The Committee on Departmental Diversity and Pediatric Health Equity

September – National Hispanic Heritage and National Women in Medicine Month

As our Department of Pediatrics community attempts to move toward social justice in medicine and healthcare, we each must challenge ourselves to understand the power structures that shape them and the factors that sustain those power structures (Tervalon and Murray-Garcia, 1998). In this context, the DDPHE would like to acknowledge September as both National Hispanic Heritage Month (https://www.hispanicheritagemonth.gov/) and Women in Medicine Month (https://www.ama-assn.org/member-groups-sections/women-physicians/women-medicine-month). In honor of these important acknowledgements, we share the reflections of one of our women physician leaders, Dr. Michelle Hamline, on her time volunteering at the Rady Children’s Hospital/UCSD-led effort to provide urgent care to unaccompanied and primarily Latinx minors seeking aid at our southern border in the summer.

Reflections from a Crooked Room: Migrants, Refugees, and Standards of Care

Each had a different story. A teenager with ingrown toenails fleeing gang violence had just walked hundreds of miles in shoes that didn’t fit. A young girl with depression was escaping a lifetime of cruelty suffered at the hands of her brothers.

Lacking proper supplies, I told the teenager to soak his feet in water and come back if his toenails got worse. I “treated” the girl’s depression with a brief therapy session.

Fleeing starvation and death, desperate children were forced to manage injuries, hygiene, puberty and the common cold—not to mention a global pandemic—without trusted adults to guide and reassure them. And one after the other, I provided inadequate care.

While the economic and political realities facing these children are unique, it reminded me of the inadequate care I often provide in my daily work as a pediatrician who specializes in improving healthcare quality in world-class American hospitals. Across the U.S., for example, referrals to local psychiatrists and therapists frequently take months to fulfill due to a shortage of qualified professionals, insurance blocks, or a myriad of other barriers.

Even if fulfilled, these attempts may do little to relieve childhood depression stemming from a lifetime of mistreatment and socioeconomic hardship. Ultimately, the care provided to the neediest American children is often only minimally better than the care I provided through a temporary program for unaccompanied migrant children.

How did substandard care become our standard?

During her recent Grand Rounds presentation, Dr. Rhea Boyd described the “crooked room” concept, which may help illuminate the path from mistreating our own children to mistreating the new Americans arriving at our doors. It comes from an experiment in which participants seated in a crooked chair in a crooked room were asked to sit straight. People could be misaligned by up to 35 degrees without perceiving themselves askew.

Perhaps the reason those of us practicing medicine in the wealthiest country on earth nonetheless often feel helpless to fulfill even basic needs when confronted with humanitarian crises is that we are practicing in a “crooked room” that conditions us to accept what should be unacceptable standards of care.

We may be doing the best we can under the circumstances, but when providing inadequate care to our most under-resourced children becomes the norm, our daily experience - not to mention research that fails to take into account the complex social realities these children face - fools us into believing that we are providing proper care.

Most medical professionals are trying to “sit straight.” I believe this is especially true within pediatrics, where many have chosen work that brings them into close contact with the neediest children and families. Many of us desire to use our privileges to help as much as we can, from providing medical and financial support to the global movement for racial equity, to supporting children who recently crossed the border.

But the migrant children I met will come to understand that we didn’t care for their basic needs. How will they perceive us? How will they perceive themselves in relation to American society? Compared to what they have already experienced, maybe they will see things as relatively straight.

But it falls on those of us with the ability to recognize that things are asked to do what we can to make sure the room (society) and the chair (the place in society we are offering care) are both as straight as possible. Where we can’t personally provide the needed support, we should demand that our leaders and politicians improve on our system to ensure everyone receives high-quality care.

Michelle Hamline, MD, PhD, MAS, is a UC Davis assistant professor, pediatric hospitalist, and quality improvement specialist. This piece was inspired by her recent work as a medical volunteer serving unaccompanied migrant children housed in a nearby government facility. She references the “tilting room, tilting chair” experiment, which was originally reported by cognitive psychologist Herman Witkin in his 1954 book, Personality through Perception: an experimental and clinical study.