

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**Advancing Health Equity by Avoiding Judgmentalism and Contextualizing Care**

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**Abstract**

This article examines the care of a Spanish-speaking woman with end-stage renal disease who returns repeatedly to the emergency department with complications related to missing hemodialysis. Her life circumstances suggest that she has been making difficult but rational decisions in an untenable situation, which is then readily resolved with the assistance of her care team. The case illustrates the pernicious effect of judgmentalism on patients from poor and marginalized communities, which exacerbates health inequity and illuminates the ethical importance of contextualizing patients' care.

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**Case**

IG, a 62-year-old Spanish-speaking woman with chronic renal failure, came to the emergency department (ED) 4 times over a period of 6 months because she'd missed her hemodialysis.<sup>1</sup> Each time she had more or less the same symptoms and signs, including electrolyte abnormalities, fluid overload—and even, on one occasion, ominous electrocardiogram changes. The physicians who cared for her were technically proficient: they would stabilize her myocardium with calcium gluconate, drive potassium into her cells with insulin and glucose, and get her onto dialysis within a couple of hours.<sup>2</sup> She'd be discharged the next day with instructions not to miss her dialysis again and to follow-up with her primary care clinician.

What no one did, until the fourth admission, was to ask her why she kept missing her hemodialysis. All they'd documented in the medical record was that she was “noncompliant.” Finally, during that admission, a member of the inpatient team—a fourth-year medical student—reached out through an interpreter and learned that IG was responsible for a grandchild who had an unrelated chronic kidney condition and often needed to be seen in the medical center's pediatric nephrology clinic. This situation posed a logistical challenge for her, as the medical center was located about 7 miles north of her home and the site where she received her dialysis was located south of

where she lived. The Medicaid transit van that she relied on to get to appointments could take her either to her dialysis site or to the medical center, but it couldn't take her from one facility to another. Hence, whenever her grandson needed medical care or hospitalization, she was forced to choose between his care and her own. She prioritized his needs.

Once members of the inpatient team elicited this backstory, they contacted a social worker who arranged for IG to receive all subsequent dialysis at the medical center—the same site where her grandson received his care. She would no longer have to choose between his well-being and her own. A review of her chart a year later showed that she hadn't missed dialysis again.

### Commentary

A few questions have implications for health equity here: Why did it take 4 ED visits before anyone thought to ask IG what was going on? How might the label *noncompliant* have contributed to the delay in her receiving definitive care? And how should we prevent expression of cognitive biases that seem to account for the label?

A common reason we don't ask questions is that we think we already have the answers. In other words, we make assumptions. When we assume that individuals are behaving irrationally without any knowledge of their situation, we are passing judgment on them. Rather than looking for situational explanations for an observed behavior, we are attributing that behavior to dispositional or personality-based factors. Jumping to such a conclusion is known as the fundamental attribution error (FAE).<sup>3</sup> It's typically an error made when assessing the actions of others and is not likely to be one that we make about our own actions. It amounts to thinking, *If you don't show up for a medical appointment it's because you are irresponsible or lazy, but when I miss appointments it's because of traffic or my day care provider calling in sick...* Passing such judgments undermines health care, as we see in the case of IG.

While all patients are at risk of being judged by their doctors, there are reasons that the FAE may disproportionately affect patients from marginalized or low-income communities. First, such patients are typically coping with more challenging life circumstances than people who are privileged. For IG, there are things that can get in the way of making it to dialysis appointments because she has fewer resources to arrange workarounds than, say, a caregiver who can afford childcare, taxis or rideshares. Additionally, individuals with low incomes **from marginalized communities** experience an ongoing cognitive load just getting through their day.<sup>4</sup> For instance, while shopping for basic necessities, they must balance competing needs and priorities to avoid or manage debt. To privileged members of society, the behaviors of those who live with these stressors seem like character flaws when in fact they are rational responses to difficult situations. And, even if privileged members of society (in this case, physicians) have lived with some of these stressors, they cannot have experienced an identical situation. No one actually ever walks in another person's shoes.

A second reason that privileged members of society may be prone to judge those less advantaged than themselves is a **cognitive bias** known as the delusion of "belief in a just world," or the just-world fallacy.<sup>5</sup> Advantaged groups may believe that the world works for those who try hard and do right and hence that those who are faltering have simply made poor choices. Even physicians who have overcome great odds are not immune, as they can fall into the trap of thinking, *I pulled myself up from my bootstraps;*

*what's wrong with you?* Studies indicate that such a bias minimizes unease with the reality that bad things happen to those who thus far have been fortunate.<sup>6</sup> The FAE and just-world fallacy disproportionately affect patients who are struggling with poverty and discrimination because they are most likely to appear like they are floundering, given the impediments they face. Unfortunately, these are the individuals who most need their physicians to understand the life circumstances that complicate their care.

### **The Antidote to Judgmentalism**

IG's underlying situation could have been identified and addressed the first time she showed up in the ED if the physicians caring for her had seen her behavior as a clue that required exploring, just like puzzling symptoms or signs of a disease. Such clues have been termed "contextual red flags" because they indicate there is a context—ie, a backstory—for the apparently "irrational" behavior.<sup>7</sup> Other common examples of contextual red flags include sudden loss of control of a previously well controlled chronic condition (such as diabetes or hypertension), not refilling medication prescriptions, or missing appointments.<sup>8</sup> Once they are recognized as clues rather than failings, contextual red flags become mysteries to solve. Solving mysteries begins with asking questions, starting from the premise that individuals have reasons for their behavior or are at the mercy of factors that are beyond their control.

Hence, the antidote to passing judgment is to ask patients questions instead of making assumptions. The subtle ways in which we express our biases, however, can undermine this approach. For instance, labeling patients like IG as medically noncompliant can leave the unwarranted impression that they are "problem patients."<sup>9</sup> To comply is to "conform ... as required."<sup>10</sup> Not complying, it then follows, is not doing what you are supposed to do. But what are you supposed to do when you have a grandson who depends on you for his health at critical moments when you need medical services, too? How might IG have been regarded by the pediatricians who cared for her grandson had she *not* brought him in when he was sick and prioritized her dialysis instead? Physicians should consider replacing the term *noncompliant* with *nonadherent*.<sup>11</sup> Doing so could be especially important when caring for patients from marginalized groups, given how prone physicians are to label them.<sup>12</sup> To say someone is not adhering to their treatment plan is to make an observation without judgment. Rather, it raises questions. Instead of saying, "IG has not been following instructions to attend her dialysis sessions as directed," one might say, "IG seems to be experiencing something that is making it difficult for her to adhere to her dialysis schedule." The latter, because it does not specify a cause, calls for an explanation. Before proposing a treatment plan, the physician will need more information, which implies that there are more questions to ask.

Another impediment to asking questions about supposedly irrational behaviors is not knowing how. On the one hand, medical students and residents nod agreeably when I say that it is important to find out why a patient like IG is behaving as she is, but when I ask them to role-play how, specifically, they would articulate their questions, they are often at a loss. Many feel awkward because they don't want to appear confrontational or accusatory. Paradoxically, they're afraid that directly asking, "Why did you do that?" seems judgmental. I'll suggest another perspective: Is it more respectful not to ask patients why they aren't following a treatment plan and assume it's a personal failing or to ask them? Also, in the case of IG, which approach is more likely to benefit her health and health care? We'll then discuss ways to frame questions that feel comfortable to students. My recommendation is always to begin by stating what you have observed to

the patient and then following it with a direct, open-ended question, such as: “IG, it appears you’ve missed your dialysis, and it’s gotten to the point where you are in a dangerous condition. Can you tell me how this happened?” And, in her case, the conversation would also require the assistance of an interpreter or Spanish-proficient clinician.

### Thinking Contextually

Once members of the care team asked questions, they learned that IG lived in a crowded home that included a couple of adult children and a son-in-law. These individuals had work responsibilities and functioned as an interdependent unit, sharing income, costs, and childcare. The grandson relied on her. The overall situation was precarious enough that IG felt compelled to make decisions that led to her periodic ED visits.

How can we help patients like IG sooner rather than labeling them? We can start by considering their life context. Patient “contextual factors”<sup>13</sup> that can account for seemingly irrational behavior include competing responsibilities (eg, a new job or a sick family member), loss of social support, financial hardship, loss of access to care (eg, lack of transportation to a clinic or **lack of insurance coverage**), and environmental factors (eg, unsafe neighborhood for exercising or lack of nutritious food). Patients who are from marginalized communities or who are poor are probably more likely to encounter such challenges. As noted above, these challenges often present as contextual red flags—seemingly irrational behaviors such as missing appointments, not refilling medication prescriptions, skipping hemodialysis, and so forth.<sup>8</sup> The key is to regard these behaviors not as personal failings but as clues to underlying circumstances. The process of recognizing red flags, asking about them, identifying the underlying contextual factors, and attempting to address them in the care plan has been described as “contextualizing care.”<sup>7,14</sup> Because contextualizing care is based on the premise that everyone is doing the best they can given the cards they’ve been dealt, it advances health equity. Rather than judging patients, physicians partner with them to identify and help address the challenges they face that so often complicate their care.

Such open mindedness tends to lead to productive engagement, such as when a resident I was supervising in clinic noted that a patient’s previously controlled diabetes and blood pressure had deteriorated. Recognizing this change prompted key questions about his diet and medication adherence. Looking discouraged, the man replied that he’d moved to a lower-rent, higher-crime neighborhood for financial reasons after losing his job and that medications mailed to his home were twice stolen from the portico where deliveries are left. With some discussion and a few mouse clicks, the resident rerouted his medications to a clinic pharmacy for in-person pick up. She also asked a social worker to help assist the patient, a veteran, in exploring federally subsidized housing options. Contextualizing care not only illuminates challenges that patients from marginalized communities face but also demonstrates how caring professionals can mitigate them. Physicians can’t achieve health equity alone, but they can help disadvantaged patients navigate a perilous journey.

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**Editor's Note**

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