

BIAS CHECKLIST	
HEALTH DISPARITIES References to health disparities in terms of genetics/biology rather than social and structural determinants of health Does the lecture include:	-
References to race/ethnicity as risk factors for a disease or as criteria for screening?	
References to race/ethnicity in the description of a patient?	
If yes to the question above, is there literature to support the inclusion of the patient's race/ethnicity for clinical decision-making purposes/improvement of patient outcomes? Was this evidence specifically discussed in the lecture?	
Additional comments (positive or areas for improvement):	
PATIENT BEHAVIORS Attribution of patient behaviors to patient race/culture/other stereotypes Does the lecture include:	-
Attribution of a patient's health belief or behavior to race or cultural values/beliefs/practices?	
Suggestion of how to approach groups of patients based on their racial/cultural identity alone rather than eliciting individual patient values/beliefs/practices?	
Additional comments (positive or areas for improvement):	
LANGUAGE/IMAGES/OTHER Further considerations	-
Use of health behaviors/diagnoses as adjectives to describe the patient? (e.g. "drug addict or alcoholic" vs. "person with substance use or alcohol use disorder" or "a diabetic" vs. "person with diabetes")	
Any other derogatory/discriminatory/non-inclusive language (consider ableism, ageism, sexual orientation, low-income/educational attainment, etc.)?	
Non-diverse case images or images that carry implicit messages that may serve as a hint for what is to come later in the case?	
Additional comments (positive or areas for improvement):	



Mrs. Smith

- 62 year old African American female with history of metastatic mucinous adenocarcinoma, alcohol abuse, and HIV presenting as a direct admission from for workup of fevers
- Frequently misses appointments and has been lost to follow up for past 6 months
- “rule out infection”

HPI

- Re-initiated on ART with Triumeq (Dolutegravir, Abacavir, Lamivudine) two weeks prior to admission
- Daily fevers over 38.4, potential peaking in afternoons but unclear
- Noncompliant with medications

HPI continued

- Increased fatigue, proximal muscle weakness symptoms for last few months
- Soft stools beginning two days prior to admission
- Confirmed 40 lb weight loss during prior 6 months
- Immigration law consultant, her husband travels regularly from Senegal to visit, last contact a month prior to admission

Past Medical History

- HIV (CD4 158 VL 46) counts from 3 weeks prior to admission
 - Via heterosexual contact
- History of CVA no residual deficits
- CKD Stage III, biopsy proven HIVAN, baseline Cr 2.3
- History of PE three months prior to admission, only took 1 month of anticoagulation
- Gout
- Malaria, last in 2013
- Metastatic mucinous adenocarcinoma
 - extensive involvement of intraperitoneal tissues and peritoneal carcinomatosis s/p debulking surgery, chemo with 3 cycles of cepecitabine and oxaliplatin (Xelox) with re-staging scan showing progression of disease
 - Plan to initiate irinotecan

Physical Exam

T 39.1 HR 86 RR 20 BP 109/65, **orthostatics positive**, SpO2 100% on RA
 Gen: thin African American female, in no acute distress
 HEENT: extraocular muscles intact, moist mucus membranes, oropharynx clear without lesions
 Neck: supple trachea midline, no cervical LAD, no JVD
 Cardiovascular: normal S1 S2 regular rate and rhythm, no murmur rubs or gallops appreciated
 Lung: clear to auscultation bilaterally, no rales or rhonchi
 Abdomen: soft, nontender, nondistended to deep palpation, normoactive bowel sounds
 Ext: 2+ dorsalis pedis pulses, no lower extremity edema, cap refill <2sec
 Neuro: CN II-XII intact, **mild proximal muscle weakness**
 Skin: warm and dry, **hypopigmented lesions across scalp line**

Patient Follow Up

- Received irinotecan the following week
- Readmitted two weeks after discharge with diarrhea, the day prior to MAI results returning found to have a malignant obstruction
- Had not continued any medications on discharge as they are “too expensive”
- ID recommended azithromycin and ethambutol for treatment, clarithromycin sensitivities added to testing

Mrs. S - signout**WATCHER**

85 yo F R hip fracture; to OR in am for repair

#HTN

#CKD

Meds – dalteparin, acetaminophen, amlodipine

NTD

Avoid CNS active meds due to risk of delirium

FULL CODE

Non-opioid analgesia

- Acetaminophen and/or NSAIDs can augment opioids
 - Consider scheduled acetaminophen
- Avoid NSAIDs in the elderly
 - Renal failure, CHF, GI bleeding risk
- Caution with NSAIDs in inpatients
 - Renal failure (especially when volume depleted)
 - Bleeding risk (GI, surgical, other)

New admission: Mr. G

- 73 yo Asian-American M metastatic prostate cancer
- On hormonal therapy, XRT to spine mets
- Admitted with increased pain, somnolence, new renal failure with Cr 3 from baseline 1.0
- Meds: acetaminophen, morphine, ondansetron, senna.

Mr. M

- RN calls to report that Mr. M, a 50 year old male IV drug user admitted last night with endocarditis, is becoming agitated, complaining of pain, and demanding . . .

"METHADONE!"

Mr. M - signout**WATCHER**

HD#2

50 yo M IVUDU presumed endocarditis

Meds: vancomycin, acetaminophen

NTD

Opioid withdrawal

- Signs and symptoms:
 - Pupillary dilation, lacrimation, rhinorrhea, yawning, sneezing, nausea, vomiting, diarrhea
- Peak for heroin at 36-72 hours, lasts 7-10 days
- Peak for methadone at 72-96 hours, lasts >14 d
- Ask about:
 - Use of other drugs
 - Hx methadone maintenance
 - Pt wishes regarding detox