beeped. Was the machine's beeping an alert of something bad or routine? What do all the numbers on the monitor mean? Why is Lily being checked on by so many different people, and what are they typing in the computer? They were in a foreign place—a place that had its own language, protocols, and procedures—a place where I had become comfortable, but they, fortunately, had not.