Cultural Competence Case Presentation
Sickle Cell Crisis (Race, Gender)

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Case Scenario/History

A 22 year old African-American male comes to the ED with a case of sickle cell crisis and requests pain medicine. He has never come to this ED before; he usually goes to the one across town but he can't be bothered with those docs because they never give enough pain medicine. When asked how much pain he has, he states it's a 15/10. The patient is writhing in pain. The doctor assesses the patient and addresses the need for pain control.

a. Review of Symptoms
Painful extremities, no fever, no chest pain, no respiratory distress.

b. Past Medical History
Sickle cell disease; pneumonia. NKDA allergy.

c. Family History
Sickle cell trait, hypertension.

d. Social History
None.

e. Physical Exam
Temp: VS: T 98.6ºF, HR 110, RR 20, BP 135/80
General: Patient writhing in pain
ENT: EOMI, PERRL, clear TM
Cardiovascular: Sinus tachycardia, normal S1/S2, no murmurs, rubs or gallops
Lungs: CTA bilaterally
Abdomen: Soft, non-distended, diffusely tender
Extremities: No clubbing/cyanosis/edemal, pain everywhere
Neuro: Grossly intact

ED Course
An IV was started and IV morphine was promptly ordered by the doctor and administered by the nurse. The patient's pain was adequately controlled during his two-hour stay in the ED. No labs or xrays were ordered.

Questions for discussion

1. What barriers to care do sickle cell patients have?
Physicians in general undertreat pain. Physicians may underestimate the amount of pain that a patient may have. Thus doctors may prolong the time between doses of pain meds

or may give the medicine IM to deter the patient from asking for pain medicine. There is a fear that giving a lot of opiods for pain will create an addict and a cross-over effect of illicit drug use. In addition, most sickle cell patients are African-American; most emergency physicians and nurses are not African-American, and there is a mistrust from the patients. Patients may also present melodramatic in order to receive the pain medications that they need. Also, few patients have private physicians to manage their chronic pain.

2. *What actions should be taken by the doctor to avoid/prevent stereotyping in this situation?*

Treat this patient like you would any other patient. Obtain a good history and do a thorough physical exam.

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

Numerous organs can be affected by sickle cell disease: pulmonary (intrapulmonary shunting, embolism, infarct, infection), vascular (anywhere), liver (hepatic infarct, hepatitis secondary to transfusion), gallbladder (gallstones), spleen (acute sequestration), urinary (hematuria), genital (decreased fertility, impotence, priapism), skeletal (bone infarcts, osteomyelitis, aseptic necrosis), cardiovascular (CHF), central nervous system (CVA), skin (stasis ulcer), eye (retinal hemorrhage, retinopathy)[1].

Helpful labs include CBC and retic count, electrolytes, ABG as baseline for chronic hypoxia, and U/A. Helpful radiographs may include a CXR if pulmonary symptoms, bone films if localized pain, abdomen U/S or CT looking for gallstones, pancreatitis, appendicitis, abscess, bowel infarct, and head CT if neurologic symptoms.

4. *How should you manage this patient's pain?*

Most management is symptomatic. Hydration: either oral or IV, normal saline boluses. Analgesia: start with morphine IV push, then a morphine drip or constant morphine boluses; some also give promethazine and ketorolac to help; sometimes a PCA is needed. At some point a determination needs to be made whether the patient should be admitted or sent home. Outpatient therapy can include vicodin or percocet as well as NSAIDS – non-steroidal anti-inflammatory drugs.

<u>Cross-Cultural Tools & Skills</u>

<u>Attitudes/Assumptions: The physician</u>

Administering high doses of opiods for sickle cell pain crisis will create an addiction and a cross-over effect of illicit drug use.

The patient is over-estimating his pain because he's an addict and he wants more medicine.

<u>Attitudes/Assumptions: The patient</u>

These doctors never give enough pain medication. They're not taking care of me.

I have to emphasize how much pain I'm in so they will give me enough medicine for pain relief.

The doctor and nurses are not the same race/ethnicity as me and therefore don't understand my pain.

Provider knowledge

Knowledge of community: beware of stereotyping. Learn/understand more about treating pain and that treating acute exacerbation of pain does not necessarily lead to drug addiction[2].

Knowledge of cultural disparities/discrimination: African-American people have been discriminated against in this country. African-American people may be mistrustful of the medical profession[3].

Cross-cultural tools and skills

Treat this patient no different than you would any other patient. Obtain a good history and do a thorough physical exam.

Communicate effectively to the patient that you want the best for him and that you want to work with him to get his pain under control.

Make a goal with the patient (end point to treatment) and reiterate that pain will be eased, not eliminated.

5. *What sections of the case incorporate the 6 ACGME areas of core competence?*
    a. **Patient care** – compassionate and appropriate care with mutually beneficial outcome with adequate pain control
    b. **Knowledge** – demonstrates cross-cultural clinical skills by recognizing the severity of pain in patients with vaso-occlusive crisis with sickle cell disease
    c. **Interpersonal & Communication Skills** – generates effective information exchange with patient thus validating the patient's genuine symptoms
    d. **Professionalism** – demonstrates sensitivity to patient's distress rather than stereotyping or making assumptions of drug-seeking behavior

Case Outcome

Diagnosis: Sickle cell vaso-occlusive crisis.

The patient's painful crisis was appropriately treated. There was no fever and no perceived infection. Consequently, no labs were obtained. The patient was new to this ED and the physician-patient interaction was appropriate. The patient was discharged home on oral pain medication and told to follow-up with his primary care physician.

Disposition: Home.

References

1. Samuels-Reid JH. Common problems in sickle cell disease. *American Family Physician*, May 1994, 49(6): 1477-8, 1483-6.
2. Murray RF Jr. and Soble A. Case Studies in Bioethics. Drug treatment or drug addiction? Can a physician differentiate between true sickle cell crisis and inatrogenic arodtic addiction? *Hastings Center Report*, June 1974, 4(3):10-2.
3. Clark PA. Prejudice and the Medical Profession. Racism, sometimes overt, sometimes subtle, continues to plague US health care. *Health Progress*, Sept-Oct 84(5):12-23.