CHAPTER 2
Disparities in Health Care: Race and Age Matters

Nearly all men can stand adversity, but if you want to test a man’s character, give him power.

—Abraham Lincoln

Behavioral Objectives

At the end of this chapter the learner will be able to:
1. Examine the concept of access and the extent to which it is addressed.
2. Discuss at least three race-based disparities in health.
3. Discuss at least two age-based disparities in health.

Key Concepts

EPIC
Metabolic syndrome
Prevalence

Introduction

America has always been referred to as “the land of the free and home of the brave,” the most powerful country in the world, rich in human and fiscal
resources, and world leader in the advancement of scientific knowledge. Despite its wealth and position globally, health care is so unevenly distributed in the United States that a quick assessment reveals some individuals receive fewer services than others. Being an older adult and disenfranchised can greatly influence care received and overall health outcomes. The United States is one of only two countries in the industrialized world without a universal system of health care. In fact, the healthcare delivery system in the United States has a rather embarrassing track record, with disparities in health care being an important underlying factor. Although limited progress has been made in passing a healthcare bill, the newly drafted legislation lacks a “public option” and falls short of providing coverage for everyone in need. Even when the healthcare plan is fully implemented, it will not eliminate disparities. It is imperative that health providers acknowledge the imperfections in the system’s care delivery, and clearly conceptualize the true meaning of access to quality health care, so that policies and procedures might be implemented to address these serious matters.

This chapter raises five questions that require serious attention by health providers if true access and elimination of disparities are to be addressed. What is all the disparity fuss about? Is access adequately defined, or is the concept outdated and in need of redefinition? Is lack of access perceived or real? How do providers determine quality outcomes? Finally, how if at all, can compliance be better addressed? These are not new topics but are discussed in such a way as to assist providers to better understand and address disparate care in their practices.

WHAT IS ALL THE DISPARITY FUSS ABOUT?

Since 2002, when the Institute of Medicine released its report on ethnic and racial disparities in health care, the topic has been prevalent in the literature. Many have documented unequal diagnosis and treatment of underrepresented cultural groups in the United States (Schneider, Zaslavsky, and Epstein, 2002; Smedley, Stith, Nelson, 2002; Petersen et al., 2002; Hill, Shipp, and Wilson, 2002; Clegg et al., 2002; and Margolis et al., 2003).

Although cardiovascular disease is the leading cause of death in the United States for all races and ethnicities, African Americans are 50% more likely to develop heart disease, have a 43% greater incidence of death from heart disease, and tend to die earlier as compared to European Americans. Additionally, African American women have a 25% higher chance of dying within a year of diagnosis, as compared to men (Patlak, 2001).

In a large study using Medicare data from more than 294 plans, Schneider et al. (2002) found that African American patients received fewer appropriate
medical services such as mammography, diabetic retinal examinations, beta blockers at discharge after a heart attack, and follow up for mental illness, than white patients, leading the authors to conclude that access is not the only driver of racial and ethnic healthcare disparities.

It is common knowledge that African American patients receive far fewer invasive cardiac procedures than white patients (Conigliaro et al., 2000; Peterson et al., 1994; and Whittle et al., 1993). However, African American patients in one study, although considered ideal candidates, were 42% less likely than whites to receive life-saving thrombolytic therapy upon arrival at the Veterans Health Administration Hospital, a facility considered an equal-access care system. African American patients were also less likely to receive bypass surgery, but more likely to receive aspirin at discharge (Petersen et al., 2002). Racial disparities in the use of medications, angiography, and angioplasty among veterans with acute myocardial infarction (heart attack) were not observed.

African American women are in double jeopardy, facing differential treatment as a result of being black and female. They are more likely to die of a heart attack before ever reaching the hospital and less likely to be recommended for, or actually receive, therapeutic surgical procedures. The reasonable explanation is that physician differential treatment of women directly and indirectly influences their health outcomes (Hill, Shipp, and Wilson, 2002). Hill, Shipp, and Wilson (2002, p. 3) indicate “from our research, we have found that there is differential treatment of African American females with heart disease and that there are disparities in outcomes among African American females with heart disease due to differential treatment on the part of the physician in proposing invasive treatment plans or prescribing particular medicines.”

ACCESS DEFINED: OUTDATED OR IN NEED OF REDEFINITION?

Most health professionals define access to health care as typically having insurance, or the ability to pay out of pocket for quality health care, and having transportation to get to and from healthcare services. Therefore, in the eyes of the provider, insurance coverage and transportation equates to access. Access so narrowly defined creates a dilemma for most of the nation’s disenfranchised. True access, in our view, goes beyond getting to and from the service and having the ability to pay. Rather, true access includes patients getting their needs met once they enter the system.

In a study of adolescents attending a clinic, Pope and John (1999) found that patients were often labeled before even being seen, and interventions
were clearly negatively skewed during provider interactions with minority patients as compared to majority patients. When this occurs, access to care is impossible. Because the typical health provider honestly believes that the system is fair, and that people living in the United States generally have equal access to health services, they are puzzled by, and at times react defensively to, the mere suggestion that physicians and nurses would intentionally give better care and treatment to some patients over others. However, it happens more often than most would like to think.

The discussion about disparities is an age-old topic among the health-care community. It is time, however, to move the disparity agenda from the boardroom to the action-oriented workplace, particularly as hypertension and chronic respiratory problems such as reactive airway disease, diabetes mellitus, renal failure, metabolic syndrome, and multiple organ dysfunction with its debilitating complications are raising havoc in the African American and Latino American communities even when access is not a factor (Prussian, Barksdale-Brown, and Dieckmann, 2007). Each of these preventable problems disproportionately affects racial and ethnic minorities. Some racial and ethnic minorities have much higher percentages of metabolic syndrome than general population estimates. For example, Latinos have a prevalence rate of 32%, African Americans have a 22% prevalence rate, and women have a much higher prevalence rate than men (American Heart Association, 2005).

*Prevalence* is the total number of cases at a particular point in time.

*Metabolic syndrome* is defined as a set of health factors that are associated with an increased chance of developing heart disease, stroke, diabetes, or a combination of these problems and it is strongly linked to insulin resistance. Several factors contribute to developing metabolic syndrome, including being overweight, physical inactivity, and genetics (Prussian, Barksdale-Brown, and Dieckmann, 2007). Prussian et al. (2007) suggest that African Americans have high rates of hypertension even without considering metabolic syndrome, and may be at more disease risk than other populations. Hispanics have an increased risk of diabetes associated with metabolic syndrome.

These examples illustrate the importance of moving the disparity topic from discussant roundtables to implementation of healthcare policies that can be fully operationalized. Otherwise, we lose the battle against quality of life for many who we claim to serve. The foundational basis for these health problems are threefold: 1) lack of true access, 2) inability to pay for prescribed medications, and 3) inadequate patient and family teaching to enhance compliance. Not one of these problems is new but if they are to effectively addressed, then they must be examined in a new way.

Decades after the implementation of federal initiatives such as Medicaid and EPIC (a prescription plan for the elderly), and years after Child Health
Plus (health insurance for infants and children), racial and age disparities still exist in this country. Once the problem is acknowledged, health providers must push for an agenda for change—a call for action. Much of the world’s population is dying from illnesses and conditions that are well within the realm of prevention.

Redefining access is perhaps long overdue. In addition to getting to and from services and having the ability to pay, we propose that true access to health care is also defined as when individuals enter the healthcare system and leave having had their needs met. This might include routine visits to primary care offices, clinics, health centers, or specialty offices; visits to the emergency room or urgent care centers; or even stays in hospitals or other healthcare facilities. When patients attempt to access these services and perceive they have been insulted, offended, disrespected, labeled, or even ignored, they have been denied access.

It has been well documented in the literature that African American patients are more likely to report distrust of the healthcare system, to report being treated with disrespect during healthcare visits, and to report feeling that they might be better served by a nonwhite physician (Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995; Cooper-Patrick et al., 1999; Saha, Komaromy, Koepsell, Bidman, 1999; Doescher, Saver, Franks, Fiscella, 2000). Patients often share stories of visiting the same primary care provider (PCP) for over 20 years and being poorly received, repeatedly labeled, misunderstood, and/or misjudged by the first person who greets them in the office or with whom they speak on the telephone. In these cases, even if patients are received well by the PCP, true access in this office is still a problem.

Much of the problem results from what we describe as “the front desk syndrome,” the receptionist or secretary consistently oversteps their boundaries and speaks for, or intervenes on behalf of, the provider. This behavior is often pervasive and damaging. It sometimes occurs with the full knowledge of the busy provider, resulting in some patients dropping from the practice without explanation. An easy fix might be to consider sensitizing staff to respond better to the needs of clients from various cultural backgrounds. This would help to maximize provider–patient interactions. Another strategy might be to carefully review and revise hiring goals to include persons reflecting the racial and ethnic backgrounds of the clients seen by the provider. This good faith initiative is important, especially as patients report never seeing an employee who even remotely resembles their age, race, or ethnicity except in cleaning positions. A more culturally representative staff might model appropriate behaviors and encourage staff competency in communicating across cultures.

A classic example of ineffective communication across cultures is dismissing the verbal and non-verbal cues conveyed by patients who report
they are in serious pain and instead labeling them as “drug seeking.” Pain
is subjective, it must be thoroughly assessed and is not to be undermined
or minimized. Another example is taking a patient’s response to assess-
ment questions literally without consideration for their age or culture. For
example, when a provider in the emergency department seems annoyed or
openly makes statements such as, “This is the third patient I’ve seen today
claiming their problems just started. If I see one more patient today who
tells me he has had his symptoms ‘for a minute,’ and yet, showed up in this
ED, I’m going to scream.” The physician’s frustration with the patient who
responds he has had his symptoms “for a minute” shows lack of cultural
knowledge. For many, especially younger persons, the phrase “for a minute”
means they have been sick for a long time. This provider is demonstrating
age and cultural insensitivity.

In many instances, although dissatisfied with support staff and/or their
provider, patients feel trapped, and remain with a practice because they
feel they lack other options. A final example of failure to communicate
across cultures involves depression, especially in Asian women. Asian
women who complain of pain in their head, heart, and stomach for three
years or who present in the ED with complaints of their heart hurting
might receive a battery of diagnostic cardiac tests, but depression might
be the problem. Being initially assessed by a provider without regard for
the patient’s culture leads to a cardiac workup instead of tests for depres-
sion (Estin, 1999). Settling in America can often lead to a dramatic role
change for Asian women. This example demonstrates how important it
is for health professionals to educate themselves about the health beliefs
and practices of the ethnic groups most prevalent in their practice areas
(Estin, 1999).

LACK OF ACCESS TO CARE: PERCEPTION
OR REALITY?

Is lack of access to care in the eyes of the patient or is it real? Lack of access
needs a critical new look. As explained earlier in this chapter, lack of access is
typically viewed as the patient’s inability to see the provider, or to pay for
services. With regard to transportation, many providers, partly due to the
availability of Medicaid transport services, would argue that very few of
their patients have legitimate excuses for not getting to their provider’s
offices. While getting to the provider’s office may not be a problem, in
reality, true access goes beyond just making it to the appointment. In many
cases, although the patient gets to see the provider, some report later that
they leave without having their health concerns addressed. The next section highlights three specific patients who were actually seen by their providers yet still lacked true access.

**QUALITY HEALTH OUTCOMES: THE PROVIDER’S PERSPECTIVE**

Part of what makes the discussion of true access so vibrant in regard to achieving quality health outcomes is what occurs in practice settings after patients arrive. Three situations illustrating patient attempts at accessing quality care and getting their needs met are described in the following scenarios.

A Latino patient who lives within walking distance of the provider’s office arrives at the practice without difficulty. This patient may be considered to have great access. Yet the provider, after spending 15 or 20 minutes with the patient, misses the real message being conveyed during the visit and the patient leaves feeling his needs were unmet. Missing critical cues during an encounter with a patient may happen just because the provider knows nothing about the patient’s culture. The provider may be culturally insensitive or simply providing disparate treatment. In other words, the provider may have let the patient’s race negatively influence the care decisions. However, if asked, providers may be unaware that patients in their offices are treated differently.

Another example of denied access can be seen in the case of an older adult, European American diabetic patient who comes in for a routine visit and is dehydrated (e.g., lips cracked and skin tenting). This patient needs more than a routine encounter. During the encounter it seems obvious that the patient is probably not taking his medication. He did not bring his glucometer to the visit but says his sugar checks have been okay at home. In spite of this, the patient gets a flu shot, has his feet checked, and leaves with an appointment for a four week follow-up visit. There is other information needed, and diagnostic tests are indicated. Yet, not even a fingerstick blood glucose is obtained during the encounter. When later questioned, the provider seemed honestly surprised that an office glucose check was not done, the need for increasing fluids was not discussed, and the patient was not sent for labs.

Another lack of access example is seen in the intervention with an African American hypertension patient who is being currently treated with Vaseretic 10-25. The patient’s blood pressure is 196/100. She is either not taking her medication, or in need of a medication adjustment, although she does not complain of any particular ill feelings except her usual chronic headache.
She also leaves with a one month follow-up appointment after being reprimanded by her provider for “gaining three pounds since her last visit, poor BP control, and being non-compliant.” The patient reported that no one rechecked her blood pressure during the visit or before leaving.

When later discussing this scenario with two uninvolved providers they agreed the patient was clearly non-compliant but someone should have rechecked the blood pressure. Neither made mention of the fact that a more thorough assessment of the patient’s neurological status should have been done because of her headaches. Also, perhaps Vaseretic (a combination drug containing enalapril, an ACE inhibitor, and hydrochlorothiazide, a thiazide diuretic) may not have been the best medication for this patient. ACE inhibitors are generally less effective in African Americans (Exner et al., 2001). In one study of black and white patients with left ventricular dysfunction, white patients showed significant reduction in blood pressure after being treated for 1 year with enalapril, black patients did not; the black patients also had higher rates of hospitalization and death (Burroughs et al., 2002; Exner et al., 2001). Furthermore, although the JNC VII guidelines, recommend thiazide diuretics as the first line of treatment for hypertension, because it has an adverse effect of increasing the blood sugar (NPPR, 2008, p. 24) it may also not have been the best diuretic choice for a patient already at risk for diabetes mellitus type II. Kudzma (1992) and Munoz and Hilgenberg (2005) encourage health providers to be more selective when prescribing medications for their patients, suggesting that medications, although effective in treating one group of individuals, may not be the right choice for a different group of individuals.

On the surface, each patient appears to have had access to health care because they each completed their visits with their primary providers, the one person who knew them better than anyone else in the practice. However, despite being seen by competent providers that day at least two of the patients are in serious trouble. Not one of the three had true access. For whatever reason, obvious signs and symptoms were missed, ignored, dismissed, or considered as something to be addressed during the next visit.

Listening with your eyes, ears, and a caring attitude to what patients are really trying to convey, or even conceal for fear of being labeled non-compliant, or to a drug seeker, uncaring or not responsible for his or her own health status, is essential to providing true access to health care. Being in sync with every patient’s health need and concern is no easy task but is required if a provider is to address true access to care.
Another common problem impacting access is that the Medicaid system is so structured that when patients present with multiple across-service problems, they can only have one problem addressed on any given visit. This prevents a health center patient who keeps an important appointment with the primary care provider (PCP) from seeing a dentist in the health center on the same day. Even if the PCP discovers that the patient is in need of immediate dental care, Medicaid will not pay for a second visit on the same day. Once the encounter has started, the PCP must suspend that visit, not document it, and send the patient across the hall for an emergency dental visit instead. Providers must make difficult decisions based on how the patient presents, about the most important intervention needed, and follow-up visits. The flu shot or pneumonia vaccine might have to wait for a few days until after a dental visit.

LACK OF RESOURCES FOR PRESCRIPTIONS

A problem of particular concern that results in disparities is that some clients lack the ability to pay for medications. Despite the fact that the medication they need may be stockpiled in a storeroom at the practice site, some patients are never offered samples by the provider. This is particularly reported to be true of the working poor and older adults who are on fixed incomes. They leave with the prescription sometimes knowing in advance they have no money to fill it, but pride prevents them from revealing this information. Consequently, their condition worsens, and they return either to the ED or present to their provider’s office at a later date with a now, significantly more complicated problem which is more costly to treat. Sometimes out of pride, or maybe even fear of being labeled poor, not a hint of this is shared with the provider.

A child, then, with reactive airway disease (asthma) who does not get asthma maintenance medication will repeatedly return to the emergency department for rescue treatments when the acute attack, which is certain to happen, occurs. The parent in this case might be openly criticized for not filling the prescriptions but also allowed to leave without samples, a social work referral, or intervention, only to have the emergency cycle repeat itself.

There is even inequity in terms of which patients actually get the drug samples to tide them over until getting the prescription filled; this boils down to how the person is viewed by the provider. Unfortunately, the decision is sometimes race-based. It is essential that providers monitor the dissemination of samples and ensure that they go to the patients most in need.
TEACHING FOR IMPROVED COMPLIANCE

It has been well established that often people of African descent will not go on antihypertensive medications. They share a common notion that “once on it, you’re on it for life.” Somehow, they have gotten the inaccurate notion that the problem will improve without the medication. They negotiate a personal bargain, “If I just start eating right, avoid the extra salt, and lose a few pounds the blood pressure will come down.” Although weight reduction and diet will help, by the time medications are needed the problem won’t be resolved with diet and weight control alone. Patients need to be given all the necessary information to make decisions about management of their health and if the decision is contrary to the providers, they will learn to deal with it.

I recall recently taking a client’s blood pressure at church because she was complaining of a terrible headache. One glance in her eyes revealed broken capillaries leading me to believe it prudent to do so. I knew her blood pressure was elevated, even before taking it, and suspected she knew she had hypertension. I said, “I can tell you haven’t been taking your blood pressure medicine.” She replied, “I was given a prescription five weeks ago but never filled it because someone told me once you start taking blood pressure pills, you can’t stop, you’re on them for life.” Her blood pressure was 200/110. I told her daughter to take her mom directly to the ED. I explained that without medicine she was at risk for having a massive stroke and dying, but with medication she could control her blood pressure and headaches and still lead a long, quality life.

This was not likely her first time hearing this information but her response was, “Oh my God, my mother and aunt both died from a stroke, I’m going to get the prescription filled today.” She made a point of following up with me during our many church encounters and she reports her blood pressure is now well controlled, as are her headaches. She has also worked out a weight reduction plan and exercise program with her PCP and is beginning to read food labels to increase her awareness of especially high sodium and fat content.

A casual informative session with a person who isn’t even responsible for her health care probably made a strong enough impact on her to lower her risk of target organ damage and preserve her life. Even if she reaches a point at which she no longer complies with the regimen developed by her PCP, she has all the necessary information to improve her compliance, if she so desires. When patients understand their illness and the importance of following specific regimens they are more likely to comply. Although
scare tactics were not the intent during the church encounter with this individual, being candid with patients sometimes helps them to put the situation in perspective, which might result in them taking action.

**SUMMARY**

Researchers often take differing positions on the causes of disparities and the solutions needed to address them. However, many would agree that resolving the disparity problem is a multidisciplinary effort. Healthy People 2010 placed eliminating health disparities among its most important goals (USDHHS, 2006). Long, Chang, Ibrahim, and Asch (2004, p. 811) suggest that “the elimination of hypertension, HIV infection, diabetes, and homicide would contribute the greatest to eliminating racial disparities in mortality” (Long et al., 2004, p. 811), an accurate, but unrealistic achievement. Improving the health of all people is achievable when everyone comes together to collaborate on putting forth the best efforts in creating an environment of health equity and change. The nation’s healthcare leaders must ensure that 21st century practices are better than those of the previous era.

The final pages of this chapter present case scenarios that call attention to disparities in health, evidenced by differential practices and access to care issues. The cases can be used to facilitate discussions in class and training forums.

**CASE STUDIES**

As this chapter on disparities so vividly points out, diversity issues are uncomfortable; they take us outside our realm of understanding. The following scenarios are designed to stimulate candid discussion about disparities in health care, and to help staff identify best practices for building a climate of cultural competence. Each scenario draws on a real-life experience. The cases demonstrate how seriously cultural differences, when unattended and not addressed explicitly, can impact workplace relations, staff performance, supervision, administrative policy, and ultimately, the quality of patient care.

The letters of the scenarios spell out the phrase “ASK ME.” Interpreting the meaning of this title could be an effective warm-up activity in this series. We believe it is worthwhile to ask participants what they think the title means. Some staff may suggest that “ASK ME” means never to forget the
patient in the treatment situation—we must work with, rather than around, the patient. We must talk to, rather than about the patient. We should remember to listen to patients, ask for clarification, and re-state their concerns and feelings.

Another interpretation of “ASK ME,” and one that falls in line with facilitating this exercise, is that we should recognize the people who do the work. In the sensitive context of diversity, health practitioners not only follow policies and procedures, they must manage a number of situations with few rules and precedents. The scenarios ask staff to talk about their encounters with culturally different patients. The lessons of cultural competence are embedded in their stories. The scenarios establish a forum for staff to discuss what they know, what they find perplexing or difficult, and how they have finessed potentially explosive situations. Over a busy work day, this kind of discussion and the valuable insights that surface may get passed around at the proverbial water cooler but they are rarely written down. This exercise provides a structured opportunity to turn this situation around.

Facilitating the Scenarios

The scenarios are intended as discussion starters and therefore do not prescribe a “right” answer. This exercise is flexible. For example, the facilitator can work with one case or the whole set of scenarios. The context for the scenarios can be a formal training session or an informal small group meeting. The aim of the discussion is to produce strategies that support the development of cultural competence. The dialogue should be a vibrant exchange of ideas for developing a culturally competent workplace: What are we doing well? What needs work? Participants’ comments should be recorded on flipcharts or whiteboards. This approach validates and reinforces the importance of each person’s contribution to the discussion.

The scenarios include three key questions for participants followed by discussion points the facilitator can utilize for further exploration of the topic.

Diversity discussions typically evoke strong emotions and should be carefully planned. For example, who should facilitate the discussions—someone within the agency or an outside consultant? Who should attend these discussions? Should we have a mix of administrators and staff or conduct separate sessions for each group? All too often the good intentions of diversity discussions break down because these critical issues are not thoroughly considered.
Case Study #1

INSTRUCTIONS

Critique the case and analyze the situation. Ask yourself the following questions:

1. Did this patient have access to care? If your answer is “No,” why not? If your answer is “Yes,” why?
2. What, if anything, should the provider do?
3. Is there anything the patient can do?

Mr. Andersen is a 68-year-old, African American male who recently recovered from a Trans Ischemic Attack (TIA) commonly known as a mini stroke. He has a history of hypertension and takes Metoprolol 50 mg and hydrochlorothiazide 25 mg once a day. He is just completing his follow-up visit with his primary care provider. As the visit is winding down the physician writes a prescription for Plavix 75 mg (a 90-day supply) with directions to take one tablet every day. He also tells him to take 1 baby aspirin a day. As the physician proceeds to write the prescription he stresses repeatedly the importance of taking both medications without fail in order to “prevent another TIA.”

Unknown to Mr. Andersen, having a first TIA puts him at great risk of having a second one. Mr. Andersen works his way through the packed waiting room to the front desk. The receptionist glances down as she is scheduling Mr. Andersen’s next appointment. Seeing the prescription Mr. Andersen is holding, she buzzes the physician over the intercom stating, “the patient has no insurance so he will have to pay out-of-pocket for the Plavix, what do you want him to do?” Out comes the physician who, as he rips up the prescription, tells Mr. Andersen to just take the aspirin, assuring him he would be just fine.

DISCUSSION POINTS

1. What prompted the physician to make such a dramatic turnaround in his advice to Mr. Andersen?
2. What message is the doctor sending to Mr. Andersen?
3. Identify the medical issues that require attention.
4. Explain the receptionist’s behavior in this situation. How do you think Mr. Andersen felt when she announced his lack of insurance over the intercom? What happened to patient confidentiality in this situation?
**Case Study #2**

**INSTRUCTIONS**

Critique the case and analyze the situation. Ask yourself the following questions:

1. Did this patient have access to care? If your answer is “No,” why not? If your answer is “Yes,” why?
2. What, if anything, should the provider do?
3. Is there anything the patient can do?

Mr. Smith, a 52-year-old, African American male lives down the street from a prominent health center. He enters complaining of a chronic, dry cough for 3 months. He offers to the doctor, “I think it’s all these medicines you have me on. How do you expect a person to get better taking all this junk anyway?” His BP is 170/98, pulse 64, and he has gained 10 pounds since his last visit 6 months ago when he was placed on an ACE inhibitor and told to stop smoking cigarettes. The doctor responds to Mr. Smith’s statement with, “You are obviously not taking your medications. You need to stop smoking and lose 20 pounds.” He quickly examines Mr. Smith and gives him a follow-up appointment stating, “On the next visit you must convince me that you are serious about following the plan I prescribed for you. Otherwise, you are just not going to get better.”

**DISCUSSION POINTS**

1. Mr. Smith asks the doctor: “How do you expect a person to get better taking all this junk anyway?” What is Mr. Smith getting at? What is he feeling?
2. Identify the medical issues that require attention.
3. How would you characterize the doctor’s approach to Mr. Smith (e.g., straightforward, helpful, punitive)?

**Case Study #3**

**INSTRUCTIONS**

Critique the case and analyze the situation. Ask yourself the following questions:

1. Did this patient have access to care? If your answer is “No,” why not? If your answer is “Yes,” why?
2. What, if anything, should the provider do?
3. Is there anything the patient can do?
Ms. Kirk is an African American women’s health nurse practitioner who, after witnessing an interaction between another nurse practitioner (European American) and a 30-year-old woman, intervenes. The 30-year-old, Latina mother of three entered a prominent health center with the primary complaint of severe lower abdomen pain. She walked in slumped over, holding her abdomen, tears rolling down her cheeks, with her children ages 6, 4, and 3, walking hand in hand and appearing frightened. She was dropped off by her boyfriend who was already late for work. Before leaving, the boyfriend instructed her to phone him when she was ready to be picked up.

The European American triage nurse insisted, “either call the boyfriend back, call someone else to watch the children, or reschedule your appointment, otherwise I will have to call the social worker.” The triage nurse further explained to the patient that she was going to need a pelvic exam and there was no way that could be accomplished with her children present.

Ms. Kirk, the nurse practitioner who witnessed the encounter, ushered teary-eyed mom and children into an examining room while reassuring her that it would be just fine. She positioned the children close to mom’s head, put the 6-year-old in charge of the 3-year-old giving them all coloring books to distract them and proceeded to perform the pelvic exam without the children’s awareness of what was going on. In less than an hour mom was on the way to the emergency room to be prepared for surgery for a ruptured appendix and her children were in the care of their grandmother.

**DISCUSSION POINTS**

1. The most obvious concern in this case is: How is it that the two nurses responded in such markedly different ways to this situation?
2. Once things were settled and the young mother was off to the emergency room for treatment, what do you think transpired between Ms. Kirk and the triage nurse?
   a. Did they argue about the way things were handled?
   b. Did the triage nurse claim there was a breach in health center policy?
   c. Does Ms. Kirk’s ethnicity (African American) have anything to do with how she managed this issue?
3. Conflict is inevitable in the workplace. Do we have skills for working things through in difficult situations?
4. It could be argued that experience rather than race was the driving factor in how things played out in this situation. What do you think?
5. How do you think health center administrators responded to the way Ms. Kirk handled this situation?
6. Under what circumstances is it appropriate to exercise creative approaches to solving problems, and when should we enforce strict adherence to policy?
7. Identify what might have happened if the rules had been followed and the mother had not received treatment.
8. Did the ethnicity of the patient have anything to do with the triage nurse’s response in this situation? Did any stereotyping take place?
9. Should the patient have insisted that her boyfriend stay with her?

**Case Study #4**

**INSTRUCTIONS**

Critique the case and analyze the situation. Ask yourself the following questions:

1. Did this patient have access to care? If your answer is “No,” why not? If your answer is “Yes,” why?
2. What, if anything, should the provider do?
3. Is there anything the patient can do?

Ms. Ming, a 90-year-old, Asian female, accompanied by her 65-year-old daughter, presents to the emergency department with complaints of nausea, projectile vomiting for several hours, and constipation for two weeks. She speaks only Chinese but the daughter is fluent in Chinese and English. The patient complains that her body has been out of balance for several weeks. She feared she would become very ill when none of her normal remedies restored her balance.

A CT scan of the abdomen reveals a major bowel obstruction. The surgeon informs the patient, with the daughter translating, that she will need immediate surgery. The daughter translates this to her mother who consents to the surgery and willingly signs the permission form. Within a half hour the patient’s 68-year-old son arrives in the emergency department, speaks with his mother and sister, and the patient changes her mind about the surgery. The surgeon (European American) returns to speak with the family and attempts to convince them that without the surgery their mother will get sicker and eventually die. The family still refuses. They leave the hospital against medical advice.

**DISCUSSION POINTS**

1. Would things be different if an Asian doctor advised the family?
2. What does the patient attribute to her illness?
3. Why did the patient change her mind about the surgery?
E  Case Study #5

INSTRUCTIONS

Critique the case and analyze the situation. Ask yourself the following questions:

1. Did this patient have access to care? If your answer is “No,” why not? If your answer is “Yes,” why?
2. What, if anything, should the provider do?
3. Is there anything the patient can do?

Angel Eber, a 20-year-old, European American female arrives in her doctor’s office for a routine sports physical. During her last office visit, two years ago, she was seen by the nurse practitioner for a college physical. Except for being treated during her mid-teens for severe acne, she is healthy, physically active, and has no complaints.

The doctor greets her as he enters, “Hello Angel. I haven’t seen you for a long time. How’s everything? You’ve grown up to be a beautiful young lady. The boys are probably in hot pursuit!” Angel frowns and looks away.

Near the end of the exam, the doctor asks Angel if they should be discussing birth control. She firmly replies, “No.” Smiling, the doctor begins writing out a prescription, saying, “Trust me, an attractive young lady like you needs to be on birth control. You can’t be too careful.” Passing the prescription to Angel, he continues to advise, “If you’re not sexually active now you soon will be; take this and read the directions carefully before using.” Angel hangs her head quietly, and for the remainder of the visit she answers the doctor’s questions with “yes” and “no” answers. As she leaves the office she rips up the prescription and disposes it in the trash basket.

DISCUSSION POINTS

1. What do you believe accounts for Angel’s behavior?
2. What assumptions may be influencing the doctor’s approach to Angel?
3. What non-verbal cues did the doctor miss? Why is this important?
4. In what way could the doctor have altered his approach to be more responsive to Angel’s needs? For example, would the doctor have made more headway with Angel if he had brought up “safer sex”?

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