



“I Can’t Help You”

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“RED PATIENT TO Resus 3” is called out as the EMS crew rushes Mia into the Emergency Department (ED). I perform a quick assessment and ask the bedside nurse to call “Code Sepsis.” The ED buzzes to life as the Vocera alert broadcasts – our team seems energized after the recent lull of lower-than-normal volumes. Quickly, our nurses and techs do what they know so well.

It is July 2020 in the pediatric ED. I am a first-year pediatric emergency medicine fellow, and, with the spunk of a new trainee, my mentality is “*I can help you!*”

The bustle of lines, labs, oxygen administration, fluids, and antibiotics begins, and this previously healthy, term 8-week-old girl who presented to our ED with sepsis is stabilized as we follow our evidence-based neonatal sepsis protocol.

As I go through the rote explanations with Mia’s mother regarding our interventions and plan for her daughter’s hospitalization, she questions if we have to perform a COVID-19 test. A simple question I think as I sit next to her and try my best to convey my concern for her and Mia, yet my nonverbal communication feels limited by the layers of masks, goggles, face shield, gloves, and gown I wear. As we talk, she conveys her hesitancy of performing a COVID-19 test before they leave – believing she will be discharged home from the ED with Mia in a matter of a few short moments.

As I listen intently, the flurry of the orchestrated though chaotic protocol-driven care in the Resus Bay is blurred; her mother tearfully becomes more vulnerable and discloses she and her family are currently homeless. I learn that her family of five is staying in a nearby shelter. Her eyes are down-cast, and I feel overwhelmed by the information she openly shares even through her visible embarrassment. I am uncertain how or why in this hectic and strained environment she is willing to share such intimate information and voice her fear of losing their spot in the

shelter. She continues to share her distress that if Mia is COVID-19 positive the implications of the required 14-day quarantine period would have on her family. She tells me that it would leave all of them on the streets due to lack of shelter resources for the family to quarantine there and would restrict them from the required daily check-in to secure their spot at the shelter for that night. During our conversation, she accepts Mia’s need for hospitalization but her question changes from asking me to not test Mia to asking for my help in finding shelter for her family.

I think back over the several years of my medical training. Each patient has a unique story, and yet in that moment, all I wanted was to feel the success of stabilizing a critically ill child. I didn’t want to think of the potential consequences of providing necessary care, but for this family, the cost of their visit was beyond the scope of what I was equipped to help with. For them, the cost was more than a medical bill.

For them, the cost was the loss of shelter from the summer heat and the crime on the streets. It was the loss of guaranteed food and water. It was the loss of a buffer from the emotional distress of their homelessness. The cost for them was more loss than I could even fathom.

Focusing on her mother’s trust in me, I attempted to embody the courage and strength I just witnessed in her vulnerability to advocate for Mia and her family. I knew Mia required hospital admission for ongoing medical care, but now understood this would leave her family without shelter and much more. I asked our charge nurse if case management could help with housing options. Surely, there would be funds or a partnership for short-term housing for Mia’s two siblings and parents while she was hospitalized.

With dismay, I learned our hospital had no resources to offer Mia’s family “given the current strain on the hospital system during the pandemic.” I was outraged. I had been

sure that if I had a concern, I could help find a solution in our large, academic medical center. Now, I faced having to tell her mother, “I can’t help you.”

In these last few moments of caring for Mia in the ED, I was overwhelmed by her mother’s penetrating gaze each time I entered the room and felt as though my inadequacies were on full display. Her eyes were wide with focused attention on the medical updates and hopeful there would be help for her family out on the streets in the desert heat. She remained quiet and didn’t ask us much, yet there were many unspoken questions in attempting to understand what lay ahead for Mia, for her, and for the rest of her family.

I couldn’t hold her gaze; I saw in her eyes that she was aware of my failure. I didn’t want to tell Mia’s mother I couldn’t help, so I hid behind my medical role, admitted Mia to the PICU, and did nothing more to address their social needs. I left this encounter angered by my own cowardness, frustrated by the inadequacy of our healthcare system and social supports, and saddened by how often we cannot meet the needs of the families we care for. Despite my knowledge that “social determinants of health” impact every aspect of health, caring for Mia made it even clearer to me how much easier it is to be involved in a code than it is to navigate social needs.

As my fellowship continues, I feel the growing burden of being a pediatric ED provider — being stretched thin and left juggling many patients while constantly triaging what warrants utmost attention. Unfortunately, as with Mia, I feel the satisfaction of my growing confidence and ability to provide quality medical care, though disheartened when presented with social concerns that I allow to fall in a lower tier of tasks to address. At times, I struggle with the reality of our immediate access to standardized protocols for sepsis, strokes, seizures — you name it, we’ve got it, but something as common as protocols for addressing social needs? Nope.

With the drain of a never-ending respiratory season and COVID-19 pandemic surges, I often ruminate on Mia as

well as other social situations that I can’t help fix and contrast these with the traumas and critically ill patients that I am well equipped for with a magnitude of available resources. I grapple with the disparity in healthcare delivery between how much we stabilize patients’ bodies and do so little to stabilize patients’ lives. When I remember caring for Mia, I realize that — in avoiding her family’s homelessness — I did not, in fact, provide “good” medical care. I failed her and her family. I damaged any trust that her mother placed in me or in healthcare to help them and care for them when they were most vulnerable.

However, through these reflections, I also ask myself to recall the motives that drew me to medicine. My desire to be a physician is rooted in providing evidence-based and quality care, helping those in need, and finding solutions for positive change. Mia’s case demonstrated to me the impact of social influencers on health for patients and their families, and I am motivated to change how we in healthcare respond. I know that social needs are complex and will not be resolved during one ED visit; however, I believe an ED visit is an opportunity— to link patients and their families with community resources and initiate help that will impact their health and lives.

In a sense, I will always be “in-training” to become a better physician, and I am more confident in my ability to navigate encounters similar to Mia. Even now, I can still feel Mia’s mother’s gaze and her courage and strength, as I go on to advocate for so many others. Now more than ever, I am unwilling to say “*I can’t help you*” anymore.

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