

CASE EXAMPLE



This is part of a series that illustrate encounters of implicit bias, health inequity, and disparity in the provision of health care.

CASE EXAMPLE #7 — Part 1 Severe maternal disparity

See added safety strategies on page 2

CASE EXAMPLE

A 26-year-old Black patient recently moved to a new city and, due to the pandemic and restricted availability of appointments, was not able to immediately establish care with an OB/GYN. At 36 weeks gestation, she presented to the Emergency Department on a Saturday with complaints of acute abdominal pain, fatigue and nausea.

During triage, the patient shared with the nurse that she has a history of sickle cell anemia from birth and had started to experience more severe pain throughout the day, extending into her abdomen. Well versed in this experience, she shared her history of pain crises and that her at-home comfort care regimen wasn't working; she was in significant pain and needed treatment urgently. Despite advocating for herself given her history and experience with sickle cell crises and knowledge that her pregnancy was high risk, the nurse dismissed her concerns as symptoms associated with anxiety and pregnancy and sent her back to the ED lobby to wait.

As time passed, the pain and nausea intensified further. After an hour, the patient approached the triage desk and attempted to share that her pain was worsening, and this was worrisome to her as it was different from previous experiences. The triage nurse sent her back to the waiting room, believing the patient to be exaggerating symptoms, and told her she needed to wait. She waited several more hours until she was seen for a more thorough medical evaluation.

She was brought to an open room. A provider entered and stated to the understanding that the patient was pregnant and experiencing pain and nausea. The patient shared again that she felt this was a pain crisis and had received a specific pain medication and IV fluids previously for a similar experience while pregnant. The provider dismissed this information as drug-seeking and proceeded with the medical screening exam using Doppler to confirm the presence of fetal heart tones. No attempts were made to obtain the patient's clinical history or other diagnostic tests to inform diagnosis. The patient was given acetaminophen, treated for nausea, and discharged home with instructions to follow-up with the on-call OB physician group on Monday.

The patient returned to the ED two days later with exacerbation of anemia and pain and lack of fetal movement for two days. She had attempted to establish an immediate appointment with the OB physician group, citing her recent visit to the ED, but was unable to make an appointment until the following week. An ultrasound confirmed intrauterine fetal demise. The patient was induced to deliver, and the fetus was delivered five hours later.

The patient was not listened to, she was not believed, and she felt devalued.^{1,2,3,4}

Black women are approximately three times more likely to die from a pregnancy-related cause than white women.⁵ Contributors to this disparity are multifactorial and include implicit bias, discrimination and racism, which can result in a patient's mistrust and avoidance of care and/or feelings of not being heard, believed, or treated in a timely manner while seeking care.^{3,4}

The organization lacked an established, consistent process to respectfully triage, respond to, and expedite care for high-risk patients presenting to the ED. The organization also lacked a clinical protocol that would allow the nurse to escalate concerns about the patient's condition.

The provider was in a hurry and spoke without engaging in respectful dialogue with the patient about her symptoms, experience, medical history and concerns.

Research has shown that Black women and other women of color were twice as likely to report that a provider ignored their request for help, refused requests for help, or failed to respond to requests for help in a timely manner.⁷

The patient languished in fear, discomfort and pain without reassessment.

Studies have demonstrated racial bias in pain assessment and treatment of Black patients, reporting that Black patients are less likely to be given pain medication and, if given pain medication, are given lower quantities as compared to white patients.⁶

Compounding disparities faced by Black women, the provider further lacked the knowledge and training to consider and value the lived experience of a patient with sickle cell anemia, furthering disbelief of symptoms and bias towards drug-seeking behavior. The provider also failed to consider alternative interpretations.

As a product of institutional and interpersonal racism and implicit bias, patients with sickle cell disease – an inherited blood disorder with life-threatening consequences – report longer wait times, being treated as if feigning symptoms, and being dismissed as drug-seekers.^{8,9,10} For patients with sickle cell disease, this situation can be compounded if the patient has no history with the organization, as in this example.

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Case Example #6 — Part 2

Safety Strategies

Severe maternal disparity

A look at safety strategies

SAFETY STRATEGIES

With a focus on addressing disparities in care for women of color, the organization made equity a strategic priority within the institution and implemented mandatory annual anti-racism and cultural humility training for all staff to facilitate self-examination of one's own biases, enhance empathy for lived experiences of patients, and promote respectful, equitable and inclusive care absent of bias and discrimination.^{3,4,14,15}

Organization leaders implemented daily safety huddles to proactively anticipate patient volume, flow and resource constraints in order to better promote conditions and allocate time for effective communication and decision-making.

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The ED collaborated with obstetric and ancillary services to implement evidence-based guidelines and an obstetric triage algorithm to consistently and quickly determine appropriate care for pregnant patients presenting to the emergency department.¹¹

This included evaluating the organization's capacity to effectively manage care based on the patient's specific needs and level of risk and establishing a plan for consultation and referral should higher maternal levels of care be required.^{10,12,13}

The organization implemented extensive training for its ED personnel on clinical management of high-risk pregnant patients.

The organization activated a campaign against discrimination and inequitable care facilitating actions patients can take if they feel unheard, disrespected or discriminated against.¹⁷

It further established an incident reporting mechanism for patients, family members and staff to communicate experiences of disregard, disrespect or discrimination. Reported experiences were incorporated as a metric within a disparities dashboard to identify areas for improvement.^{8,16,17}

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Case Example #6 — Resources

Severe maternal disparity

RESOURCES

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