

Strive for Cultural Competency To Improve Perinatal Care

BY SHERRY BOSCHERT
San Francisco Bureau

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.

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 could not 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



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MS. MARTIN

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.

Cultural differences go beyond words, Ms. Martin noted. For example, in Greece and Bulgaria, shaking the head up and down means "No," not "Yes."

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," which can be taken literally. ■

Management of First Delivery Influences Later Surgery Risk

Cesarean section in a first pregnancy may reduce a woman's risk of having pelvic floor surgery later in life, reported Ramalingam Uma, M.B., and colleagues at the University of Dundee, Scotland.

The researchers said their study was prompted by the increasing attention to pelvic floor morbidity following childbirth, and by indications that cesarean section may be protective against damage to the pelvic floor support structures and impairment of pelvic floor innervation that can occur during vaginal delivery.

The nested case-control study of first-time mothers was drawn from a population of 7,556 women who had given birth in the hospital between 1952 and 1966. Of these women, 5% underwent pelvic floor surgery in later years (BJOG 2005;112:1043-6).

On univariate analysis, cesarean section (odds ratio 0.24) and greater gestational age at birth (OR 0.20) were associated with a reduced risk of pelvic floor surgery, compared with spontaneous vaginal delivery. In the final multivariate model, only cesarean section was associated with reduced odds of future surgery (OR 0.16).

Subgroup analyses comparing the 61 elective and 68 emergency cesarean sections suggested that both were protective against pelvic floor surgery, compared with spontaneous vaginal delivery (OR of 0.19 and 0.29, respectively).

Dr. Uma and colleagues caution that "the absolute risk of pelvic floor surgery in relation to mode of delivery needs to be put in the context of the adverse effect of pregnancy itself. It has been reported that 46% of nullipara have pelvic organ prolapse at 36 weeks antepartum. ... Cesarean section may reduce the risk of pelvic floor surgery relating to the mode of delivery but it will not eliminate the risks associated with pregnancy itself."

In contrast to previous studies, this analysis did not find an association between forceps delivery and increased risk of pelvic floor surgery.

—Bruce Dixon

BV in Pregnancy: Neither Oral Nor Vaginal Metronidazole is Optimal

CHARLESTON, S.C. — Oral and vaginal metronidazole appear to have comparable efficacy for the treatment of bacterial vaginosis in low-risk pregnant women, but neither is optimal for prevention of infectious complications at delivery, Jane Hitti, M.D., reported during the annual meeting of the Infectious Diseases Society for Obstetrics and Gynecology.

In a double-blind, placebo-controlled study of 126 women with bacterial vaginosis who were randomized at or before 20 weeks' gestation to receive either oral or vaginal metronidazole, the treatment failure rate was similar for both groups (29% for oral administration vs. 35% for vaginal administration), Dr. Hitti of the University of Washington, Seattle, reported in a poster presentation at the meeting.

The oral administration group received 250 mg of metronidazole three times daily for 1 week; the vaginal administration group was treated with 5 g of 0.75% gel twice daily for 5 days. Treatment failure was defined as persistent BV at 4 weeks after treatment, she noted.

Although treatment outcomes in

regard to bacterial vaginosis persistence were statistically similar for the two groups, the rate of certain infectious complications at delivery was of concern.

For example, the cesarean wound infection rate was 33% in the oral metronidazole group, compared with 18% in the vaginal metronidazole group, 0% in a group of 47 women with intermediate Gram stain results, and 6% in a group of 190 women with normal Gram stain results.

The difference between the oral treatment group and the normal controls reached statistical significance.

Furthermore, the rate of chorioamnionitis was 20% in the vaginal treatment group, compared with 9% in the oral treatment group, 7% in the intermediate Gram stain group, and 10% in the controls. These differences did not reach statistical significance, but the findings suggest that infectious complications remain a concern in patients with bacterial vaginosis, regardless of metronidazole treatment delivery method.

—Sharon Worcester

Attention Problems Tied To Alcohol Use in Third Trimester

BY BETSY BATES
Los Angeles Bureau

SANTA BARBARA, CALIF. — Prenatal alcohol exposure is most likely to affect children's attention problems when it occurs during the third trimester, a prospective study of 492 children determined.

There is a high degree of correlation between teacher- and parent-assessed attention deficits in children exposed to alcohol in late pregnancy, compared with alcohol exposure during the first or second trimesters, Beth Nordstrom Bailey, Ph.D., and her associates reported at the annual meeting of the Research Society on Alcoholism.

"These findings provide yet one more piece of evidence that the timing of prenatal alcohol exposure impacts child outcomes," concluded the investigators, who presented their study in poster form.

The study from East Tennessee State University in Johnson City, where Dr. Bailey serves on the department of family medicine faculty, carries substantial weight because it prospectively tracked women's substance abuse throughout pregnancy and followed their children for 6-7 years.

The cohort was from urban Detroit and was mostly made up of African Americans with a low socioeconomic status, 90% of

whom agreed to participate in the follow-up study.

Caregivers completed the Achenbach Child Behavior Checklist. Classroom teachers completed the Achenbach Teacher Report Form. Both standardized tools include Attention Problems scales.

In a logistic regression analysis, third-trimester prenatal alcohol exposure independently correlated with attention problems as assessed by both caregivers and teachers. Lead levels and custody changes also correlated with attention scores as assessed by parents and caregivers. Violence exposure factored into the equation only when teachers' assessments were considered.

Prenatal exposure to cocaine, cigarettes, or alcohol during the first and second trimesters failed to independently correlate with later attention problems in children.

In an interview, Dr. Bailey explained that first-trimester exposures have the potential to affect global development of the fetus, possibly resulting in physical deformities, major cognitive impairment, and diminished growth.

In the third trimester, higher order functions are most affected. Alcohol exposure during this time appears to affect children's specific attention and behavior functions that can be readily assessed during the school-age years. ■