Cultural Competence Case Presentation
The "HLF" (Race, Gender)

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Case Scenario/History

Six months into your intern year as an EM resident, you begin your shift in the Emergency Department taking care of 52 year old Mrs. Ramirez. Chief complaint: "Chest Pain". As you approach her doorway, you hear loud moaning and groaning. 'Ayyy, I am feeling so short of breath, my chest hurts, too ….' Chuckling, the senior resident states that she is well-known to the ED and is a bona fide 'HLF' – which he explains as a 'Histrionic Latin Female'. Upon reviewing her medical records, you find that she has been in and out of the hospital for the last two weeks with multiple general complaints and has had numerous cardiac, GI and pulmonary workups, none of which have had objective findings.

a. Review of Systems

Positive for chronic headaches, sinus drainage, occasional chest palpitations, dyspnea on exertion, occasional paresthesias of her face and extremities, bouts of constipation-diarrhea with two prior episodes of blood-tinged toilet paper and "nervousness".

b. Past Medical History

HTN, Diabetes, Anxiety, Major Depression, Irritable Bowel Syndrome, Obesity.
Medications: Metformin, Simvastatin, Amlodipine, Lisinopril, Diazepam, Gabapentin, Paroxetine
Allergies: Sulfa, Codeine

c. Family History

Mother with diabetes.

d. Social History

No history of tobacco, alcohol or illicit drug use. Used to work as a nursing assistant until 10 years ago. Married with 4 children.

e. Physical Exam

Temp: VS: T 97.0ºF, HR 85, BP 175/100, R 24, O_2Sat 91% on room air
General: Anxious, alert, obese female in no acute distress
ENT: PERRL, pink conjunctivae, moist oral mucosae
Neck: mild, nontender submandibular adenopathy
Cardiovascular: RRR, nl S_1=S_2, S4 gallop present, no murmur or rubs
Lungs: BS equal bilaterally, no crackles, no wheezing, no rhonchi
Abdomen: obese, BS present throughout, nontender, nondistended, no masses
Extremities: 1+ nonpitting edema bilaterally, good pulses, no skin changes

Neuro: AA+Ox3, 5/5 strength throughout, decreased sensation on dorsum of feet and lower ankles bilaterally, DTRs 2+ bilaterally

Questions for discussion

1. *How would you approach this patient?*

No different than you would approach any other patient! Obtain a good history, ask about her pain and its quality, radiation, associated symptoms etc. This patient is obviously not healthy – she is on several medications and is exhibiting physical signs and symptoms that could be potentially serious. Do a thorough physical exam.

2. *What components of the physical exam would you pay close attention to?*

Rule out dangerous causes of her chest pain and shortness of breath. A careful cardiopulmonary exam is always a necessity in any patient with chest pain, whether she has a 'histrionic' personality or not.

3. *What components of the physical exam aid your diagnosis?*

Although none of the findings directly lead to a particular answer, you should note that this patient has chronic changes from her hypertension (S4 gallop) and her diabetes (peripheral neuropathy).

ED Course

The senior resident states that this patient has had similar symptoms at least twice in the last week and each time has been relieved with benzodiazepines. He suggests PO Ativan for the patient and states that this lady is a crazy woman having an anxiety attack. You order the anxiolytic. Mrs. Ramirez feels some relief, and you turn to your next patient, a gentleman with an ankle fracture-dislocation.

Two days later, you were coming on shift when you notice that Mrs. Ramirez has returned to the ED, chief complaint: "Anxiety". She now appears to have increased respiratory effort and is requiring Oxygen (2L by nasal cannula) to maintain saturations at 96%. On exam, bilateral crackles are noted in her lower lung fields as well as mild JVD. An ECG shows Q waves in the lateral leads, new as compared to the admission ECG done two weeks before. Worried, you now check labs, which showed elevations of Troponin, blood glucose and cholesterol. CXR showed early signs of pulmonary congestion.

You give Mrs. Ramirez prompt diuresis and her respirations become less labored. Echocardiogram shows a fixed lateral wall defect.

Case Outcome

Mrs. Ramirez is admitted to the Cardiology service for a Non-ST-elevation MI and new-onset CHF. Her MI was appropriately treated and her medications were adjusted to control her blood pressure and blood glucose. She is maintained on a diuretic, cholesterol-lowering agent and an anxiolytic. She was discharged in three days of admission to follow up with her primary care physician and cardiologist.

4. What happened?
The patient has had an MI but with the evolution of Q waves on EKG and low cardiac enzymes - the actual event must have occurred several days prior. She now has decreased cardiac function and is accumulating fluid in her lungs.

5. What could have changed the outcome of this patient?
Cultural and gender bias are culprits. In primarily Hispanic communities where many Latin women are regarded as being dramatic, histrionic or attention-seeking, symptoms are ignored or attributed to psychiatric causes. Careful history, physical and appropriate workup should be given to EVERY patient.

Discussion
Rienzi assessed gender stereotypes for paranoid, antisocial, compulsive, dependent and histrionic personality disorders[1]. Gender-role stereotypes tended to be paranoid, antisocial, and compulsive viewed as male and dependent and histrionic disorders viewed as female. The literature documents that all ethnic minority populations in the United States lag behind European Americans on almost every health indicator, including health care coverage, access to care, and life expectancy while surpassing whites in almost all acute and chronic disease rates[2]. It is important that health care providers appreciate the influence of culture in the understanding of individuals, families and communities regarding their health and wellbeing[3].

Multiple studies have confirmed cultural differences in patients' treatment choice, end-of-life care and even choice of hospital or health care provider. As an example, Geller found that African-American and Hispanic women are not well-informed about behaviors that would promote and maintain optimal bone mass and, consequently, are not practicing appropriate lifestyle and dietary habits to decrease their risk of osteoporosis[4]. Furthermore, in a series of interviews, Perkins found that most Mexican-Americans believe that the health system controls treatment and trusted the system to serve the patients well; while African-Americans viewed that the health system controls treatment, but few trusted the system to serve patients well[5].

An understanding of a patient's culture is fundamental to medical care, and culturally informed communication is key to effective doctor-patient relationships. Patient training to communicate with doctors has demonstrated positive effects on patient compliance, as well as improvements in health care outcomes[6]. Our understanding of patient cultures may be enhanced by increasing diversity among our residents and faculty and developing policies and procedures that integrate the principles of cultural competency and consistent, periodic consultation with the community to determine the effectiveness of these interventions. Medical education should integrate an ethnogenic perspective in medical schools to produce physicians who are truly qualified to give competent patient care in our increasingly complex society[7].

6. *What sections of the case incorporate the 6 ACGME areas of core competence?*
   a. **Patient care** – All patients, regardless of age, sex, race or cultural background should be treated equally and without stereotype or preconceived notion. A thorough history and physical examination must be obtained on every patient
   b. **Knowledge** – Early recognition of signs and symptoms of an Acute MI (and its mimics), appropriate treatment and consequences for a missed diagnosis
   c. **Interpersonal & Communication Skills –** supervisory level clinicians (senior residents, faculty) and even experienced nurses have a powerful influence and must be aware that their comments could negatively bias junior level clinicians (ie junior residents, medical students) which can stereotype the patient even before the trainee's first interaction
   d. **Professionalism** – It is our ethical duty as physicians to treat every patient equally and without bias

References

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