Welcome to the Information Podcast Series brought to you by the Lerners Injury Law Group.
This podcast has been designed to help answer some questions you may have as you make a decision to hire a lawyer.

Now, here's Bill Simpson and Nigel Gilby.

Bill: Well, Nigel, we're really happy to have Sue McLean with us on our episode today. Sue is a social worker in the Paediatric Critical Care Unit at the London Health Sciences Centre and Sue, thanks for joining us.

Sue: Happy to be here.

Nigel: We wanted to talk to you today so people would understand what your role is when somebody comes in and has suffered a significant trauma, so perhaps we could start by just asking you what your role is and describe for us a little bit what the Paediatric Critical Care Unit is.

Sue: The Paediatric Critical Care Unit (PCCU) is a very busy unit. It is 13 beds and we service children from infant to the age of 18 who are in life-threatening situations and that is where all our traumas come – any traumas that are significant enough where a child needs life support, essentially.

Nigel: And what is your specific role in the unit?

Sue: My role in the unit, specifically for families, I do a variety of different things, but when I am working with families, my role is really to provide parents with crisis counselling around the potential loss or injury of their child.

Nigel: And how long have you been there and what is your background in order to get that job?

Sue: I have been in PCCU now for 21 years. I was away from the unit for a couple of years so but essentially worked there for 19, and my background is a Bachelor of Arts in psychology, a Bachelor of Social Work and a Masters of Social Work.

Bill: I think most people probably associate a social worker with counselling. Is that still an active part of the job to do on a day-to-day basis?

Sue: It is an active part of my job. It is my favourite part of my job. Because of the busy nature, frenetic nature of the unit and all of the different things that are going on when a child has experienced a trauma, families are in the grips of having to do many different things at the same time. So oftentimes those counselling sessions get interrupted and we need to do other things and I am spending a lot of time with the families orienting them to the unit, accompanying them to meetings with physicians, getting them hooked up with resources in the community, so that accompanies the counselling role for sure.

Nigel: Now nobody obviously ever wants to see their child injured or ill. Can you help us with – is there some criteria, or how is decided if somebody under the age of 18 is injured, how would they get into the unit in London as opposed to going somewhere else?

Sue: Well, really if they are in southwestern Ontario, they come to our unit, but also we do get kids from other areas if there are no beds. So if there are children from the Toronto area, if there are children from northern regions that are more aligned with Hospital for Sick Children, and they should go there, sometimes they will come to us if those beds are not available. So we can get kids from really all over the province of Ontario and sometimes outside.

Bill: Is it correct that every child who ends up in the PCCU must first pass through an emergency department, or would –

Sue: Yes, that is true. I was going to say we sometimes have kids transferred by air ambulance, but when they come by air ambulance, they still –

Bill: They have already pre-cleared an emergency department --

Sue: That's right.

Bill: -- at another community hospital.

Sue: That's right.

Bill: You said a minute ago that counselling remains one of the favourite parts of your job. Do you have a least favourite part of the job?

Sue: Paperwork. (Laughter.)

Sue: It's my least favourite part of the job. I just find that when families are in those situations it's probably really one of the scariest times of their lives and I think it's really important for them to get support.

Nigel: I know that today we see more accidents that occur as a result of texting as opposed to even drunk driving, but can you tell us in terms of the unit or if you have an idea, what percentage of the kids that you would see that would be trauma, as opposed to other types of illnesses or injuries?

Sue: It varies on the time of year, to be honest, sometimes. And it also varies on the year sometimes. We can go for three or four months without a trauma and then suddenly we may have, you know, a trauma a week for two or three months. So it really ebbs and flows.

Nigel: And is there any difference in the role that you would play when somebody comes in that is a trauma patient as opposed to somebody that is coming in as a result of an illness?

Sue: Yes. Trauma patients most specifically usually have higher priority, just because of the acuity of the situation, the distress that is involved, the emergent nature of the entire situation for the family. Not that illnesses are, you know, a sudden diagnosis that isn't important, but with a trauma there is just so much more happening and so much more accommodating that has to go on in terms of situating families. Because oftentimes they are coming from outside of at least the City of London.

Nigel: I appreciate that traumas can be anything from, you know, kids getting injured at hockey games, falling out of trees and of course motor vehicle accident cases. And is there a difference in your role when somebody comes in as a result of a motor vehicle accident or an ATV (all-terrain vehicle) accident or a boating accident as opposed to them coming in as a result of being injured in a hockey game or being injured falling out of a tree?

Sue: No. Not really. Again, my role with that family, not so much my role but my time with that family, would be dependent on their acuity of the crisis.

Bill: When a child leaves the PCCU but stays within the London Health Sciences Centre, do you continue to work with that child or his or her family or do you have to pass off the case to another social worker?

Sue: That is different in different hospitals but in my situation, I follow all motor vehicle traumas from Paediatric Critical Care up to the regular floor and I follow those families until

discharge from hospital, or until the child is transferred to another facility like, for example, Bloorview Rehab in Toronto.

Bill: Is that because you or the hospital believes that provides a better continuity or level of care for the family?

Sue: Consistency is very important when people are traumatized.

Nigel: We have talked on this show before about certain benefits that people who are involved in motor vehicle accidents are entitled to receive, and when you are dealing with somebody that is involved in a motor vehicle accident as opposed to a trauma as a result of something else, does that affect what you do at all?

Sue: Yes, quite significantly. What, what we find, sadly, is that the best trauma to be in is something that involves a motor vehicle because people then have access to insurance and other supports that parents would not have if their child fell out of a tree or tripped over a curb or had some kind of brain injury as a result of a stroke, for example. It is very, very different in terms of not only the monies that are available but also community supports.

Nigel: Okay.

Sue: So my role in some ways – with trauma patients it is busy activating those supports, and then patients that don't have that, then my role is very busy searching for ways to help these families as they transition through the hospital back to home and community.

Nigel: So things like CCAC (Community Care Access Centre) and that?

Sue: Yeah. Private companies, other counselling companies.

Nigel: And do you take any role in an individual who is involved in a motor vehicle accident in terms of helping them to access that insurance?

Sue: Yes.

Nigel: And what role is that?

Sue: In fact, what surprises me quite often is that there are many families who do not know what motor vehicle insurance is, that don't know whether they have access to it, and then are – once they are informed about it are actually afraid to deal with it. And when – also, when you

mention how important it is to involve a personal injury lawyer for a significant trauma, people often get very anxious about that because the whole idea of entering the legal world is overwhelming.

Bill: Well, we see that. When Nigel and I go to the hospital, we often say to each other, “Can you imagine this must be just about the last thing this family wants to deal with – the two of us coming here to talk about insurance claims, the paperwork and legal proceedings.” How have you found it effective to raise that topic when you are having to bring it up with them for the first time?

Sue: To say it almost exactly the way that you did. I usually tell families, you know, I have to give you a heads up about something that is really important but we don’t have to do that today. We don’t have to do that tomorrow, but sometime in the next week it is going to be really important for us to involve some other people that are going to help you through this process. And right away it is going to feel a little overwhelming because it is about paperwork and, you know, organizing these resources when you are trying to concentrate on your child’s welfare, but in the long run it is going to benefit your child hugely in terms of their rehabilitation and that seems to give them a chance to kind of catch their breath. And then once that process starts, parents are always saying, “Oh, my gosh, we had no idea. That was so helpful, thank God.”

Nigel: And is the initial fear one of their concern about their insurance going up –

Sue: Yes.

Nigel: -- if they contact their insurance company? Is it a fear that lawyers are generally thought of as being very expensive people --

Sue: Yes.

Nigel: Or what do you find in your experience? What lack of motivation is for people to get involved with their insurance companies and to get involved with personal injury lawyers?

Sue: Definitely fear. Definitely, simply people being uninformed about what those processes look like. The expense. People are very worried about expense, very worried about their insurance rates are going to go up or suddenly that their insurance companies are going to somehow bail on them. And in dealing with lawyers, they wonder oftentimes if they are going to somehow get charged or they are going to be found responsible in some way for what has happened to their children.

Nigel: And how do address those fears in counselling the family members?

Sue: Just to have open conversations about that and to also invite families to think about allowing consultants to come in. So we will suggest to them, we can have a lawyer come into the hospital to sit down and explain this process to you and this would be on the hospital turf, so you don't have to leave, you don't have to go away from your child's bedside, and then this process could be explained in a way that is going to allow you to have time to think about it and hear, you know, the information from a source that can answer your questions.

Nigel: I know that if we go up to the hospital, one of the things that we tell families of a child that has had an injury, that we don't charge them any money and they'll only be charged if in fact we get the money. Is that sort of a common theme, or do you see differences between lawyers?

Sue: That tends to be for the most part a common theme in PCCU. That hasn't always been the parents' experience but what I do know is when parents tell me that that has been said to them, the relief is visible because, again, they are just going through something horrific and the last thing they want to be thinking about is spending money and having to go through transactions where they're thinking about, you know, expenses that are way beyond what they could have imagined affording.

Nigel: We get into those sorts of issues sometimes in the legal world of what we call liability, so a child that is in a car as a passenger cannot be found at fault for an accident. A 14-year-old, for example, just steps right off a curb in front of a car may have some negligence in having done that. Do you deal with the difference between when a child may be completely innocent for the accident or where they may be at fault, or do you just leave that to the lawyers to explain if lawyers get involved?

Sue: Usually I leave the complexities of those situations to the lawyers to deal with, but I am often dealing with the emotional side of that because whether the child is a passenger and was innocent or whether a child did something that resulted in an accident occurring to them, parents inadvertently feel guilty – always -- expressing guilt around why wasn't I there, I should have been there, didn't I tell him enough times not to do that, there was something I must have done wrong or I must have lacked. And then if it's a situation where it's passengers, parents question themselves continuously about "I should have done this. What if I had done that?"

Bill: It's literally every parent's worst nightmare.

Sue: Every parent's worst nightmare.

Bill: Over your career, Sue, you have seen, I'm sure, all make and manner of lawyers come and go and, just in very general terms, I'm wondering when you speak with a family who have met with a lawyer for the first time, are there consistent themes that strike you as being positive that come out of those first conversations? And similarly, are there things that are not received well by families in the way that information or a presentation is given by the lawyer they have met with?

Sue: I think what I've learned from families over time is that the conversations that are most helpful for them are conversations that are brief yet informative, that allow time for them to ask questions, because inevitably in these situations, they are still operating a lot of times in kind of a shocked state. I really believe that in those first meetings, I am wondering sometimes whether families really hear everything that has been told to them, so I think very much the approach, tone of voice and just the invitation that if you need to talk about this again, if you need us to come back and discuss this again, you know, we're here for you. That, that is the approach that seems to work best with families, in terms of solidifying their readiness to retain a lawyer or to move forward with that and feel comfortable about it.

Nigel: You talk about trying to provide some help and counselling to family members and often there is a feeling of guilt. There are a couple of questions I wanted to ask you on that. Is there what I'll call an average stay of time that you would spend with a family before they would move through the system and out of the hospital, and then the second part of that question is of course a lot of people don't understand, but that family members are also entitled to receive benefits including counselling outside of the hospital, and what do you do in terms of trying to either (a) encourage that; or (b) set that up so families can continue to get treatment by way of counselling once they have left the hospital and you are not involved in their lives anymore?

Sue: The first question – length of time with people – can vary again depending upon the severity of the accident. That really is what it depends on. Because I can be involved with a family for three weeks, six weeks, three months and sometimes I've been involved with the family up to almost a year. And of course the longer I'm involved with a family or more intensely, the more that relationship is solidified. In that process, especially length of time allows me to have more opportunity to explain resources to people. And by the time people do have insurance adjusters and lawyers involved, they are then meeting rehab teams that are coming from outside of the hospital to be involved and that process starts there, and then they

can access counselling through that. For families who do not have the, quote, motor vehicle accident where they do have insurance and monies to pay for those things, I am connecting them with counselling resources back in their home communities and finding ways to do that so that they don't have to pay for it or if they do have to pay, that that payment is minimal. And we have – sometimes we do have donations in the hospital or ways to offset some of those costs for families.

Nigel: I know in unfortunately a number of situations, we are dealing with a family where the mother and the father don't live together, perhaps are separated. Does that create problems for you, and if it does, what do you try to do to resolve those problems or conflicts?

Sue: Separations, divorces, custody and access kinds of issues always add a little bit of excitement to those situations. However, I think that, again, approach is really important. Sometimes people have very strict boundaries, guidelines already set in place for who has primary custody or who has access to their child and who doesn't and when those are set in place then we just follow that. Where those relationships are less defined, we spend a lot of time talking with parents about the importance of setting aside their differences while the counselling process takes place while the hospitalization is happening.

Bill: Sue, I just finished reading a novel that had me thinking about you and your work at the hospital because in the story, there was a child who needed a critical blood transfusion which was not something that his mother and father were prepared to accept, and it got me thinking about this. As London and southwestern Ontario generally become more multicultural and more diverse, are you seeing situations arise in the hospital that challenge the way that things maybe have been done in the past? And are there new or different kinds of resources that you are reaching out to try and handle those situations – everything from language issues, religious beliefs, cultural practices? Is that becoming more of an issue?

Sue: Absolutely true. We talk about, regularly, the fact that families' situations irrespective of culture, spirituality are just becoming more and more complex – blended families, divorced families, families where there are custody issues. So we are spending much more time having crucial conversations with parents in these situations and reaching out to community resources that can help us with that. Also, we operate from a new perspective which is family-centred care or patient-centred care, so that philosophy espouses that we work with families in such a way that we respect their point of view, that we invite partnership with them, we invite

collaboration and we find that when operate from those principles it helps immensely, especially in working with families where there are many differences or lots of layers of complexity.

Nigel: When I have gone into the hospital to see a family whose first language is not English, I will try to bring somebody with me that speaks their native language. Does the hospital have interpreters, or do they have a resource so that they can bring somebody in that can even translate what it is you are trying to tell a family that may be a first generation and don't really speak English very well and obviously you don't speak, whether it is Chinese or Arabic or Portuguese or whatever the family's native tongue may be?

Sue: Yes, we routinely use a service called Across Languages. I'm not sure whether the LHSC (London Health Sciences Centre) entirely uses them, but through the social work program we use Across Languages for our interpreters. They are very available, usually available the same day that you call them they can arrange for somebody to come, so it's very helpful. And there was a time when we would offer to have family members that could translate if they spoke both English and another language but we stopped doing that because we realized that that really was a conflict of interest. To an aunt and uncle, another family member cannot separate completely their own emotions from a situation and so – and also we couldn't be convinced that they would accurately reflect what was being said from a medical perspective, so that is why we strictly use professional interpreters now. Only in a crisis situation where – like a trauma, where we needed to share very grave information immediately – would we use a relative or perhaps a staff member at the hospital if we couldn't get a hold of Across Languages fast enough.

Nigel: And then, unfortunately again, we have been involved in what really is the nightmare and that is where a family member has in fact caused the injury, so mom is the one that is driving the car, lost control, went into the ditch, badly brain-injured their child; the cousin caused the injury. You obviously see that scenario, and does that create further complexities for you, and how do you deal with those?

Sue: Definitely they cause further complexities, and that really is in terms of, first and foremost, the counselling time would be much greater. Those parents need so much more support in terms of just managing their guilt and the way that they feel other people are going to see them or view them as parents. Sometimes we have parents in situations like that that can't even come into the Critical Care Unit for a few days because they are dealing with so much grief around that specific issue. And potentially police. My role primarily there is to try to help

them to feel as respected and accepted as possible given that there is no way their own acceptance is going to be there. And some of that involves doing teaching with staff, with nursing staff, with respiratory therapists and other people that are going to be involved with those families around boundaries and not making judgments about people.

Nigel: Does that make it harder for you to get families to accept intervention by way of lawyers because of their concern that one of the family members is going to be – I'm going to use the word "attacked" but obviously not in a physical sense – but their perception is that the blame is going to become greater because lawyers are going to say, "You're the one that we're going to have to sue because you're the one that was at fault for the accident"?

Sue: No question that becomes a difficulty but I think, you know, over time and discussion, people realize that they need those extra hands that are skilled, that – you know – that knowledge to help them through that situation, because if they didn't have it then they are not going to have the support that they need and those relationships potentially could really crumble even further without some direction.

Bill: Sue, there may be somebody listening to this interview who has a grandchild, a niece or nephew who is in the PCCU right now and they have very high anxiety about what lies ahead. Certainly Nigel and I have experienced that kids and adolescents have an enormous resilience and when we meet a family for the first time it is often shocking, literally shocking, to see how much progress and recovery has occurred by the time we see them a second time, but from your years of experience, can you offer some advice to somebody listening to this who is really uncertain about lies ahead and what they can do to best support not only the young person but also their larger family?

Sue: The first thought that jumps into my head is, slowing down, taking one day at a time. Because, especially with brain injury, it is the type of injury that is so sophisticated and our physicians who have been working in the unit for years cannot – still, cannot say to families, "We can predict this, we can predict that, this is when you're going to see changes." Everything is really unknown because each injury is very different and each child takes a different course and time to heal. So I would say also that what parents really need is for people to just be emotionally supportive. There can be a lot of reason to judge. I think in those situations, parents just need people to be there for them, to listen, to help out at home in different ways. You know, it's the small things sometimes that matter, like having somebody to cut your lawn or get your groceries or bring your mail and look after your pets. All those things, even though

they sound insignificant, are huge if you're having to spend hours and days and potentially weeks or months in a hospital setting.

Nigel: Sue, I noticed in giving some of the examples, you made reference to suffering a brain injury a few times, and obviously if a child has a broken leg and they need it to be casted, they go to the emergency department, and they are probably not even admitted to the hospital. Is there, for lack of better words, some criteria as to how a child would end up in the Paediatric Critical Care Unit as a result of the trauma? And do you see a disproportionate amount of kids that have brain injuries that end up in the unit?

Sue: We have many kids that come into emergency with different kinds of injuries that get assessed and treated and go straight up to the paediatric floor. What would require intense management would be the need for breathing support, if there was brain swelling. Oftentimes they'll base an admission to PCCU on a Glasgow Coma Scale which reflects how well the brain is working by numbers, an assessment that they do. So most of the time, children need to require the support of a ventilator to be admitted to PCCU, which oftentimes they do, in a significant trauma. Or they may, if they need surgery right away, and the surgery is going to be complex or there's multiple surgeries that have to be done, then they have to be observed in PCCU afterwards.

Nigel: Bill and I were in the hospital the other day meeting with the hospital staff and parents – something that is called a team meeting, which you would be obviously familiar with. And the question that the parent asked was, "When is my child going to be normal?" How do you deal with that when you know that normal is never going to happen again?

Sue: Yeah. It's sort of a – again, a process of helping them understand that perhaps there is a new normal. And that's just easy to say, and their process of understanding that is just going to be time, lots of tears, lots of adjustment. Parents often think that they can't imagine that being the case. They can't imagine themselves being able to cope with that. They don't believe that they can handle something different than what they've always known. But people are incredibly strong and incredibly resilient, and I've seen many families get through horrific things that they thought they couldn't deal with. But it's certainly not without hurdles.

Nigel: And the other thing -- I've said this, I know, to you before – and that is, I can't imagine (a) doing your job; or (b) the length of time that you've done the job because of all the heartache that you must see. How do you manage to do your job and how have you been able to do it for such a long time?

Sue: Well, I would say that the value in this job is every family that you meet, every family that I meet, I learn something from. All of these parents that I have seen over the years – kids, siblings I've seen over the years – I have been impacted so much by their resilience and by their strength, by their courage. And those kinds of things are what continue to keep me hopeful and keep me strong in the job, but for sure there are days that I go home and it seems so obscure to be driving away from the hospital where somebody has just – you go home and then suddenly go through your front door and say hi to your own healthy kids and say, "What would you like for supper?" and start making spaghetti as if your previous eight hours didn't just happen. That's, that's sometimes a struggle, and it's important to put in place self-care kinds of supports like having good hobbies, having lots of ways to get out and enjoy your own life and connect with your own family and rest, exercise – putting those things in place for oneself, debriefing with other colleagues. Those kinds of things are important to do.

Bill: All of that was hugely informative and I think helpful, and Sue, I know you've got a busy work life up at the hospital so thank you for giving us your time to come down here and participate and answer all these questions. It was great.

Sue: My pleasure.

Nigel: Thank you. Thanks for coming.

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