Case 1 - Obstetrics

The patient is a 24-year-old African American cis-gender woman G2P1011 who presents to her local emergency department on post-partum day 4 due to 24 hours of congestion and cough. She is diagnosed with an upper respiratory infection and discharged home with recommendations for supportive care. Incidentally, a blood pressure of 150/102 mmHg was recorded at the time of the ED visit, but no mention was made in the physician notes.

Pregnancy History:

The patient began her prenatal care at 12 weeks of gestation and had 11 prenatal visits. She received her care from a certified nurse midwife in a hospital-based office practice. Her pregnancy was complicated by preeclampsia without severe features diagnosed at the time of her delivery hospitalization at 39 weeks of gestation. She had a normal, uncomplicated spontaneous vaginal delivery. She was discharged home on postpartum day 2 with plans to follow up in one-week for a blood pressure check.

Interval History:

While visiting her mother in a nearby town, the patient starts to experience unremitting severe headache and double vision. Soon afterwards, she presents to another emergency department on post-partum day 6. Upon presentation she is found to be severely hypertensive with a blood pressure of 178/112 mmHg. CT imaging of the head reveals several areas of subarachnoid hemorrhage. Blood pressure is controlled with IV labetalol and hydralazine and the patient is transferred to the neuro ICU at an academic referral hospital for continued treatment.

Questions for discussion:

1. How may structural oppression/inequity have played a role in the obstetrical health outcome described?

2. How may structural determinants (upstream policies, systems, practices) and social determinants (housing, food access, schools, healthcare, etc.) have impacted our patient's health outcome(s)?

   Structural determinants:

   Social determinants:

3. What kind of system changes can be implemented to reduce risk of maternal morbidity/mortality as it relates to this case?

Case 2 - Cervical Cancer

S.R. is a 41 year old Hispanic cis-gender woman with a history of schizophrenia. She has a history of abnormal pap smears and has missed her colposcopy appointments on multiple occasions. Despite many attempts, her medical care providers have been unable to reach her and she ultimately presents to the emergency department with profuse vaginal bleeding and a hematocrit of 9% (normal: 36–48%). A pelvic examination reveals a large bleeding cervical mass. Emergency biopsy result is consistent with invasive squamous cervical cancer. The patient undergoes emergency radiation treatment and receives multiple blood transfusions. Social Services becomes involved in her care, and she is eventually discharged home in stable condition with a detailed plan for radiation therapy and sensitizing chemotherapy. She completes her treatment over a prolonged, sub-optimal duration because of missed appointments.

Questions:

1) List possible reasons why S.R. misses her clinic appointments. Hint: think of individual, interpersonal, organizational, community and policy level causes.

2) Imagine yourself as her primary OB/GYN who is invested in her care. Propose ways to address the reasons you listed above. What ancillary resources can you mobilize for her care?

Case 3 (Family Planning):

The patient is a 25-year-old cis-gender female who presents to the OBGYN office with amenorrhea and nausea. Urine pregnancy test is positive, and ultrasound shows a 12-week intrauterine gestation. She is upset with this diagnosis and the clinician provides her with pregnancy options counseling in the shared decision-making framework. Following counseling, the patient expresses her decision for abortion care. Her insurance is Medicaid, and she is concerned about the cost as a barrier to receiving this care in a timely manner.

She lives in Missouri, a state in which abortion is illegal for most indications. Missouri Medicaid covers abortion only in cases of maternal life endangerment, and rape and incest. The patient will have to travel out of state to Illinois to obtain an abortion. A first trimester abortion costs $650 and it takes the patient 6 weeks (3 pay checks) to save the money to pay for her care and to get an appointment when she can have time off work. After these 6 weeks, she is now in the second trimester, the procedure costs $950 and takes two days. She must wait one more week for her next paycheck and borrow from her family to cover the increased cost. In the end, with the cost of gas, hotel, medical care, and lost wages from 3 days off work, she has to pay $1,200 to receive her medical care. This is more than one month’s income for her.

Questions:

1. Does Medicaid cover abortion care?

2. Why or why not? Where?

3. If the patient had commercial insurance, would this cover the cost of her abortion?

4. Who are the people affected by the Hyde Amendment?

Case 4 – Infertility

You are an attending Ob-Gyn at a Reproductive, Endocrinology and Infertility (REI) clinic and seeing a heterosexual couple for evaluation of infertility. Your patient is a 32-year-old cis-gender woman, G1P0010, and her partner is a 28-year-old cis-gender man. They have been trying to conceive for the past two years without success. The patient adds that she was with her previous male partner for five years and never became pregnant despite inconsistent use of contraception. She's a hairstylist and owns and operates a small business. She desires infertility work up, but her insurance is Medicaid, and she is worried about cost.

Questions:

1. Does Medicaid cover infertility work up and care?

2. What assisted reproductive technologies (ART) are covered by Medicaid?

3. Who are the people that have access to infertility work up and ART?

4. How does this policy perpetuate the principles of eugenics?