

CASE 1

Ruth Franklin

A 40-year-old African American woman with heart failure

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Educational Objectives

- Explain how perceived racial differences and stereotyping by physicians may impact the patient–physician relationship.
- Review the health-related issues such as obesity that may be viewed differently by various racial and ethnic groups.
- Identify several factors that may lead to poor adherence to prescribed medications.
- Describe an approach for engaging a colleague whose behavior demonstrates cultural insensitivity.

TACCT Domains: 1, 3, 6

Case Summary, Questions and Answers

Mrs. Franklin is a 40-year-old African American woman who came to see Dr. Cox, a cardiologist, for management of congestive heart failure. She had seen another cardiologist in the group (Dr. Moore) 3 months earlier who had told her, "There is nothing wrong with you that losing 50 pounds won't cure." [She is 5'4" and weighs 235 lbs (BMI = 40) and has been overweight for all of her life.] This comment greatly angered Mrs. Franklin and so she did not follow-up with Dr. Moore.

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1 What factors may have contributed to Mrs. Franklin's anger?

The insensitivity of Dr. Moore would certainly have provided sufficient reason for Mrs. Franklin to be angry. Clearly, it would have been better if Dr. Moore had addressed her need for weight loss in a more tactful and thoughtful way. However, it is important to recognize that Mrs. Franklin's past experiences with the health care system as an African American may shape the significance she might ascribe to Dr. Moore's comments and the intensity of her reaction. That is, Dr. Moore's comments are seen not as the mere words of a tactless individual, but are taken as another clear expression of a system that is hostile to African Americans. For Mrs. Franklin, the physician's behavior becomes part of a list of racially motivated mistreatments (real or perceived) she has experienced that are carried forward into her relationships with other physicians.

Rates of overweight and obesity are higher in African American and Hispanic females compared with other racial or ethnic groups, due to still incompletely understood interactions of genetic and/or environmental factors. Research suggests that minority women may be more accepting of larger body frames, more satisfied with their bodies, and less likely to perceive themselves as overweight. Further, when weight loss is attempted, African American women are less likely to have success. Thus, as an African American, the issue of weight loss for Mrs. Franklin may be one that involves ambivalence and/or past failures at managing her weight.

Consequently, understanding the nature of Mrs. Franklin's anger (*is it just about the insensitivity of Dr. Moore, or is there more?*) and then responding to it are essential for Dr. Cox to establish her relationship with the patient.

2 How should Dr. Cox address Mrs. Franklin's anger about her colleague?

The importance to the patient-physician relationship of addressing the patient's anger cannot be overstated. Mrs. Franklin's anger potentially interferes with her ability to listen effectively and may undermine trust and confidence in the recommendations and care of the physician. Further, her anger may be used to control the encounter and to prevent Dr. Cox from pursuing questions or issues that the patient may be uncomfortable answering. Conversely,

making the effort to effectively respond to her anger provides a powerful message of respect that enhances the physician's alliance with the patient. Although the response should ultimately be individualized for each patient, it should be done in as nonconfrontational a way as possible using open-ended questions. Suggested questions include:

- *It is clear that what was said was very upsetting to you. Why did this make you so angry?*
- *What do you think motivated him to make this kind of comment?*
- *Given this experience, what concerns do you have about how I might treat you?*

Over the past two years Mrs. Franklin has developed progressive dyspnea on exertion, and now has severe exercise intolerance. In addition, for the past 8 months, she has had increasing pedal edema, which is now severe and has resulted in venous stasis ulceration of her right leg. This is quite painful and she is also seeing an internist at the health clinic. In addition to a diuretic (furosimide), Mrs. Franklin had been prescribed an angiotensin receptor blocker (valsartan) but did not fill the prescription.

3 What additional information would be helpful in understanding why Mrs. Franklin did not fill her prescription?

A number of factors may influence the level of patient adherence to prescribed medications, recommended treatments, or health-promotion activities. These include life responsibilities, familial commitments, employment obligations, the level of financial resources, the quality of health insurance, as well as the psychological and emotional distractions resulting from these factors. The ability to pay for not only health insurance, but co-pays and deductibles, has been shown to be an important barrier. Also important are folk beliefs and the patient's understanding of his/her disease or illness. As she interviewed the patient, Dr. Cox learned that Mrs. Franklin is divorced with three children, 8- and 21-year-old daughters who live at home and a 19-year-old son who is away in the military. She is a manager at a convenience store and has employer-provided health insurance, but her plan does not cover prescription medications, such as valsartan. In the past 2 months, she has missed

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several days of work because of severe pain associated with her venous stasis ulcer. She has therefore been fearful of losing her job and her health insurance. Mrs. Franklin was not prescribed a more appropriate and less-expensive ACE inhibitor, but instead was prescribed a more expensive substitute. This may have been due to pharmaceutical samples that influenced the doctor to give these out. However, the ultimate consequence of her receiving these samples is that she is prescribed a medication that costs much more than other appropriate generic medications and she decides not to get it filled.

Medical therapy for congestive heart failure was subsequently begun with furosimide, spironolactone, enalapril, and metoprolol. Over the next 4 months, her blood pressure normalized and the pedal edema improved slightly, but there was no significant change in her dyspnea on exertion. During this time, she missed five of seven scheduled clinic visits without calling to cancel the visit, but she would call complaining of continued symptoms. For the two appointments Mrs. Franklin did keep, she was noted to be "hostile" and "distant." Dr. Cox did not confront Mrs. Franklin over these behaviors.

4 How could Dr. Cox address missed clinic visits?

"Assuming" rather than "asking" is not necessarily respectful or culturally sensitive. The challenge is to be understanding, accommodating, and supportive without enabling behaviors and actions that are detrimental to the patient's care or health. In the patient-physician relationship, both sides have responsibilities. Failure by the physician to address self-defeating behaviors on the part of the patient ultimately undermines that relationship.

Six months after her initial office visit, Mrs. Franklin was admitted for worsening congestive heart failure. Dr. Cox suspected that Mrs. Franklin may not have been adherent in taking her medications but was also concerned that her underlying cardiomyopathy had progressed further. Dr. Biali was therefore consulted for cardiac transplant evaluation and for specialized heart failure care. The following day when Dr. Cox entered Mrs. Franklin's room, Mrs. Franklin angrily told her that she

wanted to be discharged from the hospital and that under no circumstances should Dr. Biali be allowed in the room. She reported that Dr. Biali had criticized her for not taking her medications and for being overweight. He told her that she was not a transplant candidate unless she lost 100 lbs. Mrs. Franklin was incensed over Dr. Biali's approach and attitude.

5 How should Dr. Cox respond to Mrs. Franklin?

Dr. Cox faces the potentially difficult task of reestablishing the relationship in a way that does not dismiss or trivialize the emotion and pain of the patient, but still addresses appropriate concerns of the consultant. To that end it is important to not immediately take sides before first hearing from everyone involved. An initial comment of, *"What a terrible thing for Dr. Biali to say"* or *"There is no way Dr. Biali could say something like that,"* would not be helpful. Further, as noted above, it is important to recognize that the intensity of the patient's anger may reflect past negative experiences and/or culturally based perceptions or understandings of obesity. Dr. Cox should therefore first listen to Mrs. Franklin, respectfully acknowledging her emotions and then promise to speak with her again after meeting with Dr. Biali, hopefully presenting a plan with reasonable and achievable goals.

Cardiac Transplantation

Cardiac transplantation is the treatment of choice for selected patients with end-stage heart failure who remain significantly compromised despite optimal medical therapy. This has been made possible by the improvements in recipient and donor selection, advances in immunosuppression, and prevention and treatment of infection. Currently, there is a 15% to 20% mortality in the first year, with a mortality rate of about 3.4% per year thereafter. The major causes of death are acute allograft rejection, infections (other than cytomegalovirus), allograft vasculopathy, and lymphoma and malignancies.

Although more than 4000 cardiac transplants are performed worldwide each year, there continues to be a chronic and severe shortage of available donor hearts. As a result, recipient selection and donor allocation are significant clinical and ethical issues.

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Dr. Cox went to speak to Dr. Biali about the interaction. Dr. Biali noted that the patient had admitted to him that she intermittently used cocaine and in his judgment was not a transplant candidate. He said flatly, "Your patient is a dirtball with cocaine cardiomyopathy and I'll transplant her over my dead body." [Dr. Biali is the only transplant cardiologist at the hospital. He is the only person who can list the patient for transplant, and there is no other transplant program in this city.]

6 Is Dr. Biali just using colorful language, or does his choice of words reflect a bias or prejudice? If so, what might that bias or prejudice be?

In most instances, we can never know with absolute certainty what motivates an individual's behavior. However, the use of the word "dirtball" (a very pejorative phrase), reference to "cocaine cardiomyopathy" (a questionable entity), and insistence of a 100-lb weight loss (an arbitrary requirement) all raise concern about Dr. Biali's attitudes and motivation. His possible biases include not only race, but also class and socioeconomic status, along with the clash between the lay culture and the culture of medicine.

7 How should Dr. Cox approach Dr. Biali regarding his perception of Mrs. Franklin?

In a respectful but professional way, Dr. Cox should directly discuss with Dr. Biali her concerns regarding his behavior, while acknowledging the need to be a good steward of a scarce resource. Ultimately, she needs to continue to be an advocate for the patient, working to establish achievable goals that appropriately address Dr. Biali's concerns (e.g. 6 months of negative random drug screens, 20-lb weight loss, compliance with office visits). Unwillingness on the part of Dr. Biali to cooperate with Dr. Cox in developing a fair and appropriate plan for the patient may require mediation at a higher, institutional level.

Ethnic and Racial Disparities in Organ Transplantation

According to data collected by the United Network for Organ Sharing, there are currently more than 98,000 people in America who are waiting for organ donation. Nearly half of that list is comprised of people who identify themselves as non-Hispanic whites. More than a quarter

(27.2%) are black, 15.5% are Hispanic, 5% are Asian, 0.9% are American Indian/Alaska Native, 0.5% are Pacific Islander, and the remaining portion identify themselves as multiracial or unknown. The same data reveal that the ethnic make-up of the population who received transplant in 2006 was somewhat different, substantiating the claim that ethnic minorities are receiving fewer organ donations. For those patients who received a transplant in 2006, 62.7% were non-Hispanic whites, 18.9% were black, 12.3% were Hispanic, 4.1% were Asian, 0.8% were American Indian/Alaska Native, and 0.3% were Pacific Islander. Compared with their white counterparts, black and Hispanic patients encounter longer delays in getting referred, spend longer times on transplant waiting lists, and have lower rates of graft survival and higher mortality after receiving a transplanted organ.

The causes of these disparities are multiple, complex, and not fully understood. Biological processes that have been proposed to account for these observed racial and ethnic differences include greater variations in human leukocyte antigen polymorphisms, differences in immunosuppression requirements, and differences in the pharmacokinetics of immunosuppressive medications and immunologic responsiveness. A number of other nonbiological, sociocultural explanations have also been offered, including racism, socioeconomic status and class, unfavorable geographical location, lack of organ donation by minority groups, differences in social networks, culturally related health beliefs, and poorer control of hypertension in African Americans. Eliminating these disparities will prove to be challenging because the precise attributable disparity risk associated with the various factors is not known and many of the causes are tightly intertwined with each other.

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