

**When Practice Questions Become Real Life**

"That looks so sad. At least they can fix it," I thought. I was a first-year medical student in anatomy class glancing at a slide about cleft lips and palates. Two years later, while navigating an emotional reproductive journey, my husband and I looked at an ultrasound revealing a cleft in our baby. My mind jumped back to those slides, and I couldn’t help but think, “This actually happens to people?”

A week after I delivered, I was pumping in the middle of the night in a hotel room across the street from the neonatal intensive care unit (NICU) where my 6-day-old son was still admitted. Beyond exhausted, I called for the first time at that hour just to check in. “How did you know?” was the nurse’s response. “He just had a bloody diaper and we’re talking to the doctor. We’ll call you back with the x-ray results.” Twenty minutes later, but what felt like forever, the doctor called to confirm a diagnosis of necrotizing enterocolitis. He said it was every neonatologist’s “worst nightmare.” I started gasping for air. I used to be happy when I identified the diagnosis of necrotizing enterocolitis on an examination question. It was an easy answer. The baby always died.

The difficult news continued to arrive as my baby’s problem list grew longer. After 2 months, we finally identified the cause of apneic spells that made him turn gray and stop breathing. I used to be happy when I identified the diagnosis of necrotizing enterocolitis on an examination question. It was an easy answer. The baby always died.

There is a high incidence of early death (15 to 20 percent) associated with neonatal seizures. The following long-term outcomes have been reported: Global developmental delay (55 percent), intellectual disability (20 to 40 percent), cerebral palsy (25 to 43 percent).¹

The list of poor outcomes went on and on. I remember that young patient who presented with shock-like jerks. At the time, I was perversely grateful that I wasn’t the child’s mother. But now I was that mother.

Not only do I have to navigate the many diagnoses associated with having a medically complicated child as I return to complete my clinical rotations, but I’m constantly surrounded by reminders of how atypical my experience has been. Every part of my obstetrics and gynecology rotation was challenging. Assisting with normal vaginal deliveries that I had so desperately wanted for myself. Observing Cesarean deliveries that did not end with the infant being intubated and whisked away to the NICU. Participating in prenatal appointments where patients expressed anxieties about their otherwise picture-perfect pregnancies. But the moment that finally got me to break down, sobbing in the call room was a simple shelf-examination practice question. The question described a newborn with a cleft lip and palate, microcephaly, shortened fingers, and a murmur and asked the reader to identify the cause. The answer: maternal consumption of phenytoin. The explanation depicted a cartoon of an affected infant. I wanted to scream at the question writer: “Do you know what it’s like to have a baby with a cleft and microcephaly? This was not caused by anything I took. And now he is on antiepileptics that are saving his life!” How ironic.

Before my son was born, life as a medical student biased me toward focusing on the worst possible outcome, even when such an outcome was statistically unlikely. I can understand why. When you are clinically responsible for a patient, it’s important to be prepared for all possibilities and plan for worst-case scenarios. My now 6-month-old son has taught me, however, that when interacting with patients and families, it’s just as necessary not to forget the most likely scenario. In fact, an estimated 89% of full-term neonates with necrotizing enterocolitis survive;² about 45% of neonatal seizures are successfully managed with first-line medications;³ around 70% of clefts do not have an identifiable cause.⁴

When clinicians present the facts but emphasize the positive, this optimism is more than just a fuzzy feeling: it has practical benefits. It can translate into genuine empathy via a few extra minutes of presence at the bedside, a compliment on a baby’s appearance, or an anecdote about how a similar child prevailed. As a parent, it has become easy to tell when a physician thinks deep down that a child will not recover. I also notice when someone focuses on my son’s big, curious eyes rather than trying to match his overall clinical picture to an infraographic or statistic every time she examines him. More often than not, parents are just searching for that glimmer of hope and human connection.

---

**Conflict of Interest Disclosures:** None reported.

**Additional Information:** I thank my husband for allowing me to share our son’s story.