S
everal months ago, I agreed to take a
complicated new patient on referral
from one of my pain and palliative
care colleagues. I met the girl and her
mom (and, to my surprise, her previ-
ous primary care nurse practitioner, who
came to help with the transition) for an
initial visit. We spent about an hour going
over the child’s problems and the mom’s
questions. At the end of the visit, I recom-
mended I see the child in about a month
for follow up.

On the morning the child was sched-
uled to see me back in clinic, she was ad-
mitted to the pediatric intensive care unit
(PICU) in respiratory distress. While she
was there, the PICU doctors and the pal-
liative care doctor kept me up to date on
what was happening, as I was not directly
involved in the child’s in-patient care.
I intentionally did not visit her for two
reasons: First, many other doctors were
involved and I thought my presence might
complicate things. Second, I had only met
the patient once, so I didn’t think my pres-
ence or absence at the bedside would make
much of a difference for this family. As I
learned later on, I was very much mistaken
on both counts.

At one point, I was informed that the
patient had come off the ventilator and
that her mom had made the decision to
not reintubate the child if it was needed.
Instead, she would take her home with
the expectation that she would die. A day
or two later, I found myself sitting by the
child’s palliative care doctor at Grand
Rounds. She encouraged me to visit the
girl. She told me she thought it would
mean a lot to the mother.

I stopped by after Grand Rounds and
had a very nice 15-minute visit with the
mom. I mostly reinforced what the rest of
the medical team had been telling her and
emphasized that I thought she was doing a
great job advocating for her child and try-
ing to do what was best for her.

At the end of our visit, the girl’s mother
said she had wondered why I hadn’t been
by to see her child or her at the hospital. I
gave my two reasons, and she seemed to
understand but told me she appreciated
me coming by.

I shared my thoughts about the visit
and what we talked about with the girl’s
intensivist and palliative care doctor later
in the day. That evening, as I was going
through emails, I saw one from her pal-
liative care doctor, who informed me that
our patient had died peacefully with her
mom and family around her. I traded
emails with this doctor, mostly to thank
her for encouraging me to visit the family.

Mom, I learned, had actually mentioned to
this other physician how glad she had been
to see me.

This event made me realize that even
a few short encounters with patients and
families can be significant for them, and
that it doesn’t take long to establish a bond.
It also made me realize that it doesn’t take
much effort on my part to visit a patient in
the hospital—even just to say hi.

I was fortunate to have been sitting
by that extraordinary doctor at Grand
Rounds, who encouraged me to visit the
family because I had no idea that within 12
hours, the child would die.

We clinicians should not underestimate
the role that we are allowed to have in our
patients’ and their families’ lives. MM

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