The Sick Bias

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This perspectives piece shares the experience of a trainee during the COVID-19 pandemic as it pertains to initial patient evaluations and the subsequent impact they have on patient outcomes. Specifically highlighting the value of approaching every patient as sick before deeming them as well — this approach to triaging is defined as a “sick bias” throughout the piece. Unfortunately, this initial evaluation can be influenced by explicit and implicit biases of the provider that highlight health inequities within their patient’s care.

INTRODUCTION

Bias, in its simplest form, is an inclination for or against something. From a research perspective we view bias as a negative, weakening the integrity of studies and leading to incorrect conclusions. In medicine, we also tend to view bias as a negative – commonly as disparate care provided for patients of different backgrounds. Objective data, including vitals and the physical exam, helps guide initial treatments. Unfortunately, this objective data is not always available, particularly when triaging a patient over the phone, and the clinician may have implicit biases. A generalized gestalt of a patient, internally declaring them “sick” or “not sick” can then influence the initial workup, or care, provided for a patient. The idea of quickly evaluating a patient is not meant to take the place of critical thinking or application of years of education and training, but rather is a necessity in initially dictating next steps, which has become increasingly important throughout the COVID-19 pandemic.

TOPICS

An Unexpected Outcome

When I was on a night-float rotation my intern year, holding the low-risk pager, I received a call from a patient who was nearing the end of her second trimester. She had been on her feet at work for about 4 hours and was endorsing one-sided pain that was intermittent, unpredictable, and seemed to radiate from the back to the front. She had no vaginal bleeding, had no abdominal pain or tightening which would be concerning for contractions, was endorsing fetal movement, and had no other obstetric complaints. Upon quick chart review, her most recent clinic note had documented similar back pain attributed to round ligament pain. I counseled her regarding round ligament pain, recommended getting rest, utilizing heat or ice packs per her preference, and Tylenol as needed. She expressed understanding of our plan and was in good spirits.

She presented to our triage area in the hospital 2 hours later with a fetal demise.
During residency my co-residents, chiefs, and attendings have encouraged me to develop my own practice. Originally, I thought this hinged on one’s fundamental knowledge or skill set, but throughout the COVID-19 pandemic I have come to believe it speaks to one’s personal approach to patient encounters. While running our high-risk obstetrics service my chief on the labor floor constantly encouraged us to have a “sick bias.” It took me a while to fully understand what this meant, but I now realize I may have fallen victim to having a “well bias.”

The Importance of Triaging

While on service, declaring someone as “sick” helps motivate the providers to proactively see and evaluate patients. It is not uncommon for there to be multiple patients presenting at any moment who require initial triaging. In obstetrics and gynecology, as well as other medical fields, things can escalate and change very quickly. Whether it’s an infection, vaginal bleeding, or a labor evaluation – all of these situations can evolve over the course of minutes, not hours. These scenarios, and the patients’ outcomes, are therefore greatly impacted by the initial decisions made by the healthcare team.

As providers we either have a tendency to view patients as well or as sick. This is what we view as a “sick bias” or a “well bias.” Labelling someone as “not sick” or “well” carries far more risk. While the “well” patient will still be seen, evaluated, and cared for – they may be triaged below other patients. This is appropriate if they are truly “well,” but can be dangerous if they were inappropriately labeled as such. In medicine, the majority of the time things work out. This speaks to the reserve the human body has and compensatory physiologic changes that take place in the setting of illness and insult. Assuming all good outcomes can be attributed to our clinical decision-making is dangerous and promotes a level of overconfidence that can present as a “well bias.” It is important to critically judge one’s own clinical decision making in order to further promote effective initial evaluations.

When working in the emergency department at the Yale New Haven Hospital in the Spring of 2020, I was managing patients with COVID-19 and triaging persons or patients under investigation (PUIs) for COVID-19. I witnessed wide variations in practice between providers during this time. Not that any of the care was incorrect, unethical, or malicious – it was simply a normal variance amongst providers dealing with something new, unknown, and quite frankly, scary. Fear motivated some providers to be conservative. The unknown pushed some providers to be cavalier. The safest approach was to carry a “sick bias” into every patient interaction.

One obstetric patient I won’t forget during this pandemic was a young woman in her fourth pregnancy who presented to the ED in respiratory failure. She ultimately died from cardio-respiratory collapse, attributed to COVID-19. Upon reviewing her chart, I noted she had been triaged over the phone multiple times. She had been dealing with mild respiratory symptoms and was instructed to monitor at home and present to the ED if needed. Throughout the pandemic it was common for providers and patients to selectively limit in person interactions with the healthcare system, or defer presentation to the hospital for care, depending on their individual comfort. From chart review, the care provided appeared to be compassionate, informative, and correct. Unfortunately, the outcome was death. While the outcome may have been unavoidable, it is reasonable to question whether this patient suffered due to “well bias.” Would someone with a “sick bias” have chosen to assess the patient earlier before her symptoms progressed to respiratory failure?

The Impacts of Health Equity

Unfortunately, some providers’ initial evaluations of patients are not solely based on medical assessments or accurate objective data, but rather are influenced by implicit and explicit biases. The acquisition and interpretation of objective data is also impacted by systemic racism, as seen in the decreased efficacy of O2 monitors in patients with darker skin tones [1]. Specifically, within obstetrics and gynecology, we are privy to extremely personal topics including a patient’s intimate relationships, history of abuse, past and current sexual activity, and history of interactions with child protective services. It is important to recognize how these sensitive topics may emotionally impact the providers. If we as providers are unable to separate these influences from our medical judgements, we may make suboptimal decisions based on non-medical information.

An indirect aspect of health equity, or health inequity, is patients with poor health literacy may not understand more complex medical issues. This became more apparent during the COVID-19 pandemic when numerous patients avoided healthcare visits and the hospital, because that was perceived as the most effective way to stay safe and avoid getting sick. This approach though, ultimately delayed care and evaluation for medical conditions. It is reasonable to think that improved education for patients emphasizing the importance of engaging the healthcare system during such fear-inducing times would be beneficial for their health.

Language and trust both have integral roles in our healthcare system. Particularly for the OBGYN community, having prominent social figures like Serena Williams experience inappropriate dismissal by their providers, highlights the lack of health equity in our community
This inequity is amplified in patient encounters with a language barrier where eliciting the primary complaint or patient symptoms takes more time, energy, effort, and commitment than with other patients. It is important to recognize these pitfalls in order to properly address them in our patient encounters.

Improving health equity is a natural way to improve patient outcomes by both improving the physician’s ability to impartially triage patients primarily by their medical needs, as well as by empowering patients to better understand their medical situations and enabling them to become self-advocates in situations where they are not receiving adequate or equitable care. Starting every patient encounter or evaluation with a “sick bias” could help overcome biases that are amplifying health inequities between patients by emphasizing our role as providers. Every patient is worthy of an equitable evaluation.

CONCLUSIONS AND OUTLOOK

My chief residents encouraged me to bring a “sick bias” onto the floor when caring for patients. I believe this mentality has helped avoid near misses and promoted safe and effective patient care. Diagnosis and management of patients is unfortunately impacted by both implicit and explicit biases that are present within the healthcare system and carried out by healthcare providers. Recognition of these biases and system-wide shortcomings, as exemplified with medical devices like pulse oximeters, may allow providers to overcome these limitations. Each provider’s ability to discern important features of patient presentations helps them determine whether or not a patient should be viewed as well or sick. My “sick bias” is different from those of my chiefs because we are at different points in our training and have unique experiences. As I continue to care for patients during my training, I am committing to embracing a “sick bias” and encouraging others to recognize their own “well bias” when triaging patients to promote health equity through action.

During the COVID-19 pandemic this has become even more important. The ability to accurately triage patients over the phone or through video chat will dictate the outcome for innumerous patients. Imploring a “sick bias” during these triages can help make sure patients receive safe care during an unsafe time.

As this pandemic continues, we will unwaveringly continue to provide care for our obstetric and gynecologic patients. The majority of our patients, luckily, will not contract the virus during the COVID-19 pandemic, but that does not preclude them from being “sick” when they approach us for help. As a trainee it is important to recognize that I am exposed to new presentations, pathologies, or diagnoses on a daily basis. Conservatively approaching our patients with a refined “sick bias,” regardless of whether they are considered low- or high-risk at the onset, will help my patients receive quality care and avoid negative outcomes wherever possible. I know the next time my pager goes off I will be carrying a “sick bias” in the hopes of that mindset ultimately making my patient well, and I encourage others to do the same.

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