The Hand on the Door

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SOMETIMES A MOMENT can alter your life. For me, one such moment came in the middle of residency. I was moonlighting at the local health department—as residency obligations permitted—just 2 hours a week, seeing children and teens in foster care for their "annual exam." The clinic provided basic care for about 200 of the 1200 children and teens in foster care in our county. Back then, the clinic operated very differently. Every patient got a 9 AM appointment time and was given a number by which they were called back for what amounted to a brief physical. The nurses took the histories. I spent my first few weeks there working on some changes—providing individual appointment times, using names instead of numbers, and obtaining health histories myself. Each time I went, I was greeted by Eleanor, a veteran nurse who often said to me, "These children deserve better." But it wasn't until I met 16-year-old Jason, around my sixth week at the clinic, that I truly understood what Eleanor meant.

Jason came in on a sunny Thursday morning. During our visit, I learned that he had asthma but had no idea of what his triggers were, how to use his medications, or even what medications he was on. It was a quiet morning, so I took the time to teach him about asthma: how to identify and monitor his symptoms, take his meds, and when to call for help. Jason was bright and articulate and caught on quickly. I learned he had been in the same foster home for nearly 16 years, with a family he enjoyed and felt part of. We must have spent about 40 minutes together, including time to write new prescriptions. I finally had my hand on the doorknob, ready to leave the room, when I turned and asked him what I often asked my patients at the end of a visit, "Is there anything else I can do for you today?"

The room developed that quiet stillness that tells you something important is about to occur. I stood waiting, my hand on the door, as Jason sat, looking at me, assessing and thinking. I waited some more, a bit impatient to move on, a bit uncertain and anxious about what was coming. Finally, after what was surely no more than seconds, but felt like minutes, he replied, "Yes. You can tell me what I did when I was 6 months old to be put in foster care."

I could feel in the space between us how hard it was for him to ask this question, and how much pain and hurt lay behind the words. It hit me then how little I knew about him and his life, and about foster care. I felt the incredible vastness of my own inexperience. I grappled with what to say back. I had his chart, but even though he had been in foster care for 16 years and received his health care in this clinic during most of that time, the chart was razor thin. No help would be found there, so I didn't even bother to look.

I did let go of the doorknob, turned fully to him and said the only truth I knew: "I don't know why you're in foster care, but there was nothing you could have done when you were 6 months old to cause that to happen." I then offered to find the answer to his question, and we set up a time for him to return in 2 weeks, when I would share what I learned with him.

That moment, ready to exit a visit in which I felt I had done a great job of meeting my patient's needs because I had spent so much time educating him about his asthma, changed my life. It was the moment when I realized that this young man's real health issue was not his asthma, but his overwhelming sense of loss. That moment, when I had been turning to go but instead turned back and truly stood in the presence of my patient—when I heard not just the question but the child behind the words and the pain in his voice—was truly humbling. It began my education about foster care; childhood trauma; child mental health; and the impact of separation, loss, and uncertainty on children and their families. Ultimately, it changed my path in pediatrics.

That morning, I spent some time on the phone tracking down Jason's caseworker. He had had many over the years, and the list of contacts in the chart was not up to date. When I did reach her, she told me Jason would soon be aging out of foster care. I learned that the many volumes of Jason's files were spread throughout the child welfare offices, as it was years before child welfare records would be computerized. His caseworker would have to hunt down the original reason for placement. She promised to get back to me.

Meanwhile, I started to pay more attention to the circumstances that brought my patients into foster care. I read the only 2 papers that existed in the pediatric literature, before discovering the mental health and social work literature. I asked Eleanor questions that she, as a nurse in that clinic, might have had an inkling about. She, in turn, referred me to a few child welfare administrators who educated

me about the impact of abuse, neglect, removal, and uncertainty on the lives and well-being of children and their families. I talked to foster parents about their experiences taking care of other people's children. I learned about the legal conundrums of foster care and child welfare regulation and oversight. I found mental health experts who taught me even more about trauma and loss. But my greatest insights came from the people on the ground, the caseworkers, foster parents, and the children in foster care themselves.

As a resident, before this experience, I had made child protective referrals, greatly relieved the few times when those referrals resulted in an infant or a child being removed from an abusive or neglectful family. I had never given much thought to what happened afterwards, however—to the child or their family. Previously, upon making the referral, I thought I had done my duty as a mandated reporter. I assumed the child's life, after removal from their abusive home, would be better than it had been.

As I continued to work in that clinic for the rest of my residency, I learned that foster care is not a place with fairy-tale endings. I saw children who moved from placement to placement, who went into and came out of residential care, or who returned to foster care after reunification or, rarely, a failed adoption. During a developmental elective, I learned about attachment theory and how children build the templates for their sense of self and future relationships through their earliest relationships with their parents. And, I watched what happened with children in foster care—children who did not have healthy attachments before entering a system defined by its transience. Visitation, the best predictor of reunification, was frequently inconsistent. There was little mentoring for birth parents, who often lacked even rudimentary parenting skills and frequently had their own trauma and mental health histories to deal with. Foster parents, the major therapeutic intervention of foster care, often lacked the skills, knowledge, and resources to truly help traumatized children with often overwhelming needs. And, in addition to their tremendous mental health needs, children in foster care had rates of developmental, educational, dental, and physical health problems that far surpassed those of other children and teens. They were truly a population with special health care needs. And, most of them were not as fortunate as Jason—he had a sense of belonging in a family in which he was truly loved. And, yet, even he still wondered about that other family, the one into which he had been born and that had rejected him.

Jason's caseworker did get back to me. She explained that he had been removed from his mother, a chronic alcoholic and single parent who, by the time Jason was born, had been in and out of mental health institutions and recovery programs for years. He was the youngest of several siblings, whom he barely knew. He was fortunate in his foster family but adoption out of foster care was not common in 1986. Jason's caseworker had thought Jason knew all of this. Prior caseworkers had documented conversations with him in which they had shared this information. But, somehow, Jason still had a huge information gap and a deep sense of loss and unworthiness.

We three—Jason, his caseworker, and I—sat down with parts of his case file a few weeks later. We talked about his mother and how ill she had been from her mental illness and her alcoholism, so ill that she had needed to be permanently hospitalized. She had not been able to take care of any of her children. Some had lived with relatives and some, the youngest, were placed in foster care. We reassured him, over and over, that it was nothing he did, nothing he could have done—his mother couldn't take care of herself, let alone a baby. By the time he arrived, his mother was already well down the path of her own sad journey. She had died when he was very young.

He seemed to take at least some of it in. He walked out with copies of a few things from his case file. His caseworker promised to call him the following week, and I trust that she did.

Those moments with Jason and the exploration his question sent me on changed the course of my life. He taught me so much. He taught me about the deep hole that is left in a child's life when they lose their parents, or their parents lose them, as is more often the case in foster care. He taught me that a life-defining traumatic childhood experience can color a whole life and sense of self—even when there has been great healing afterward.

And, for the first time, I understood the depth of the power that we, as physicians, carry into each room with us. We help patients to find their strengths; we nurture their resilience; and we begin the process of healing their wounds when we listen carefully and respond authentically to their fears and concerns. And, I hadn't even known the answer to his question as I stood there with my hand on the door.

I think of Jason quite often—especially when I feel that need to finish up so I can get to the next patient and not fall behind. I think of him when I see a new child coming into foster care. I wonder what they understand about why they are here. I ask myself how I can help them and what words I can say to soothe the pain of great harm and great loss, to give a child hope, to relieve guilt, and to reduce the sense of worthlessness that is so common among children in foster care. "It was nothing you did," I say. "You're just a child. Adults are the big people, the ones who are supposed to take care of children."