



SPECIAL REPORT

# CRISIS IN THE E.R.

## Why Women Are at Risk

When an emergency happens, you don't just *hope* to be treated fairly with the best techniques medicine has to offer. You *expect* it. But unfortunately, simply being a woman can put you at a disadvantage during a critical time. *Woman's Day* spoke to experts and patients about what you need to know—and how you can stay safe.

BY TULA KARRAS

PHOTOGRAPHED BY  
PHILIP FRIEDMAN

**W**hen Kathi Hovey had severe chest heaviness and went to the E.R. with her husband, Larry, the doctor on call told her she was having a panic attack. She insisted that wasn't the case. Larry told the doctor at the Texas hospital that Kathi, then 56, wasn't one to exaggerate and asked him to call a cardiologist for a second opinion. The doctor refused, but Larry persisted, and the cardiologist had Kathi admitted. The next day, an angiogram showed a significant blockage, and a stent was inserted.

Kathi's story highlights what experts call medical gender bias, which is when women are treated differently than men who have similar symptoms and conditions, or when they're treated inappropriately for gender-specific conditions. While bias isn't more likely to happen in the E.R. than in a doctor's office, it can have devastating effects when decisions must be made quickly.

About one in five adults in the United States go to the emergency room at least once a year, according to a new report from the Centers for Disease Control and Prevention. And women are more likely than men to make an E.R. visit, so it's imperative that you understand the ins and outs of what might happen so you can protect yourself.

## #1 BEFORE YOU WALK IN THE DOOR... *You're already up against built-in bias*

Here's a bitter pill to swallow: Many E.R. standards of care are tailored to men. "For decades, women were excluded from research in part because scientists didn't want to endanger a pregnancy or their reproductive ability during a test for a new drug or procedure," says Marianne Legato, MD, director of the Foundation for Gender Specific Medicine in New York City. It wasn't until 1990, and the establishment of the National Institutes of Health's Office of Women's Health, that scientists began to include women in studies and examine how diseases affect them uniquely. But many protocols for conditions that bring women to the E.R. today are still based only on male research.

For example, "the classic heart attack model, where the large heart arteries are clogged and you feel

chest pain and heaviness, is more common in men," says Alyson J. McGregor, MD, director of the Division of Sex and Gender in Emergency Medicine at Brown University. Women may have classic symptoms, but they are more likely to also develop nausea and back pain and report that they "just don't feel right." That's because the blood vessels around a woman's heart are smaller than those around a man's, so heart disease develops differently.

Even the tests used to diagnose heart attacks may be better for men. Take the EKG, which looks at the heart's electrical activity to check for damage. "It's a great tool to show an obstruction in a major artery," says Dr. McGregor. "But because women have smaller arteries and smaller hearts, some changes won't necessarily show up on the EKG."

### TAKE-CHARGE TIP

#### *Memorize a key question*

Use this statement: "Does this test [or treatment] work well for women?" in the hospital and in your doctor's office. Although physicians may not know if a test or drug has been studied extensively on women, they should know, based on their experience, if it's effective and safe.

## #2 ONCE YOU ARRIVE...

### *You—and your doctors—may not realize bias is affecting your care*

Most of the gender bias that takes place in E.R.s is thought to be subconscious—healthcare personnel aren't aware they're engaging in it. Scant research has been done examining the reasons, but some believe the bias is likely an extension of a culture that has unfairly stereotyped women as complainers, overly emotional or anxious. "In high-stress situations, busy doctors and nurses may fall back on deeply rooted automatic patterns of response," says JoAnn Grif Alspach, RN, EdD, editor of *Critical Care Nurse* journal.

Needless to say, it's usually not a malicious or conscious decision on the doctor's part. "The last thing anyone who goes into medicine wants is to treat only half of their patients well," says James R. Miner, MD, chief of the Department of Emergency Medicine at Hennepin County Medical Center in Minneapolis.

Yet research shows the bias exists. One study published in *Stroke* found that women who came to the E.R. because of a stroke waited 11% longer than men to see a doctor and 15% longer to get brain imaging, even when they had similar symptoms. And separate research found that after a stroke diagnosis, women are up to 30% less likely to be given one of the main treatment drugs, rtPA, which dissolves blood clots. Another study in the journal *Surgery* revealed that severely injured women were 15% less likely than severely injured men to be sent from a non-trauma hospital to a trauma center.

### TAKE-CHARGE TIP

#### *Be concise and assertive*

This is not the time to question yourself. You know what you're feeling better than anyone, and the doctors are there to care for you. Resist the urge to downplay your symptoms, and zero in on the main problem right away. This will help your doctor focus on what's most important immediately.

### #3 DURING DIAGNOSIS... Your pain could be taken less seriously

When Lauren Barnhorst, 37, of New York City, went to the E.R. in October 2005 with severe abdominal pain, the first doctor to examine her poked her roughly in the abdomen. “I yelled, and she said, ‘Oh, it’s not that bad. Talk to me after you’ve had kids.’” The doctor then told Lauren it was probably period cramps and left to run some tests. Four hours later, still in significant pain, she was examined by another doctor. “He told me, ‘What you have is ovarian torsion: It’s rare and it’s extremely painful.’ I said to him, ‘Can you please say that again... to her?’ I wanted the first doctor to know that my pain was real.”

Doctors removed the torsion-causing cyst and saved Lauren’s ovary, but the experience left her rattled. “I felt betrayed,” she says. “If my pain had been believed earlier, I may have been diagnosed sooner.”

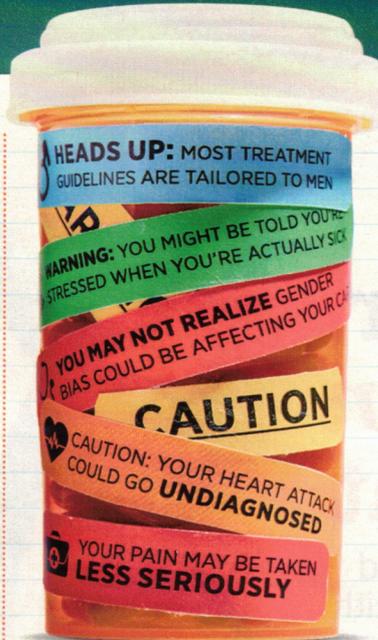
Lauren’s story underscores a serious issue: Doctors sometimes underestimate women’s pain. “Research shows that women get less pain medicine than men,” says Dr. Miner. This is despite the fact that women have a greater sensitivity to pain and express pain more readily than men. A study published in *Academic Emergency Medicine* found that women admitted to the E.R. for abdominal pain were up to 25% less likely than men to receive pain relievers such as morphine. The inequity could have to do with the imperfect way pain is assessed: The only measurement is asking a patient to rate their pain. But another culprit may be communication style. Women tend to focus on storytelling (i.e., what led to their visit), whereas men are fixated on the pain and what they want, says Dr. Miner. There’s also the chance that some E.R. personnel simply stereotype women and assume their pain is exaggerated, as in Lauren’s case.

#### TAKE-CHARGE TIP

##### Spell it out

If you’ve been given a pain medicine and it’s not working, say, “That treatment helped, but it wasn’t enough—I need another medicine.”

Or, tell your doctor, “I may appear anxious, but I am actually in pain.”



### Advocate for yourself—for FREE

Under the Affordable Care Act, health agencies like hospitals or insurers can’t discriminate based on gender. The National Women’s Law Center ([nwl.org](http://nwl.org)) can help you file a free complaint with the Department of Health and Human Services. If there’s been a violation, the agency may be required to compensate you.

SOURCE: Kelli Garcia, senior counsel, NWLC

### #4 AFTER YOU LEAVE... Experiencing bias can have lingering effects

Being told by a doctor that nothing is wrong—even when you feel like something may be amiss—can affect how you respond in the future.

Maria Quinn, 32, of Rogers, MN, went to the emergency room for chest pains in May 2015, thinking she might be having a heart attack. “My mother had eight heart attacks, and her symptoms began around my age,” she says. This was Maria’s second E.R. visit. The first time, in 2013, the doctors wrote it off as anxiety, telling her she was too young to have a heart attack. “This time my pain was worse, but again, the doctors told me it was anxiety and discharged me,” she recalls. The pain persisted, so Maria returned at 11 p.m. “I told them I had a family history of heart disease—something they never asked.” They did a blood

test, which came back normal, then sent her away without a recommendation to see a specialist or any solutions.

Maria eventually received a stress test that ruled out a heart attack, but she’s still searching for the cause of her pain, and can’t shake the feeling of being dismissed as an overly emotional woman. Since her 2015 E.R. visit, she’s experienced minor chest pains numerous times, but she’s resisted the E.R. “I don’t trust myself anymore,” she says.

Kathi Hovey, whose heart problems in 1999 were discovered because her husband spoke up, has since had several heart-related incidents that sent her to the E.R. But the decision to go wasn’t easy. “You play a game: *Should I go or not?* You want to believe that nothing is wrong, but you can’t mess with your heart.”

#### TAKE-CHARGE TIP

##### Call in backup

Having another person speak on your behalf can help. If you’re alone and your doctor isn’t available, request the services of a patient advocate or a patient representative. Many hospitals employ them to help patients communicate with medical staff.