

Cultural Competency Can Improve Perinatal Care

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STANFORD, CALIF. — The young woman who arrived in labor was accompanied by a large and loud crowd of extended family members who spoke little English. With each contraction, the family yelled louder, Marylouise Martin recalled.

Instead of simply asking them to be quiet or leave, she pulled aside one of the family members and asked why they were

all yelling. “Must yell,” the man told her. “Louder you yell, more beautiful baby will be.” Cultural differences made the yelling irritating to staff members but a routine part of the birth process to the family, she said at a conference on perinatal and pediatric nutrition.

After a separate, nearby room was found for the family to carry on in, everyone was satisfied, said Ms. Martin, a nurse educator at McLeod Regional Medical Center, Florence, S.C.

The clash of cultures in perinatal care doesn't always end so happily. She told another tale of a male resident physician at an unnamed hospital who was called to substitute at the last minute for a female physician who couldn't arrive in time to deliver her patient's baby. The mother cried and tried to refuse his care. The woman's husband fought to remove the resident from the room and was taken away by hospital security officers. The baby was delivered, but the parents left the hospital

shortly after the birth without the baby. In their eyes, the woman had been violated, and they could not keep the baby.

The stories illustrate why it's important to pursue cultural competence—the accrual of knowledge and skills that enable providers to adapt health care in accordance with the ethnocultural or religious heritage of the individual patient and the patient's family and community, she said at the meeting, jointly sponsored by Symposia Medicus and Stanford University.

In the values of traditional American health care, life is sacred, autonomous decision making is paramount, telling the truth is essential, and suffering should be avoided. In some cultures, however, the family may be the primary decision maker. Some patients may not want to hear about health risks, out of the belief that once potential problems are mentioned, the problems are more likely to develop. Some cultures accept only short-term

RESPIRATORY SYNCYTIAL VIRUS (RSV): ARE WE DOING ALL WE CAN?

Enormous progress has been made in the fight against RSV, but there remains much more to do. Despite our best efforts, RSV still sends more than 125,000 infants to the hospital each year in the United States alone.¹ And RSV continues to be the leading cause of lower respiratory tract infections such as bronchiolitis and pneumonia among young children.² In fact, an analysis of recent trends has identified 372 annual deaths that are probably attributable to RSV in infants and children.³ RSV is also the leading viral cause of death in children <5 years of age.⁴ Part of the reason may be that many infants eligible for immunoprophylaxis continue to slip through the cracks.

Premature lungs and vulnerability to severe RSV

Premature infants are especially vulnerable to infection because their lungs are not fully developed. For instance, compared to full-term infants, 34 week gestational age (GA) infants have:

- Only 52% of the estimated lung volume⁵
- About 35% thicker alveoli walls⁵

This means that the lungs of 34 week GA infants have less volume to accommodate air and poor gas exchange.

At 1 year, prematurity continues to impact lung function. Results from a study conducted in premature (≤36 week GA) infants who had no history of respiratory disease during the neonatal period demonstrated:

- Greater than 50% reduction in airway function compared to the normal predicted value^{6,7}

This means even healthy-looking premature infants are susceptible to infection.

RSV can affect all premature infants regardless of degree of prematurity. A recent study of infants hospitalized with RSV compared 33–35 week GA infants with those ≤32 weeks' GA. Interestingly, the “older” infants (33–35 weeks' GA) had a(n)⁸:

- 24% longer hospital length of stay,
- 33% longer ICU length of stay, and
- 81% greater rate of intubation

Preventable adverse events and medical errors (such as procedural, preventive, and diagnostic errors) commonly occur when infants are hospitalized for bronchiolitis, especially in critically ill infants.⁹

RSV-related hospitalizations also result in significant stress for infants, their caregivers, and immediate family members.¹⁰ The impact of this stress, such as poorer overall health and higher levels of anxiety both for caregivers and for their children, can last up to 2 months.¹⁰ Assessment of at-risk infants* for RSV can help reduce these consequences.

The need for RSV prevention is critical

While a premature infant may appear to be healthy, their lung development is not complete. That is because premature infants' lungs continue to develop and mature, while underdeveloped lungs place all premature infants, even those who are near term, at risk. In fact, healthy-looking 33–35 week GA infants face severe consequences from RSV.⁶ This patient population is often overlooked for immunoprophylaxis during the RSV season.

Unfortunately, RSV is highly contagious. And because serious RSV infections are associated with both short- and long-term consequences, as well as with increased morbidity and mortality, it is important to consider all at-risk infants* for immunoprophylaxis.

*Infants with bronchopulmonary dysplasia or a history of premature birth (≤35 weeks' GA) and children with hemodynamically significant congenital heart disease.

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Evaluate your own attitudes and biases, be open to change, and treat each person with respect.

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causes of health problems and don't believe in chronic disease.

Cultural differences go beyond words, Ms. Martin noted. In Greece and Bulgaria, shaking the head up and down means “No,” not “Yes.” Typically, white Americans prefer to keep about 3 or 4 feet between themselves and other people, but Native Americans usually prefer a greater distance.

To increase your cultural awareness and competence, evaluate your own attitudes and biases, and be open to change, she advised. Learn to treat each person with respect and equality, and never assume that a person's ethnic identity tells you anything about his or her cultural values or patterns of behavior.

Work with your patients toward common goals by asking questions and communicating effectively. Speak clearly and slowly in short sentences using simple words, not medical jargon. Avoid phrases like, “The baby crashed,” or “The belly blew up,” which can be taken literally.

For the newborn period, ask in advance about expectations for feeding the infant, including the best method and timing of the first feed. Talk with the parents about swaddling practices and about what kinds of caretaking are expected at home. Do they believe babies should be allowed to cry or should be comforted immediately? Do they plan ritual beautification practices? Where will the baby sleep? How will they care for the umbilical stump?

Incorporating new knowledge and experiences of different cultures in your practice will improve perinatal care, Ms. Martin said.

For more information, she recommended the American Academy of Pediatrics' “Transcultural Aspects of Perinatal Health Care: A Resource Guide.” ■

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ABBOTT LABORATORIES INC.
COLUMBUS, OH 43215-9724 USA

SSP05-088

Printed in USA