

Appendix A

Mini-vignettes on Disparities and Quality

Safety Example

A 39 year-old Mexican-American woman presents to the emergency department with chest pain that seems to be musculoskeletal in nature. She speaks enough English so that an interpreter is not called in. She is discharged, but returns the next day with shortness of breath and is found to have multiple pulmonary emboli.

In this case poor communication led to misdiagnosis. Similarly, it may result in overutilization of procedures (with their associated risks) as a substitute for lack of an effective history, or to lack of understanding of medication instructions and subsequent adverse medication events.

Effectiveness Example

A 63 year-old African-American man is diagnosed with stage 1 non-small cell lung cancer and is offered surgery, but is reluctant to have it done. The surgeon gives him some information, tells him to think about it and return to discuss it further, but he misses the follow-up appointment. What the surgeon did not learn is that the patient believes that surgery could spread the tumor throughout his body, and since he did not have great trust in the surgeon anyway, he opted against the operation.

Here, a myth about lung cancer surgery that is prevalent among many patients, and even more so among African-Americans,¹³³ led to a missed opportunity for effective, evidence-based care. Had the surgeon developed a more trusting relationship with the patient and inquired further about his reluctance, the problem may have been avoided.

Patient-Centeredness Example

A hospital learned that its satisfaction scores were very low for its relatively large Chinese-American community. The hospital held focus groups with community leaders and learned that the environment did not feel welcoming to Chinese-Americans due to lack of signage in Chinese, poor representation of Chinese-Americans among the staff, slow interpreter services, and several cultural taboos.

In this case, stratifying satisfaction data led to focus groups, and eventually allowed for effective systems interventions.

Timeliness Example

A Haitian family brings their 10 year-old boy to the emergency department because of a cough. The triage nurse assesses the story without the use of an interpreter. She is upset that they came to the emergency department rather than to their pediatrician for care as the cough does not seem serious. The boy waits 6 hours to be seen by the physician with an interpreter and is eventually found to have pneumonia. The “door to needle” time for antibiotic administration is significantly delayed.

Here, a professional interpreter or even telephonic interpretation could have helped the triage nurse recognize the seriousness of the child’s condition and expedited the time to treatment. A stereotype of minority and/or immigrant patients overusing the emergency department for primary care may also have contributed to this delay.

Efficiency Example

A 58 year-old Native American (Navaho) man is discharged from the hospital after a 5-day stay for congestive heart failure. He is given a handout on dietary modification and medication adherence, but little time is spent going over his own culturally based diet and beliefs and fears about medications. He is readmitted 5 days later with another exacerbation.

Proper discharge planning, and ensuring the patient understand the dietary modifications they needed to make within their culturally based diet, as well as a more thorough review of the medications might have prevented this readmission.