Cultural Competence Case Presentation
African-American Community

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Case Scenario/History

A 3 year-old African-American infant is brought to the Emergency Department by her 19 year-old mother and her 55 year-old grandmother. The infant is febrile to 104.2 and is inconsolable, pulling on her left ear and clinging to her mother. The baby is wrapped in several blankets and dressed in flannel long-sleeved pajamas. In the treatment room, the resident, a young white man, undresses the baby to examine her. The exam is remarkable for a dull left tympanic membrane with decreased movement on pneumatoscopy: the rest of the physical exam is unremarkable. The doctor, believing the child to be overdressed, prevents the mother from replacing all of the layers of clothing and blankets. The baby's grandmother became so hostile that she has to be removed by security.

a. Review of Symptoms
Given by Mother: She has been febrile, inconsolable, pulling on her left ear. She has been drinking fluids but decreased solid foods. Denies rhinorrhea, cough, abdominal pain, and all other systems negative.

b. Past Medical History
None, Normal Spontaneous Vaginal Delivery, Immunizations up-to-date

c. Family History
Diabetes only. No HTN, Cancer or other illnesses

d. Social History
The mother and grandmother live together in the same home with the infant. No history of tobacco or drug use in the home. The baby's father is not with the family.

e. Physical Exam
Temp: 104.2, Pulse 130, Respiratory Rate 20, O_2Sat 99% on room air
General: Healthy appearing baby, inconsolable
ENT: Dull left tympanic membrane with decreased movement on pneumatoscope, nose clear, throat clear, no erythema uvula midline
Neck: Supple, non-tender, no adenopathy, no meningismus
Cardiovascular: Tachycardia with no murmurs, gallops or rubs
Lungs: No use of accessory muscles, clear breath sounds
Abdomen: Nondistended, nontender with normal bowel sounds, no hepatosplenomegaly
Extremities: No cyanosis, no edema
Skin: No rashes or lesions
Neuro: Grossly intact, moves all four extremities, no obvious sign of deficit

Questions for discussion

1. *Why did the grandmother become hostile?*

Attitudes/Assumptions: The physician

Medical science is the correct approach to treating this baby.
I am the doctor, I know best.
This woman (the grandmother) is probably uneducated. She does not understand what needs to be done.
This woman (the grandmother) is interfering with my care of this patient.

Attitudes/Assumptions: The grandmother

I've raised six children and four grandchildren, I know about babies and fever.
This doctor thinks I am ignorant just because I'm black.
Add: This doctor thinks that the pediatric patient's mom is ignorant and uneducated, because she is black and therefore will not take time to educate her. He is assuming that she is unable to comprehend why the child should not be over-bundled and will not take time to educate.
My daughter can't handle this situation. It's up to me to make sure these people treat this baby right.

Provider Knowledge:

Knowledge of health beliefs/customs: Folk medicine/home remedies. Hot and cold illnesses/hot and cold remedies.

Knowledge of community: Beware of stereotyping. Learn/understand the family dynamic, ie patterns of housing with grandmother as primary caretaker while daughter works at her various jobs.

Knowledge of disparities/discrimination: African-American people have been discriminated against in this country. African-Americans may be distrustful of authority including medical authority.

2. *What actions could have been taken by the doctor to avoid/prevent this unfortunate outcome?*

Cross-Cultural Tools & Skills

- Assume the grandmother loves her grandchild and wants what is best for her.
- Assume that if you communicate with her effectively, she will recognize that you also want what is best for the child.
- Acknowledge the grandmother's experience with children.
- Ask her what she thinks is wrong with the child, how she has been treating the fever at home.

3. *What medical issues concern you about this case?*

- Discuss the treatment of fever, the physiologic difference between fever and hyperthermia (which supports the 'sweat a fever' approach) in terms she can understand.
- Collaborate with her on a treatment plan.

4. *What sections of the case incorporate the 6 ACGME areas of core competence?*
    a. **Patient care** – compassionate and appropriate with mutually beneficial outcome (Green et al, 2002 – Knowledge of caring for patients is linked to four social domains 1) Social stress and support networks; 2) Change in environment; 3) Life control; and 4) Literacy. Expanding the role of the social history will lead to improved patience care)
    b. **Knowledge** – demonstrates cross-cultural clinical skills (Betancourt, 2003 – Beware of oversimplification and stereotyping of racial groups. Clinicians should rather assess 'social and historic contexts of certain populations, their socioeconomic status, patterns of immigration, nutritional habits, folk illnesses, healing practices, etc')
    c. **Interpersonal & Communication Skills** – Generates effective information exchange with patients and their families (Betancourt, 2003 – 'Focused medical interviewing and styles of communication including autonomy vs. family decision-making'). (Singer and Lakha, 2003 – **RISK R**esources of patient and family, **I**ndividual identity and acculturation, **S**kills available for adaptation to disease, **K**nowledge about ethnic group)
    d. **Professionalism** – Provides sensitive and ethical care to diverse populations (Wright Role N Engl J Med 1998 Role modeling is an important educational method to ingrain professional values, attitudes, behaviors and values in medical training)

<u>Case Outcome</u>
Diagnosis: Lt. Otitis Media
Disposition: Home

After an appropriate history is obtained utilizing the principles above, the patient is treated for her fever, the patient is given antibiotics for her otitis media, a discussion occurs between physician, the mother and grandmother on medical instructions on how to care for the baby as well as appropriate follow-up with the child's pediatrician. The family were given the time to ask additional questions and were further instructed to return to the Emergency Department if the baby did not improve.

References

1. Betancourt, J. Cross-cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation, Acad. Med. 2003:78:560-569.
2. Kagawa-Singer, M. and Kassim-Lakha, S. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes, *Acad. Med*. 2003:78:577-587.
3. Green et al. Integrating Social Factors into Cross-Cultural Medical Education, Acad. Med. 2002:77:193-197.
4. Wright, SM, Kern, DE, Kolodner, KB, Howard, DM, Brancati, FL. Attributes of excellent attending physician role models, N Engl J Med. 1998:339:198-93.