

Practitioner's blog

Hidden agendas and hidden illness

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An East African man and woman attended the Emergency Department; both were wearing traditional dress. For the woman, this meant a billowing black djellaba with only her face exposed. The husband approached the triage nurse saying that his wife needed to see the doctor as she had not slept for three nights and required sleeping tablets. He was not prepared to take the discussion any further with the triage nurse, as he either did not understand the relevance of the nurse's role or did not believe that she could help in any way. The nurse assumed that the woman did not speak English, as the husband was clearly the spokesperson and did not defer at any time to his wife. This in itself is not an unusual scenario in London, where there are numerous migrant communities with varying levels of fluency in English, and where many of the women rely on their husbands to communicate for them.

The department was busy and the woman waited for two hours before being called to see the doctor, who immediately became concerned by her responses, particularly to her husband. It transpired that the woman did speak English and had no difficulty in expressing herself. Her husband explained that his wife had given birth just three days previously, and that since then she had not slept and had been behaving irrationally. The doctor observed the woman's detached behaviour with concern, and in order to assess her state more objectively he asked her husband to step out of the room. The woman then told the doctor that her husband was denying her food and drinks and was trying to starve her. Her thought processes were erratic and she made no reference to the birth or her newborn infant. It was clear that she was very unwell and possibly suffering from a postnatal psychotic episode. An urgent referral for a psychiatric assessment was made and she was admitted for treatment.

The risk associated with this episode was not lost on staff, who, with the benefit of hindsight, were alarmed that someone so seriously unwell and vulnerable had not been identified at triage, and instead had been left to wait for two hours before being thoroughly assessed. Of particular concern were the obvious conflicts

between cultural beliefs, behaviours and stereotypical assumptions which served to obscure the serious nature and severity of this woman's illness.

The husband believed that his wife was unwell, but attributed her behaviour to lack of sleep. He did not understand the role of the triage nurse as pivotal in prioritising patients and ensuring urgent assessment. The patient herself did not speak, but this is not unusual in some cultures where the husband is the spokesperson. However, had she spoken or had the nurse addressed her directly it might have become apparent how unwell she was. Because she was covered by a full black garment she presented no differently to many other women from Middle Eastern countries who attend our department, and thus there were no identifying or outwardly visible signs such as a swollen abdomen which might have alerted the nurse to the fact that she had recently given birth. Consequently, staff assumed that she did not speak English and, in doing so, they missed the signs that might have alerted them to the severity of her condition.

It is well recognised that there are marked cultural differences in the way that psychiatric symptoms present (Kleinman, 1996), with some groups more likely to somatise symptoms than others. Postpartum psychosis is considered to be an emergency that necessitates an urgent evaluation, psychiatric referral and possible hospitalisation (Cohen, 1997). This illness is a rare but severe condition with unexplained aetiology. It is more likely to occur in women who have had previous bipolar or schizophrenic-type illnesses (Sit *et al*, 2006). Best practice would insist that women who are identified as being at risk undergo psychiatric assessment during pregnancy and careful monitoring for any signs of psychiatric illness during the immediate postnatal period (World Health Organization, 2008). However, as psychiatric illness continues to be stigmatised, women themselves may be reluctant to declare such conditions or seek professional help, and/or may be discouraged by their families from doing so. A previous history of mental illness may be deliberately denied during the antenatal period. In some instances,

antenatal care of any kind may not be accessed until late in pregnancy, if at all. Health professionals may only be consulted when the woman is so severely ill that the family can no longer cope.

Although postpartum psychosis is rare, the risk factors for and consequences of postpartum depression are well documented, yet this disorder often remains undetected and untreated (Dennis and Chung-Lee, 2006), and the risks are likely to be higher in marginalised groups, many of whom have higher birth rates. A qualitative study by Templeton *et al* (2003) of experiences of postnatal depression among women from black and minority ethnic communities in Wiltshire, UK found that all of them had problematic lives, affected by a multitude of cultural and social factors. These authors suggested that much more research is needed to explore the needs of women from minority ethnic groups, taking into account issues of, for example, cultural specificity and urbanity/rurality. Fortunately, in this case the woman was referred for specialist care. However, the outcome could have been very different and potentially devastating for her and her family. The message here for clinicians is to approach each patient encounter with an open mind and always to remember that behind the anonymity and homogeneity of 'the veil' is a person who may be vulnerable and in need of care.

Reflecting more broadly on this episode, the root of the problem lies in failure of communication. Ghosh (1993, p. 237) highlights the challenges that this presents in contemporary global society: 'To make ourselves understood, we had both resorted to the very terms that world leaders and statesmen use at great, global conferences, the universal, irresistible metaphysics of modern meaning.' There is little doubt that lack of a shared language is a source of misunderstanding and that much is lost in translation, but this is only part of the story. There are many other aspects of human interaction, both intentional and unintentional, where meaning is misconstrued and communication falters.

How often do we miss the point because we are just not listening? Or, worse, because we already have a confirmed bias and stereotypical notions in our head and are making assumptions about people that turn out to be less than accurate or fair? In healthcare it is our job to assess the patient and make clinical judgements about their condition, but not about the patient as a person unless this is directly relevant or is having an impact on the presenting complaint. This is a fine line to draw, and it is not unusual to find that the behaviour or attire of the patient has influenced the clinician's initial assessment and perception of the patient before a comprehensive picture has been developed (Van Ryn and Burke, 2000). This kind of bias works both ways, and if the patient or their carer is

also making assumptions about the clinician, or has a poor understanding of the role of members of the clinical team, the consultation will be fraught with risk and outcomes may be less than optimal. It is well recognised that patients have their own set of expectations when they access healthcare, which can be at odds with the clinician's assessment of need and medical imperative (Bell *et al*, 2002; Peltenburg *et al*, 2004). Communication is a two-way process, and both sets of players have some power and responsibility, but it behoves the clinical care team to be extra vigilant when dealing with members of minorities who may have learned different sets of rules.

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