

## Practitioner's blog

# When first impressions are wrong

Mary Dawood BSc (Hons) MSc

Nurse Consultant, Emergency Medicine, Imperial College Healthcare Trust, London, UK

Kim Bains BSc RSCN

Sister, Paediatric Emergency Department, St Mary's Hospital, London, UK

Recently an African woman presented to the Emergency Department with her two young sons, aged 5 and 8 years. She spoke reasonably good English and seemed quite purposeful in her approach. She told the nurse that her children needed to be treated because there was something inside them eating them up, and that if they were not treated they could come to harm. The triage nurse was perplexed, as the children seemed quite well, so she continued to question the woman, who remained adamant that something was eating her children. 'Can you not see their eyes are yellow?' she asked the nurse, 'Something is inside them.' The children themselves did not say much, were well behaved, and deferred to their mother to answer questions for them. The relationship between the woman and her children was not strained or tense, but she was brusque and authoritative towards them.

The assessment nurse recorded the children's vital signs, which were normal, and advised the woman that her children would soon be seen by the doctor. The nurse explained to the doctor that this seemed to be an odd presentation and she could not decide where the real problem lay, whether there was something wrong with the children or whether their mother was mentally unwell. The children had not previously attended the hospital and were not known to the liaison health visitor.

The doctor who went in to assess the children was fairly new to paediatrics and quite junior. With hindsight, this was perhaps fortuitous, as he made no assumptions and had little previous experience to influence his thinking.

He spent a long time talking to the woman and examining her sons. Eventually he came out of the consulting room and said to the nurse 'I might be wrong, but I think this lady is trying to tell me that her children have a parasitic infection.' He requested an interpreter so that he could clarify his suspicions and make sure that he was not missing something important. The interpreter duly confirmed both the doctor's impression and also that there were not any other issues of concern in relation to the children. The

children were discharged and their mother was happy that her sons had been appropriately treated for what turned out to be threadworms, a common parasite that frequently infects children and is very easily treated. The interpreter further explained that the mother understood a parasitic infection to be malaria, and this was why she had been so anxious about the well-being of her children.

However, the outcome could have been quite different. Language plays an extremely important role in the interaction between patients from diverse cultural groups and clinicians (Weaver and Sklar, 1980). However, language on its own, although very important, is only one form of communication, and it does not always tell the whole story. The importance of also recognising and appreciating diverse cultures in health-care situations, especially in relation to children, cannot be underestimated. This is particularly pertinent in emergency care, where the pace of work, sense of urgency, and the manner in which children are presented, sometimes by ambulance, can greatly increase both anxiety levels and the risk of communication failure.

Increasingly, healthcare workers are encountering paediatric patients and their families from cultures that are different from their own (Flores *et al*, 2002). In large cities, such as London, the range of non-indigenous people accessing healthcare is broad. For some, usually the most vulnerable, the first and only point of access to healthcare is the Emergency Department. Changing demographic patterns and transient populations mean that healthcare workers need to familiarise themselves and rapidly assimilate cultural knowledge so that they can respond in a competent way to patients and parents who have a different cultural background to their own. The beneficial effects of cultural competency embrace good health outcomes, quality care and patient satisfaction, while failure to consider language and culture can have serious adverse consequences for clinical care and patient safety (Brotanek *et al*, 2008). The implications of a lack of cultural awareness, particularly with regard to differing

belief systems, and a failure to appreciate that illness may be expressed differently, are as serious as the implications of language differences for accurate diagnosis and clinical safety.

Cultural beliefs and lay understanding of illness can complicate any interaction between the patient and the clinician. Scientific medicine may conflict with traditional health beliefs and cultural practices, creating conflict and fuelling prejudice (Weaver and Sklar, 1980). Such conflicts become even more complex when the patient is a child. Children as patients present further challenges because the history is usually presented by a parent, and the clinician depends on that person's ability to explain what is wrong in order to make a diagnosis.

Doctor-patient relationships are influenced by background variables (Johnson *et al*, 2004). There may be no shared language, and even when language is shared, the two parties may still not understand each other's terminology. Wide gaps in understanding of common medical and psychological terms between physician and patient are not unusual and have been well documented (Hadlow and Pitts, 1991; Hornberger *et al* 1997; Rosenberg *et al*, 2006). Such gaps may be accentuated further when there is a stark cultural difference between the physician and the patient.

Failure to appreciate the relevance of culture and language when caring for children, particularly in emergency situations, can have serious consequences for the child and give rise to situations where consent is not truly informed and parents do not have an adequate understanding of diagnoses and treatment (Flores *et al*, 2002). Parents' beliefs and practices can be misunderstood and clinical findings misinterpreted, resulting in at best unnecessary investigations, and at worst preventable morbidity and mortality and unnecessary child abuse evaluations (Flores *et al*, 2002), which are devastating for families who may already feel marginalised and vulnerable.

It was quite appropriate for the nurse in this case to highlight her initial concern about the two boys, especially in a society where child abuse attracts high-profile media attention. Clinical staff are increasingly expected to safeguard and accurately screen children at risk (House of Commons Health Committee, 2003). Language barriers and a lack of cultural knowledge can make this process difficult, resulting in either under- or overestimates of risk. Paediatric presentations to the Emergency Department are, by their very nature,

both sensitive and emotional, and the added variation due to cultural diversity serves to highlight the importance of using a trained medical interpreter who is also familiar with the normative cultural values, traditional illness beliefs and ethno-medical treatments of the patient (Brotanek *et al*, 2008).

Fortunately, in this case, best practice was followed and this family left the department feeling happy and supported, but the outcome could easily have been very different. The staff involved realised yet again the relevance of culture and the importance of keeping an open mind, as 'things are not always what they seem' and it is easy to draw the wrong conclusion.

## REFERENCES

- Betancourt JR (2006) Cultural competence and medical education; many names, many perspectives, one goal. *Academic Medicine* 81:499–501.
- Brotanek JM, Seeley CE and Flores G (2008) The importance of cultural competency in general pediatrics. *Current Opinion in Paediatrics* 20:711–18.
- Flores G, Rabke-Verani J, Pine W *et al* (2002) The importance of cultural and linguistic issues in the emergency care of children. *Pediatric Emergency Care* 18:271–84.
- Hadlow J and Pitts M (1991) The understanding of common health terms by doctors, nurses and patients. *Social Science and Medicine* 32:193–6.
- Hornberger J, Itakura H and Wilson SR (1997) Bridging language and cultural barriers between physicians and patients. *Public Health Report* 112:410–17.
- House of Commons Health Committee (2003) *The Victoria Climbié Inquiry Report*. London: The Stationery Office. [www.publications.parliament.uk](http://www.publications.parliament.uk)
- Johnson RL, Saha S, Arbelaez JJ *et al* (2004) Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine* 19:101–10.
- Rosenberg E, Richard C, Lussier MT *et al* (2006) Intercultural communication competence in family medicine: lessons from the field. *Patient Education and Counselling* 61:236–45.
- Weaver C and Sklar D (1980) Diagnostic dilemmas and cultural diversity in emergency rooms. *Western Journal of Medicine* 133:356–66.

## ADDRESS FOR CORRESPONDENCE

Mary Dawood, St Mary's Hospital, Praed Street, Paddington, London W2 1NY, UK. Email: [Mary.Dawood@imperial.nhs.uk](mailto:Mary.Dawood@imperial.nhs.uk)