

## The other side

■ Cite as: *CMAJ* 2018 December 10;190:E1454-5. doi: 10.1503/cmaj.180637

*CMAJ* Podcasts: audio reading at <https://soundcloud.com/cmajpodcasts/180637-enc>



**A**s I prepare for morning rounds in the neonatal intensive care unit, my mind is a jumble of information about at least two dozen babies, and already I am making a checklist of tasks that I must do for the day, reminding myself to be efficient. I think of the families who will most certainly be present for rounds, and what I need to update them about. This will take longer, I know, and sometimes I even wish I could avoid them altogether.

I make my rounds differently when a baby's parents are present. When no one besides the medical team attends, my rounds are faster. I talk differently with the medical team than I do with parents and families. My conversation centres on medical details: vital signs, labs, daily plans and moving on to the next patient, the next plan. I am often

more honest, sometimes brutally so. "This baby is going to die," I will say out loud, or "What the hell are we doing here?" when things aren't working. Usually, the bedside nurse acts as spokesperson for the baby, sometimes challenging medical plans, keeping me in line: "Are you really going to increase his feeds when he just threw up right now?"

But when families are present, I find myself entering the other side of the conversation. Not the one about vital signs and labs, but the one about wellness and illness, worries and hopes. "Is my baby going to be okay?" "Is she in pain?" "When can I hold her?"

The other side of the conversation is sometimes straightforward, and sometimes hard. It is hard when a parent seems difficult or irrational, if I am delivering bad news, or simply when I

don't have a fix for their child's problem. After all, what good am I as a doctor if I can't fix things?

When families are absent, the child is identified by their illness, as if that is their only defining trait. But when the family is present, the patient assumes a personhood: they have likes and dislikes, good days and bad days, nurses who scold them for wanting to be held all day long, and allegiance to football teams. Now, their illness becomes a subsidiary, and the child emerges.

But just as the patient becomes a person, I find myself becoming one, too.

With the medical team, it is sufficient for me to discuss the diagnosis and prognosis, to brandish statistics and evidence, to have a plan and march on to the next patient. But with families, I must discuss certainties and uncertainties, and

share my own fears and hopes. Sometimes I do this well. Sometimes, I fail miserably.

On the other side of the conversation, I learn from families about forbearance. I learn that what is important to them is often not what I have deemed to be medically important. I learn that they have fears about things I shrug off, but are not worried when I tell them something truly fearful, such as the possibility of their child having a severe disability. I learn that they value hope and prayer more than my clinical judgment, and that is probably a good thing. As one mom astutely points out to me, “You may be the expert in babies, but this is my baby and I know him best.” She is right.

On the other side of the conversation, I also learn the importance of being wrong about my predictions, and the importance of acknowledging I am wrong. It takes me years to learn this, because I was taught that doctors must not make mistakes. The alternative to saying something and being wrong about it must be to say nothing at all, right? No. I learn to give parents certainty when I feel certain about an outcome, to share my instincts and

experience with them. So, to the tearful father of the fat, healthy baby who has a low blood sugar level and needs an intravenous line, I say, “I am sorry your baby needs to be poked, but I promise you, he is going to be all right.”

I realize the smallness of my role in the care of the child. Often, I find myself feeling superfluous among the sea of health care providers, asking myself, “What exactly are you contributing here?” But in such moments of despondency, a parent will say, “Thank you so much for all that you did for him,” validating my meagre presence.

On the other side, I sometimes imagine my own child, and what I would do if he were in a hospital bed for months on end. I imagine the possibility of blood draws and painful procedures, of being told bad things could happen, of being powerless to stop them from happening.

I also find moments of humour, on the other side. To one mother, I ramble on and on and on about how sick her baby’s lungs are, why they are so sick, what we are doing to make them less sick, that I worry we will not ever be able to get her off the ventilator, as sick as

her lungs are, only to have her ask me, “Yes, but what are you going to do about her diaper rash?”

I learn that there is value for me in entering the other side of the conversation. There are small rewards, such as when a parent tells me, “We will really miss the way you explained things to us,” or when a family silently looks at me when they are asked to make a life-altering decision for their child. But there are bigger ones, too: When I take the time to learn what families worry about, I feel I am more effective as a doctor. I learn that parents and doctors worry about different things, and if I ignore their perspective, I am ineffective at treating the child, no matter how well thought out my medical plans are. So, as I move on to the next patient, the next family, I challenge myself to engage in the other side of the conversation.

#### **Krishna Acharya MBBS MPH**

Department of Pediatrics, Division of Neonatology, Medical College of Wisconsin, Milwaukee, Wis.

This article has been peer reviewed.