Cultural Competence—Lessons From an Exceptional Case of Care Delivery to My Mom

Orrisha Denbow-Burke, MD, MPH[1], Neville Burke, MBBS, DM[2], Mireille Norris, MD, FRCPC, MHSc[3]

[1]Division of Geriatric Medicine, Sunnybrook Health Sciences Centre, Toronto, ON; [2]Department of Anesthesia, Pain Management & Perioperative Medicine, Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia; [3]Division of Geriatrics, Faculty of Medicine, University of Toronto, Toronto, ON

https://doi.org/10.5770/cgj.25.619

Case Presentation

My mother, a 76-year-old Black female, was well, with no prior medical history, until she nearly fell to the ground at her home in Dorval. My sister was at her side when this happened. She called me in Toronto and I advised her to call an ambulance which arrived shortly thereafter. The ambulance technician was able to speak to her in French, her native tongue, which made her feel comfortable and contributed to making my sister more confident with the care mom was receiving. Her heart rate was 110 bpm and her blood pressure 80/60mmHg. Fluid resuscitation was initiated, and mom was taken to triage at a community hospital where she was treated for severe hypovolemic (hemorrhagic) shock due to an acute gastrointestinal bleed.

A few days after her admission, I was contacted by her managing physician who knew I was a practicing Internist/Geriatrician, and was then made aware that my mother was very ill. At that time, my siblings, with their laymen's view of medicine, could not appreciate the severity of her condition. Mom was subsequently transferred to the Critical Care Unit of a university affiliated hospital.

Prior to her transfer, mom underwent multiple endoscopies which did not reveal the source of her hemorrhage. She required multiple transfusions of blood products. Shortly after her sixth endoscopy at the teaching hospital, she suffered a witnessed cardiopulmonary arrest and was successfully resuscitated. An emergency massive transfusion protocol and laparotomy were executed by the surgical team. My mother is spiritual and she recalls seeing a white light; she believed her spirit guided the hands of her surgeon to save her.

In the operating room, the bleeding source, a perforated duodenal ulcer, was surgically repaired. In total, mom received 17 units of packed red blood cells, among other blood products. After being transferred to the ward, mom experienced a syncopal attack while trying to stand up from the commode. Thankfully my son who had stayed at her side was able to break her fall. She was found to have a bleed at her surgical site and required readmission to the Critical Care Unit.

After three weeks of hospitalization, during which she improved to the point of being fit for discharge from the surgical ward, my mother was transitioned to a rehabilitation unit after strong family advocacy. This was followed by admission to a convalescent centre for a few months before she returned home safely.

Discussion

Black Canadians today have diverse backgrounds and experiences, but most share a common lived experience of trauma that may be historical, institutional, intergenerational, or personal. Anti-Black racism is a system of inequities in power, resources, and opportunities that discriminates against people of African descent.(1) This racial discrimination can adversely impact social determinants of health and thereby lead to poorer health outcomes. In that context, it may be reasonable to assume that for Black people who do not live within the confines of economic depravity (i.e., Black people who are not living in a low-income situation) should have similar health states and outcomes when compared to non-Blacks of the same economic bracket. Recent statistics indicate that 20.7% of the Black population in Canada lived in a low-income situation.(2) In this case study, the health-care experience of a member of the remaining 79.3% is reviewed.

Inequalities in education, employment, and housing—all important determinants of health—have been found to be driven significantly by anti-Black racism and discrimination.(2) In the case of my mother, a Black woman and member of a highly educated family, these determinants did not exist. It can be noted that, at the onset, she was able to access an ambulance very quickly, received prompt medical assessment, good communication in her native language, and rapid initiation of care.

Studies have established direct correlations with self-reported experiences of racism and adverse health outcomes ranging from raised blood pressure to poorer health status.(3,4) My mom did not feel racialized during her interactions with the medical team. Instead, she was particularly pleased with

the high level of detail and frequency of updates provided via telephone calls to me by the most senior member of the medical team. Also, there were numerous family members constantly at her side acting as strong advocates. In general, it has been shown from the literature that the presence of family members has decreased hospital stays, and improved patient experience and both patient and family mental health.[5] There is no literature that has been found illuminating the impact on health outcomes that occurs when family members for older Black patients are present. Hence, questions about the presence of Black family members worsening outcomes (due to being perceived as threats or for other reasons) remained unanswered.

When considering the provision of health-care resources for Black people, it is important to note the disparities that exist when compared to non-Blacks. For example Black patients who seek relief of pain experienced both the highest number and magnitude of opioid treatment disparities than any other group, raising quality and safety concerns.[6] There is no literature that has been found by these authors related to racial disparities in the management of gastrointestinal bleeds. My mother sustained an acute upper gastrointestinal bleeding (UGIB), which is a life-threatening emergency and is associated with higher rates of morbidity and mortality in the elderly when compared to younger patients. The management would require early risk assessment, resuscitation, endoscopy, and radiological or surgical intervention with ongoing bleeding. According to the American College of Gastroenterology, patients with bleeding ulcers who have failed endoscopic therapy should be treated with transcatheter arterial embolization.[7] Why then did my mother have a total of six endoscopies and a cardiac arrest before surgical intervention was considered? Could this be because of unconscious bias by the health care provider to not intervene much sooner?

Outside of the management disparities that may have been attributed to her ethnicity, my mother, being an elderly person, was possibly further disadvantaged by the potential impact of her advanced age on health outcomes. It has been well established that ageism leads to significantly worse health outcomes across a broad spectrum of patients.[8] The intersectionality of race and age, with regard to their impact on health outcomes, however, has not been as thoroughly investigated. Current findings suggest that older patients from minority groups suffer from "compounding inequalities" that result in suboptimal treatment when compared to White patients of similar age.[9,10]

The presence of unconscious bias amongst health-care providers could play a significant role in health-care disparities. It is every health-care organizations' responsibility to mitigate the effects of unconscious bias on patient care, as this impacts the outcome of care and severs trust in that organization to provide care in the future. These organizations must, therefore, learn how to improve cultural competence.

Cultural competence involves understanding the values, beliefs, traditions, and customs of diverse groups.[11] This improves communication, increases patient safety, and reduces inefficiencies and health-care disparities. In this present case, language accessibility was a culturally competent strategy used by health-care staff during mom's entire journey. This helped to foster a safe environment and good dialogue between mom and her health-care team, which led to the understanding of her cultural preferences in care. The incorporation of the Campinha-Bacote's "Process of Cultural Competence Model",[12] using the mnemonic ASKED (Awareness, Skills, Knowledge, Encounters, and Desire), aids in culturally appropriate assessments and providing care for ethnic minorities and diverse populations. This can be combined with the LEAPS care model which includes Listening and learning about the patients' lived experiences; Engaging empowering, showing empathy; Asking questions and acknowledging patients' fears and concerns; Paraphrasing and providing educational support where necessary; and Supporting the patient which would help to spark future patient engagement.[13]

While cultural competence addresses some of the pitfalls in the communication between patients and family members by health-care practitioners, its impact on decision-making where implicit bias exists is unclear. Unconscious bias may be quite intangible at times. However, its negative effects can be significantly compounded when there are multiple points of input for that bias, such as the intersectionality of anti-Black racism and ageism. In this case, this compounded effect could have further worsened decision-making during the provision of care.

Conclusion

Inequality in health-care access related to anti-Black racism affects the delivery of health care to Black seniors in Canada. Cultural competency and implicit bias training can help improve care delivery and outcome. Research is required to understand how unconscious bias amongst health-care providers impacts racialized individuals. Strong patient advocacy from family members can mitigate harm.

ACKNOWLEDGEMENTS

I acknowledge with gratitude Chantelle Harriott for her input as a Black Social Worker who provided validity to my mother's experience and brought attention to the role of family advocacy in the care Black Seniors in a hospital setting.

CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal's* policy on disclosing conflicts of interest and declare that we have none.

FUNDING

This research did not receive external funding.

REFERENCES

1. Government of Canada. Building a foundation for change: Canada's anti-racism strategy 2019–2022. https://www.canada.ca/en/canadian-heritage/campaigns/anti-racism-engagement/anti-racism-strategy.html 2019.
2. Government of Canada. Department of Health. Social determinants and inequities in health for Black Canadians: a snapshot. 2020. https://open.canada.ca/data/en/dataset/3b593726-9632-451a-beaf-e6b6bed4b37a
3. Paradies Y. A systematic review of empirical research on self-reported racism and health. *Int J Epidemiol*. 2006;35(4):888–901.
4. Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. *J Behav Med*. 2009;32(1):20–47.
5. Munshi L, Evans G, Razak F. The case for relaxing no-visitor policies in hospitals during the ongoing COVID-19 pandemic. *CMAJ*. 2021;193(4):E135–E37.
6. Meghani SH, Byun E, Gallagher RM. Time to take stock: a meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. *Pain Med*. 2012;13(2):150–74.
7. Laine L, Barkun AN, Saltzman JR, Martel M, Leontiadis GI. ACG Clinical Guideline: Upper gastrointestinal and ulcer bleeding. *Official Journal Am Coll Gastroenterol*. 2021;116(5):899–917.
8. Chang ES, Kannoth S, Levy S, Wang S-Y, Lee JE, Levy BR. Global reach of ageism on older persons' health: a systematic review. *PLoS One*. 2020;15(1):e0220857.
9. Compounding inequalities: racism, ageism, and health [editorial]. *The Lancet Healthy Longevity*. 2021;2(3):e112.
10. Mahmud SM, Xu L, Hall LL, *et al*. Effect of race and ethnicity on influenza vaccine uptake among older US Medicare beneficiaries: a record-linkage cohort study. *The Lancet Healthy Longevity*. 2021;2(3):e143–e153.
11. Ingram RR. Using Campinha-Bacote's process of cultural competence model to examine the relationship between health literacy and cultural competence. *J Adv Nurs*. 2012;68(3):695–704.
12. Campinha-Bacote J. The Process of Cultural Competence in the Delivery of Healthcare Services: a Model of Care. Blue Ash, OH; 2003. Available from: http://transculturalcare.net/the-process-of-cultural-competence-in-the-delivery-of-healthcare-services/
13. Eissa A, Lofters A, Akor N, Prescod C, Nnorom O. Increasing SARS-CoV-2 vaccination rates among Black people in Canada. *CMAJ*. 2021;193(31):E1220–E21.

Correspondence to: Orrisha Denbow-Burke; c/o Dr. Mireille Norris; Division of Geriatric Medicine, Department of Medicine, Sunnybrook Health Sciences Centre, 2075 Bayview Ave., Toronto, ON M4N 3M5
E-mail: orrisha.denbow-burke@sunnybrook.ca