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A New Narrative: Freeing Pediatricians from a Single Story

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Contributors' Statement Page

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Children grow up listening to stories. Those children become adults, and some become pediatricians who listen to stories told through the eyes of a child or adolescent. However, what happens when the story is heard through a single diagnostic related group (DRG)? Doctors are diagnosticians; a diagnosis tells a single story that shapes the course of care. The presentation of a patient calls for diagnosis and treatment, leaving very little room for other stories that shape the patient's care experience. When medical comorbidities accompany a psychiatric diagnosis, the danger of perception between a story told and a story heard can mean missed treatment opportunities and inequitable care. An adolescent pediatric patient who presents with psychiatric and medical conditions is subject to a pediatrician's diagnostic acuity, experience with pediatric psych patients, and existing constraints on providing an appropriate course of care. Too often, the psychiatric DRG becomes the pediatrician's single story of the patient, accompanied by subtexts of aggressive behavior, projections of uncontrollable outbursts, the need to protect other patients in the pediatric unit, and the pediatrician's own biases about psychiatric patients.

The novelist Chimamanda Adichie[1] warns of the dangers of a single story. As a child in Nigeria, Adiche devoured stories. The children were fair-skinned and blue-eyed in the books available to her. As Adiche began to write her own stories, her characters reflected the narrative of her childhood stories. Adiche's experience demonstrates the impact of a single story. As far as they went, the stories were accurate, but they were not the whole story, and they did not include her. In just over 20 years, California has lost nearly 30% of its acute care psychiatric hospital beds.[2] Almost half of California counties have no adult acute psychiatric beds, and most have no psychiatric beds for children.[2] Without adequate placement for inpatient pediatric psychiatric patients, the quality of specialty psychiatric care in health care systems falls short, with stark inequities for pediatric patients.

In a California hospital, a 14-year-old female (herein M.N.) presented to the emergency department (ED) following a reported psychotic episode at home with her parents. While waiting for placement, M.N. refused to eat, drink or take oral medications and remained in the ED for two days, sedated and on IV fluids. On day three, the pediatric hospitalist placed an order for admission to the adult general medicine floor. The rationale for not ordering admission to the pediatric floor was that M.N. needed to be weaned off the sedating medication and would be a danger to other children on the pediatric floor. Nothing indicated the teenager posed a safety risk to anyone on the pediatric floor; prior outbursts had been directed toward her parents at home.

The hospital lacks a designated pediatric medi-psych unit. Although a previous psychiatric DRG indicated admission to a unit where M.N. could be medically stabilized and medicated, transfer to the pediatric ward was ruled out for the perceived safety risk to other pediatric patients. The pediatrician was firm on the perceived danger to other pediatric patients and recommended M.N. be transferred to an adult ward, with security stationed "for the safety of the patient and other patients." After much back and forth about a "safe space" for care, M.N. was transferred to the adult medical-surgical unit, where, for three days without incident, she was weaned off sedating medications and was dispositioned home.

The consequence of the single story is that it robs people of dignity. It makes recognizing equal humanity difficult and puts distance between ourselves and others—and a misplaced sense of safety. Implicit biases are prejudices that impact understanding, decisions, and actions unconsciously.[3] Healthcare professionals are not immune and have the same levels of implicit bias as the general population, with significant inverse relationships between levels of implicit bias and quality of care.[4] In healthcare, implicit biases result in disenfranchisement to the disadvantage of vulnerable populations such as children, ethnic and racial minorities,

immigrants, and sexual minorities.[5] Being a child does not protect against the experience and consequences of implicit bias.[6,7]

What if M.N., a growing teenager, had been through a bad day at school and, like many teenagers, felt her parents did not understand? Did she have a psychotic episode where she lost touch with reality or an outburst of uncontrollable teen angst? The underlying events were lost in the psychosis DRG, and M.N. was reduced to a single story. What if more stories were available about teenagers like M.N. that pediatricians could hear during child and adolescent psychiatric residency programs? How might familiarity with different stories have affected the decisions about M.N.'s threat to other pediatric patients' safety? Without this familiarity, physicians in practice will continue to be shaped by a single narrative of children with psychiatric diagnoses dispensing care at a safe distance in the service of "safety."

A 17-year-old transgender patient A.T. presented to the ED with what her parents characterized as “aggressive behavior.” Due to the lack of adolescent beds in catchment-area hospitals, A.T. remained in the ED for three days. With schizoaffective disorder as a prior diagnosis, a “safety concern” arose over the adolescent’s 274-pound weight. The pediatrician would not admit A.T. to the pediatric unit due to the “challenges" of treating the patient. The physicians referred to A.T. with the pronouns him and his, disregarding the transgender aspect of A.T.’s case, and voiced their concerns that no beds for adolescent males would be available for weeks. A.T.’s prior medical history included hearing voices speaking to her of suicide, but she had never been physically violent. According to the psychiatric physician chief, her disposition was “sweet,” with her psychiatric problems triggered after her rape as a teenager. With A.T.’s story distilled down to psychosis and physical size, she was deemed unsafe for the pediatric floor. A.T. was placed on an adult medical-surgical floor after three days in the ED, then

discharged after two days to an outside psychiatric facility.

A Different Story is Possible

By holding on to a single story, physicians miss the opportunity to see a larger truth. The decisions from an incomplete narrative compromise the quality of care meted out to patients. Often the greatest harm is to patients already disenfranchised by the power imbalance in the healthcare system: provider versus patient; to diagnose and to be diagnosed; to be admitted to a ward or be excluded. When the power imbalance is so great, the stories physicians tell matter even more.

How do we change the story? We can stop telling the story of young people's psychiatric histories with the words aggressive, hostile, and unpredictable, and stop reacting to their stories with discomfort. Our healthcare system needs to embrace new models of care that offer equity, inclusion, and diversity to the least heard voices in pediatric care: minority, transgender, incarcerated, and homeless youth. We need inpatient medical-psychiatric services to address the growing issue of pediatric dual diagnosis patients. Embedding health equity in the infrastructure of care hinges on providers accepting their own biases and turning away from the child and adolescent single story.

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