Right Brain: The blind spot

Christina B. Pham, MD

Address correspondence and reprint requests to Dr. Christina B. Pham, UCSF School of Medicine, 500 Parnassus Avenue, San Francisco, CA 94143-2203
Christina.Pham@ucsf.edu

"He's not moving his left arm."

No mother wants to hear that about her newborn in the delivery room. I was a fourth-year medical student; my husband was a surgical resident. We couldn't contain the windstorm of scary diagnoses that came over us as we heard those words. Did he have a congenital syndrome? A stroke? Over the next few days, the pediatricians reassured us it was "just a brachial plexus palsy" and we had nothing to be concerned about. The comment that put my motherly fears to rest: "I've never seen a case that didn't recover."

My delivery was complicated by shoulder dystocia and my son, Andy, was born with a brachial plexus birth palsy, giving him a flaccid left arm that had the characteristic "waiter's tip," with some movement in his fingers, but none in his arm. My heart ached every time I swaddled him and felt no resistance from his left arm. "Is there anything special we should do for him?" we asked before we left the hospital. The answer was always a reassuring, "No—we treat these children normally because they all end up getting better." Four different pediatricians, no special exercises, no extra precautions, no additional visits. We were so relieved. Andy was a normal baby.

Over the next few weeks, my husband and I watched our son's arm, but we were not overly concerned, trusting what we'd been told. Sure, Andy's left arm was cooler than his right—but that would improve. Sure, his arm was atrophied—but it would catch up. Sure, it still wasn't moving—but in time it would. A few days before his 2-month appointment, we noticed that there was an unusual smell about Andy. To our horror, we found a pressure ulcer on his wrist. Because of weakness from his brachial plexus injury, his wrist was adducted and not moving, so it had remained in the same position for 2 months, other than for the occasional bath. We had been told specifically that Andy did not need special care. The guilt … the feeling that we'd somehow neglected our baby to the point that he'd get a pressure ulcer produced a lump in my throat that didn't go away for weeks.

That was the beginning of a new awareness for us—the realization that there was something our doctors didn't know about Andy's situation. For if they did know, we would have received anticipatory guidance on avoiding something as simple as a pressure ulcer in a newborn. With this new understanding, we were finally able to see what we had been subconsciously denying: Andy's condition had not improved.

The next day, we went to Andy's well-baby check-up. The pediatrician took one look at his arm and immediately the tension in the room was tangible. We didn't want to hear what our doctor was saying, but the words "permanent functional deficit" slammed through our eardrums. That phrase kept reverberating in our heads. We had suspected that our son was not recovering as fast as he was expected to, but "permanent functional deficit" threw this game into a whole different arena. My thoughts were racing: Would Andy ever climb a jungle gym? Would other children tease him at school? Over the next few minutes, our pediatrician outlined a flurry of steps: referrals to neurologists, physical therapy, and resource centers for the developmentally disabled. How, we wondered, in 1 hour, could we have gone from a well-baby visit to a referral to services for the disabled?

We were devastated, bewildered, disappointed. We were devastated by what we imagined could be the future for our son. We were bewildered by how we, as medically sophisticated as we were, could have been so blind that we didn't see the reality of Andy's situation. We were disappointed in ourselves that we didn't actively ensure that Andy was getting the appropriate care for his condition. Nevertheless, we were also grateful. We were grateful for the wake-up call.

The question that has revisited us over and over again was how at such a preeminent medical center our son could have fallen through the cracks. Over 90% of cases of brachial plexus birth palsy spontaneously recover within the first 2 months of life.[1] Andy's physicians had seen cases of brachial plexus birth

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From the School of Medicine, University of California, San Francisco.

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palsy before; most likely, all of their patients had recovered. Could our doctors have been lulled into the assumption that all these cases got better, given the benign nature of their prior experience? Why had they not discussed with us that 10% of patients with these injuries don't fully recover? What was the reason the worst-case scenario—complete nerve detachment (avulsion)—was never even mentioned?

Eventually, we realized that situations like ours are more likely to occur when, as treating physicians, we don't know that we don't know. When we do know, we try to provide the best possible care. When we don't know, we readily admit our lack of knowledge and either refer to the literature or to our colleagues. It is when our gaps of knowledge fall into our brain's "blind spot" that we get into trouble. Throughout my training in medical school, there was always an emphasis on expanding our fund of knowledge in areas we weren't familiar with, whether that was going to grand rounds on new topics or looking up new diagnoses our patients had. The focus was on trying to expand the limits of what we didn't know. Andy's case reminds us that it is also necessary to explore the limits of what we do know—or more importantly, what we think we know. Whether it's the repetitious element of becoming more experienced or the fact that what we learned at one point has become outdated, it is easy to slide into complacency. It is easy to think, "I have seen this diagnosis before; I know how to treat it." This assessment would likely be accurate for most of the patients we see. The danger, however, is that complacency—and simply, the passage of time—widen our blind spot and make us overlook things we either once knew or should now know. Perhaps what distinguishes the great clinician from the good one is the ability to maintain a fresh outlook with each patient and to wonder whether a given patient is different from the rest. For what if the patient in front of you is the 10%? What if he happens to be the worst-case scenario? What if your patient is a rare presentation of the common—as Andy was—or a common presentation of the rare?

Challenging ourselves to explore the limits of what we think we know may not change the treatment plan or outcome … most of the time. But then there are those critical moments when actively challenging the boundaries of our blind spot could mean the difference between a child being able to put his shirt on with both arms or putting it on with just one.

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REFERENCE

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