From My Own Isolette: Examining Racism in Clinical Care

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How to breathe, sleep, eat, and stay warm; everything has a protocol in the Neonatal Intensive Care Unit. It is the most ordered of worlds. Nurses and respiratory therapists execute protocols that ensure quality care for the smallest and most fragile pediatric patients. Between scheduled care times, each baby is tucked into their isolette seeing the world from the safety of a plastic box that perfectly regulates their environment. When the complex world outside is too overwhelming for the babies, the nurses cover the isolettes with blankets.

For me, the hospital has been my own safe plastic box from which I view the world.

I am a fellow in a perinatal-neonatal medicine training program and have spent most of the past 3 years caring for babies and their families. From within the Neonatal Intensive Care Unit, I have watched presidential inaugurations, royal weddings, stock market crashes, and economic collapse. And now, from inside the hospital, I have been watching a natural pandemic disproportionately kill Black individuals and the human-made plague of racism continue to kill Black people.

Being non-Black, the hospital is safe for me. However, the legacy of medicine in the United States—the history of institutionalized racism, national studies depriving Black individuals of appropriate medical care, the theft of human cells, the commodification of human bodies, and ongoing medical training grounded in racist history and theory—means the hospital is not a safe place for everyone.

One night, at change of shift, an attending physician signed out to me that there was a 19-year-old expectant woman with COVID-19, likely to deliver on our shift. The attending stated that the infant and mother would be separated because of her COVID-19 status. Upon further probing, we learned that despite guidelines for shared decision making regarding separating newborns and COVID-19-positive mothers, the medical team had not followed the guideline. There was no perinatal consult completed for this Black woman, the standard of care for all COVID-19-positive pregnant people, and the first step in shared decision making. Despite no absolute medical contraindication to rooming-in with appropriate safety protocols, the daytime team decided to separate the expectant mother from her newborn. This was a clear deviation from the guideline driven by bias. After probing discussion and questioning between the overnight and daytime team, we decided to meet with the mother, discuss her options, and in the wee hours of the morning she gave birth to twins. They roomed-in together.

Earlier that year, I cared for a preterm infant born to a Black mother. She was attentive to her baby and at the bedside day and night to participate in the care of her newborn. Soon however, unsubstantiated rumors circulated among the staff that the mother was only at the bedside because she was homeless. The young mother became more defensive and suspicious of the care. One day, a nurse told the mother not to change the diaper of her child because it was between scheduled care times. "I know how to take care of my baby," the mother stated confidently. "Do you?" the nurse responded, alluding to a remote history of child protective services involvement with her older children. Things escalated. The mother refused to allow the nurse to administer medications to her baby, now distrustful of the nurse, the medical team, and the medical system as a whole.

We convened an interdisciplinary meeting with the mother to address the situation. "Everyone told me not to come here, not to come to this white hospital. But I knew it was the best so I came, and now I'm stuck here." I stared at her, encountering my privilege. The hospital is safe for me, but it is not safe for her. Acknowledging her needs and experiences, the team ultimately let her care for her baby off schedule. We deviated from the protocol. Our plan was met with resistance from members of the care team, claiming that protocols protect patients.

The use of standard protocols and guidelines are safeguards to ensure that safe, evidence-based, quality care is

administered. When utilized universally and implemented using Equity-focused Quality Improvement methodology they can also address disparities that arise from variations in care.[1] But, we must also remember that each patient comes to our doors from a family, embedded within a community, which has a narrative and history that inform the way they view the world. Rigid adherence to protocols and guidelines can cause us to lose sight of the humanity of the patient in front of us, while the flexible application of guidelines and protocols can lead to differential care and inequity.

As physicians, we must hold the science of medicine in one hand and the art in the other. We can only achieve this when we are open to discussion, critical of our choices and curious about the choices of others, ask clarifying questions, and get to know not only our patients' medical histories, but also their personal narratives. We must be upstanders and not bystanders when we see deviation from best practices as a result of bias, while also serving as advocates to provide personalized patient-centered care. This is how we must act to begin to build an antiracist health care system and close the pervasive equity gap. Those of us who feel safest in the hospital must be the first to initiate change. The balance between guidelines and personalized patient-centered care is extraordinarily complex and can be, at times, overwhelming. But, it is time we faced the world and removed the blanket from our own isolettes.

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