Pediatricians Can Learn to Play Well With Others

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WHEN AMAL AND I were expecting our second child, we considered the stress it would create for Maya, our first. Maya had spent the first 2 years of her life in a home where she was wanted, where her parents were healthy and educated and safe, and where we had enough money for all of her food, diapers, clothing, and great child care.

Maya had it good.

As recently trained pediatricians, both Amal and I knew that the stress in Maya's life was minimal. It was similar to the stress that every baby has. For Maya, it included finishing her bottle but still feeling hungry, playing with Amal and then watching him get up and walk away, or not being able to reach a toy she wanted—normal, small stuff, stuff that may have even propelled her into trying to talk to us or roll over, stuff that we could handle.

Maya said her first word in the PICU—not as she was getting extubated after some devastating illness but in the lunch room, in the back, where she and I were meeting Amal in the middle of one of his Saturday shifts. She said "apple" fewer than 100 feet from children who might never speak.

So when Amal and I were expecting our second child and worried about the stress a new baby might cause Maya, we knew we were worrying about normal, small stress.

Still, we called our parents and neighbors and made plans for them to help us when Elina was born. Catharine from down the street would stay with Maya when I went into labor. My mother would come to Chapel Hill for two days. Then Amal's parents. Then mine again. Indeed, when Elina was born, the system worked like clockwork. After Amal brought home bagels for Catharine and Maya, he took Maya to the airport with him to pick up my mother and came to the hospital with Chinese food. Then two days later, he was back at the airport for his parents and my mother-in-law's *channa* and *saag*. Five days later, he was at the airport again for my parents and my mother's brisket. Neighbors contributed baked goods to the abundance. Together, they fed us, bathed Maya, held Elina, and answered the phone.

When Elina was two months and Maya 2½ years old, we took a beach vacation with Amal's brother's family. On the last day, we woke up early to clean the house and pack. We were caravanning home and thinking about what we would have for lunch when Amal died in a car crash.

Elina's birth no longer seemed like such a stressful event. Even at the time, I could laugh at the innocence of that.

Standing on the highway median at the site of the crash, it was hard to believe it was Amal with his head bent down on the steering wheel, only small cuts on his arm and on the back of his head. But he was not moving. I rushed back to the car I had been in, where the girls were, and stayed there watching the EMS scene unfold.

As we drove to the hospital where we thought Amal was, I called neighbors to meet us there. I sat in the waiting room, trying to breast-feed Elina, waiting for news. The neighbors who met us at the hospital had spoken to police officers who told them Amal had been declared dead at the scene and taken elsewhere. With this news, I called a friend, who in turn called almost everyone I knew.

It was still light out when I walked out of the hospital into the humid North Carolina air. I wondered how it could be so sunny, how the sun could dare to shine. Not ready to leave the emergency room, I walked back through its revolving doors and hovered in the air conditioning until I saw my sister outside. She had rented a minivan to take us home. She shared my bed that night. Within hours, my parents, Amal's parents—our extended families—arrived. The next day, more family and friends came, staying in our home or our neighbors'. Everyone who had brought food in the beginning of the summer, when Elina was born, now brought twice as much. Someone did the laundry. Someone bought milk and diapers. Someone called my internist, the girls' pediatrician, and Maya's child care center.

Over the next few days, the grandparents organized the funeral, two friends wrote the obituary, and my brother tried to figure out Amal's filing system. I remember sitting on the couch, surrounded by my girlfriends, opening baby presents. Many of them had bought a small gift for Elina

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when she was born but had not sent it; they had thrown it in a suitcase when packing for the funeral. Like many baby showers, this one included my sister handing me food and telling me I needed to eat for the sake of the baby. And like many baby showers, this one included discussions of future visits and meals. It was decided that once my parents and in-laws left, someone would fly in from out of town every weekend and stay with the girls and me. Someone local would pick up the visitor at the airport. There would be three groups of people who would organize among themselves to bring food over every other night—my work friends, Amal's work friends, and neighbors. Spreadsheets were created.

The day after the funeral, a childhood friend came with me to take Maya back to the Chapel Hill Co-operative Preschool and Child Care Center. A month later, Elina started in their infant room. When we had found the co-op, Amal and I knew it was right for us—the director was committed to her staff's growth, the food stretched our toddler's palate in just the right way, the other families could not say enough good things, and Amal and the director did the same happy dance. After Amal died, a part of me wanted to keep the girls next to me at all times. But I knew, and was reminded by my pediatrician, that they needed to see far more than my tears, my anger, and my inability to get off the couch. They needed to sing and play. Every day I dropped Maya and Elina off, I left knowing they were being nurtured and inspired. Every day I came to pick them up—even before I checked in and found them happy—the teachers smiled and hugged *me*.

The death of a parent for a child is, in the language of today, an adverse childhood event. Not surprisingly, research has long shown that adverse childhood events are associated with poor adult health. What is new in this research is learning how repetitive or prolonged adverse childhood events can impair brain growth. This excessive or toxic stress can also increase the production of stress hormones and make one more reactive to later stressful events. Fortunately, the new research also describes how consistent, loving, nurturing relationships and as much certainty as possible can reduce the likelihood of toxic stress and its effects.[1]

Amal and I had understood we were dealing with normal, small stress with Maya's impending sibling, but even then, we worked to minimize it.

With Amal's death, while I was trying to remember how to breathe, there were concentric circles of people—family, friends, and professionals—helping me figure out how to envelop my girls in love and certainty. Ten years later, I still need those concentric circles, and they are still there.

When I try to describe the lessons I have learned—and lived—about a stressful event to the pediatric residents I teach, I sound trite. It feels like asking someone to understand the simultaneous pain and joy of childbirth before they have experienced it themselves. Or it sounds worse than trite. Telling the residents I was so lucky to have hard-working friends who felt empowered to talk to professionals on my behalf doesn't sound like anything generalizable when taking care of an underserved primary care patient.

I usually make the mistake of sliding into lecturing about toxic stress and the importance of teamwork to alleviate it. I describe what the pediatrician's role can be in reducing toxic stress for the children we care for who have witnessed violence or who have experienced child abuse, hunger, or the sudden absence of a parent. I explain that the first step is to identify who will play the role of the consistent, supportive caregiver for the child—usually a parent. I explain that the second step is identifying the biopsychosocial needs of the whole family and facilitating referrals, appointments, and—the really hard part—communicating and collaborating with all those in the child's concentric circles, be they medical, educational, social, or personal.

It is at this point that many residents' eyes start to glaze over. They have been part of the medical system long enough to realize that physicians do not frequently collaborate outside their own circle. Yes, general pediatricians, hospital social workers, and subspecialists often work together. But most physicians do not routinely talk with after-school providers, gym teachers, school nurses, and others who are potential team members.

It is when I remember the power of stories that I think I am most effective in communicating about toxic stress and teamwork.

I tell the residents about a family child care provider I interviewed for a research project about child care providers acting as lay health advisors.[2] I interviewed the child care providers during the day, while they were working, and tried to schedule the interviews during nap time.

The day I drove to Amanda's house was gray and overcast. I parked in front of the brick home, opened the gate on the chain link fence, and walked up the two concrete stairs to a door with peeling brown paint. The third floor doorbell had a small handwritten sign announcing her family child care center. After she buzzed me in, I walked up three flights of dark, narrow stairs, noting the hand rails and linoleum lining the stairs but also the holes in the drywall. At the top of the stairs, Amanda stood alone in a room painted with shining suns and rainbows, full of books and toys neatly stacked. Four children were on their cots; one seemed to be sleeping, and the others were in various states of wiggledom. As we started the interview, one toddler ambled over and climbed into Amanda's lap. Amanda told me how she kept her charges healthy. They washed their hands, they ate fruit, and they jumped up and down inside when it was too cold for a walk. Amanda told me that once, with a child's mother and pediatrician, they had together diagnosed Kawasaki disease.

What makes this story important, I tell the residents, is not whether or not Amanda—without any medical training—helped make the diagnosis. What makes this story important is that every physician I tell it to is incredulous. They do not believe that a child care provider could have helped diagnose a child with Kawasaki disease—a difficult diagnosis even for experienced health care providers. Almost universally, both pediatric attendings and

residents believe that without all the medical training they have had, a child care provider—even one with a big heart and a curious mind, one spending more than 35 hours a week with the child—could not have been much help in making the diagnosis.

Amanda, on the other hand, considered herself a part of the health care team diagnosing the child and supporting the family.

Why, I ask the residents, couldn't she have been the person to notice the rash, the swollen glands, the fever, the pink eyes? And what if Amanda, with the mother's permission, had discussed the child's status with the pediatrician? Couldn't they all agree that she would watch for certain symptoms? What would it take to build that level of trust, communication, and collaboration, regardless of expertise?

I worry that our residents are learning that not only will they *lead* the team that diagnoses and cares for children—they *are* the team. I want the residents to acknowledge that we as health care providers have a valuable role on the team, but that the team is incomplete without the skills and knowledge and time spent with our patients that come from other disciplines.

I remind myself that, fortunately, there are forces working to improve multidisciplinary teamwork. Reimbursement may be changing so that physicians can be paid for coordinating care, for talking to a depressed mom about her own health, or for calling a teacher to see how a child is doing after a particularly difficult family crisis. The Association of American Medical Colleges is paying more attention to multidisciplinary and interprofessional training. Models like the Harlem Children's zone and a true medical home meet both the mental and physical health needs of children and show us that parents can serve as their child's best buffer. These examples are working to change the culture of pediatrics to one in which we genuinely value and draw on the expertise and contributions of others.

With the residents, too, there is a bright side. Today's pediatric residents are poised for teamwork as they increasingly share decision-making duties with the most important team member: the child's parent. We already have training programs that focus on the skills necessary for partnering with parents. Working with the rest of the team will take work, but I think we are ready to try.

Chapel Hill is a small town. When Amal died, most of my neighbors, our pediatrician, and the director of the child care center all knew each other. They all trusted that the others had our best interests at heart and were working to help me buffer the stress for my daughters. When I spoke to one of them about the ideas of another, I felt the respect and humility of each for the other. I don't know how each of them might have responded had I added people they didn't know to the mix. What I do know is that when we needed to move from that small town a few years later—move to a new home and child care center and job and try to make new friends—and again added the kind of stress to the girls' lives that was real but normal and small, many in my concentric circles had differing ideas on how to help. Although I didn't understand it then, their modeling respect and collaboration allowed me to integrate the best of their ideas into my parenting so that my daughters continued to experience only normal, small stress and find a space in which to thrive.

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