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Case Report

The awakening of a physician by an 8 year old

Jonathan D. Baum, Andrew L. Atkinson

Jersey Shore University Medical Center, New Jersey 33, Neptune Township, NJ, USA

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Corresponding Author:
Jonathan D. Baum,
Jersey Shore University Medical Center, New Jersey 33, Neptune Township, NJ 07753, USA
JDBaum@meridianhealth.com

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ABSTRACT

Medical student and resident education continue to evolve. Long gone are grueling work weeks, public humilation and the speak-only-when-spoken-to culture. Now, educational objectives, duty hours, case logbooks, OSCEs, and simulators are quickly replacing the experience of working with an actual human being. We cite a case of an 8 year old girl presenting to the emergency department with a straddle injury to illustrate the potential negative impact of restricted duty hours on medical education.

BACKGROUND

I feel fortunate to have trained during the 1990s. I saw the closing moments of an era in which some surgeons believed that the problem with being on call every other night was that you missed half of the cases. I learned many basic skills through see-one-do-one-teach-one, although I was never really left alone until I was able to perform each skill safely. The amount of time I spent at the hospital during my medical school rotations was without artificial limit. I remember my first overnight call during my ob/gyn clerkship in 1993. Initially, not much was going on, the labor board was clear and the emergency department was quiet. I recall myself dozing off only to be smacked on the shoulder by the intern who said, "Let's go, we have a labor admission." That admission turned into my first vaginal delivery which sparked an interest in a field that I had all but eliminated prior to that day.

My co-author is a third year resident who learns in a system in which he must log duty hours, complete case logs and get special permission from the program director in writing in order to stay beyond the now coveted 24 hour shift [1]. We brought these two very different training backgrounds to the overnight shift one evening. Regardless of educational philosophy, it must be acknowledged that there are certain aspects of medical care that cannot be learned from a simulator or a textbook, one simply must be there to experience the moment. This particular night on call was such an occasion.

CASE SUMMARY

Aaron had just begun his 3rd year clerkship in obstetrics and gynecology. He was tall, thin, polite and eager. He was ready to learn. A group of students and I were discussing medical education as I lamented that they do not get enough extended shifts at the hospital. More reasonable work hours seem to make sense but at what cost to their education? Many of us involved in graduate medical education are beginning to question this trend. I was on call and wondered if any of them would join me to experience a night on call

as an obstetrician/gynecologist. It seems as though many of the best experiences develop during off hours.

It was just after 5 pm as the students readied to leave. My phone rang. It was a senior resident calling from the emergency room. "An 8 year old, straddle injury, bleeding," the resident reported. "Straddle injury, be right there". Aaron looked puzzled and asked, "What is a straddle injury?" While straddle injuries are common in children, Aaron never saw one during his pediatric clerkship. On the way to the emergency room I began the explanation focusing mostly on how to examine a scared little girl. I think Aaron was scared too.

Kayla was a talkative little girl hiding under sheets and blankets. She asked, "Are you gonna do surgery on me?" She was seen three days prior after she fell on her brother's toy with her legs apart. She had a superficial laceration which was hemostatic after the usual conservative measures of ice packs and tincture of time. No one wants to bring a little girl to the operating room unless absolutely necessary. It is hardest on the parents, but it is also hard on gynecologists because treating children is out of our comfort zone. No imaging or lab tests to confirm the diagnosis and ease our minds. Just the basics: history, physical exam and judgment.

Kayla's parents were eager to tell her story and show us the blood soaked diaper which they used to contain her vaginal bleeding. "Everything was fine, then all of a sudden she was bleeding again." As soon as I saw that and the bloody sheet covering this adorable little girl, I knew we were going to the operating room. However, I wanted to see if my resident would arrive at the same conclusion. Fortunately, with a bit of prodding outside the room, he concurred.

We had to wait another hour because of the bologna sandwich Kayla had eaten at noon. Paperwork was done. Consents were signed. Anesthesiology and the operating room were notified. Aaron had no idea what he might see in the operating room. He never expected that an ob/gyn would be operating on a pediatric patient. "Can I stay and scrub in?" he asked. "I'll make sure you see what we're doing," I told him. "For now, just hang back so we don't ambush this young patient with white coats." Kayla asked, "Why can't I just stay here?" I knew the more we hung around, the more frightened Kayla would become. "Because they don't have slushies here," I responded. The resident took my cue and added, "So if it's okay with you and your mom, we'll bring you there, fix the problem and get slushies". There was no suspicion of abuse. We felt her injury was an accident. At that point we heard an annoying beeping sound. "Why does it keep making that noise?" she asked. Her IV tubing was kinked. "Try to keep your arm straight and we'll check back in a little while."

We were all impressed with how brave and mature this 8 year old was. "If I miss school tomorrow, I'll need a note." "It's okay honey," mom said as she leaned over and kissed her little girl. Aaron was barely noticeable as he waited patiently. I knew he was excited and keen to help. It was dark out and he knew that no other students were around to steal this experience from him.

I wish more of my patients were as strong as Kayla. She did not flinch as we rolled into the cold, sterile room with bright lights and shining equipment that would terrify most adults. She moved herself onto the operating table and the nurses placed a warm blanket on her. The anesthesiologist had already given her something to relax but she managed a smile when I asked if she was okay. We figured it would be a quick case. A brief prep, frog leg positioning, find the source of bleeding, stitch and done. At least, that was what we thought.

The prep was quick as was the positioning. A new resident had taken over. We saw a small point of bleeding on the hymenal ring. We wondered if there was another injury that we were missing. "Aaron, come over here and describe what you see, is there another source of bleeding?" Most of us remember what it is like being the ignored medical student. You feel unwelcome and in the way. I wanted Aaron to feel comfortable and involved. Involved and part of something important. This little girl was important. Still, there was too much blood. We worried about her being able to void. Textbook diagnoses go through our minds, but this is a little girl, not a textbook. We don't want to hurt her.

There was a laceration through the hymenal ring that must have caused retrograde bleeding that was filling the vagina. We hoped that a nasal speculum would give us a better view, but it did not. This case was taking much longer than anticipated. Imagine the embarrassment if we missed a foreign body. Fortunately, we never found one. A pediatric Foley catheter stopped the bleeding long enough for us to place a suture. Aaron could not believe how small the surgical area was.

Kayla thrashed about as she came out of anesthesia. "Everything's okay, we're all done!" Aaron was there to hold the little girl on the operating table so she would not fall. Kayla moved herself to the waiting stretcher and we wheeled her into recovery.

Aaron and I found her parents sitting in the empty waiting room. It was almost 9 pm. They looked so worried. "Everything's fine, it's all fixed, Kayla's

awake in recovery!" Their faces lit up as if a heavy weight was being lifted as I explained what we did. "You can see her now." "Thank you so much doctor and..." I interrupted their pause, "This is Aaron, he is one of our medical students, he was with us in the operating room." "Thank you so much, Aaron." He was now part of the team. We went back to see Kayla. "Where's my slushie?" she asked. Aaron volunteered, "What flavor do you want?"

We discussed follow up and exchanged goodbyes. As Aaron and I headed for the elevator he said, "When I saw their look of relief, I knew medicine was the right choice for me!" Kayla got her slushie and a note for school.

It was a great night on call, I helped a little girl and witnessed the awakening of a physician.

DISCUSSION

Decreased medical student schedules and resident duty hours have an obvious impact on medical education. Although anecdotal, educational experience may be enhanced after hours due to less competition for each patient encounter. There are no meetings, lectures, or conferences to interfere with clinical learning. Some dismiss this idea, however, as a trivial observation.

As resident duty hours continue to decrease, medical student schedules have been restricted as well. Our case highlights several important issues regarding medical education. Aaron, the medical student, opted to stay after 5 pm to participate in clinical learning. He saw a case that he did not experience during his pediatric clerkship. It is interesting to note that he was not on call that evening and may have unknowingly violated a medical school policy by staying. The admitting resident did not stay for the surgery due to duty hour restrictions which in part validates the old surgical concern for missing cases when one is not on call. There was much to learn from this case. A pediatric patient and her parents were counseled for surgery and the team experienced a sense of accomplishment and satisfaction from helping a family deal with an emergency. Neither of these experiences can be duplicated via simulation or textbook.

We cite the case of an 8 year old girl with a straddle injury to illustrate the potential negative impact of restricted duty hours and medical student schedules on medical education. A less rigid application of such restrictions may enhance the opportunity for clinical learning.

REFERENCES

1. Accreditation Council for Graduate Medical Education. ACGME Duty Hours. Available at: http://www.acgme.org/acgmeweb/Portals/0/PDFs/dh-faqs2011.pdf. Retrieved January 7, 2014.