A Mother's Loss and a Case of Failed Cultural Humility

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ABSTRACT

We describe a case of a 25-year-old Quiché (or K'iche') speaking G2P2022 (2 pregnancies, 2 term births, 2 live births) woman who was transferred from an outside hospital on postpartum day 3, to preserve mother-baby dyad while her infant required a higher level of care after suffering an apneic episode at 22 hours of life. Although the patient was a known Quiché speaker, lack of access to Quiché interpreters in the hospital led to the use of Spanish interpreters. Her treatment team subsequently described her affect as "flat" and reported "poor maternal care," leading to a report to the Administration for Children's Services. As we analyze this case, we use person-centered maternity care as a framework to discuss areas for improvement in providing care to peripartum individuals, as well as cultural safety and humility as solutions to cultural gaps between patients and providers. **[*Psychiatr Ann*. 2022;52(12):500-503.]**

As the world becomes more globalized, an emphasis on caring for patients from a wide variety of cultures has become even more relevant. As such, research has supported the need for providers to approach cultural differences with humility. In a scoping review looking at strategies implemented in healthcare organizations to improve and provide culturally competent care, authors found that, in many cases, efforts to increase cultural competence within our healthcare systems has a positive impact on patients. One example provided was the recruitment of a bilingual Russian internist at a medical center, with the goal of improving diabetes care for Russian patients. Subsequently, there was a significant reduction in diastolic blood pressure and cholesterol ($P < 0.0002$) among Russian diabetes patients, as well as an insignificant reduction in HbA1c and systolic blood pressure.[1] Others have shown the detrimental effects that can occur during ineffective cross-cultural interviews with providers. In a study that looked at the impact of a cultural consultation service at a hospital in Canada, authors found that, among psychiatric patients of ethnic minority and immigrant backgrounds referred to a cultural consultation service, 49% of the patients having an intake diagnosis of a psychotic disorder were rediagnosed with nonpsychotic disorders by the cultural consultation service.[2] Clearly, cultural differences between patients and providers have lasting impacts and must be approached with care and intention.

The patient was a 25-year-old Quiché (or K'iche') speaking woman, G2P2002 (2 pregnancies, 2 term births, 2 live births) at the time of admission. She was transferred from an outside hospital on postpartum day 3 to preserve the mother-baby dyad in the setting of her infant needing neonatal intensive care unit (NICU) care after an apneic episode requiring intubation and a subsequent severe diffuse anoxic brain injury. The patient had emigrated from a small village in Guatemala to the United States 3 years ago. She lives with her husband and is currently unemployed. She had no significant past medical or psychiatric history. She has a 4th grade education and had left her older child in the care of her sibling back in Guatemala. The psychiatry consult service was asked to see this patient as she was felt to have had an "inappropriate response" when informed of the severity of her infant's medical condition.

HISTORY

The patient presented to the outpatient obstetrics clinic at 24 weeks gestation. Her pregnancy was unplanned, and she had come to request a termination

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of pregnancy. Given the advanced gestational age of the fetus (although the legal limit to perform an abortion in New York State is 26 weeks), the patient was counseled on the rarity of termination so late in pregnancy. It was documented that the patient's interview with this provider was conducted in Spanish and she was noted to: (1) have limited understanding of their conversation, and (2) potentially be developmentally delayed. She was told that she would likely have to continue the pregnancy. The patient left the appointment and did not return until she was at 30 weeks gestation when she presented for her first prenatal visit.

Over the course of the next several visits, the patient was counseled in Quiché via interpreter services about having a trial of labor after cesarean (TOLAC). All the patient information given and pertinent paperwork, however, was written in Spanish, which she did not speak, read, or write. The patient continued to follow up with routine prenatal care. She was often counseled and consented in Spanish; it was documented that there was no Quiché interpreter available for the visits.

At 40 weeks, the patient's membranes spontaneously ruptured, and she underwent an uneventful vaginal birth after cesarean (VBAC), delivering a healthy baby boy with Apgar Scores 9/9 at 1 and 5 minutes.[3] The patient was counseled on breastfeeding and was visited by the Obstetrical team's social work staff, who felt that mother and child needed no further social work services.

POSTPARTUM

At 20 hours of life, the infant was observed by nursing staff to be doing well at mother's bedside. Two hours later, when the nurse came into round on the mother and infant, the mother was in the restroom and the baby was found limp, unresponsive, and cyanotic in the bassinet. The infant was coded, intubated, and transferred to the NICU. The treatment team reported that the patient was a "poor historian" and had a "language barrier," therefore, the circumstances of this significant event were unclear. The team primarily used the patient's husband to interpret from Spanish to Quiché. The providers noted that the patient's affect was "flat" and that she had "poor maternal care." As the prognosis for the infant worsened, and the circumstances leading up to the event were unclear, the case was reported to the city Administration for Children's Services (ACS) "because we do not know what happened to this baby, or the cause of the respiratory collapse and hypoxia."

The Reproductive Psychiatry consultation team was called to assess for the patient's "flat affect" and expressed concern for possible depression. The patient was a 25 year old Guatemalan woman, petite, appropriate grooming in hospital attire, with intermittent eye contact, downward gaze, and appearing younger than stated age. Patient was distantly related, and maintained behavioral control. No psychomotor slowing/agitation noted. No tics, tremors, or abnormal movements appreciated. Speech was soft, minimal, accented, with a poverty of speech. Mood was dysthymic. Affect was flat and congruent with mood. Thought process was linear and content was within normal limits. Patient denied perceptual changes. Insight and judgement were intact. Impulse control was intact. Cognition was awake and fully oriented, not formally assessed. Diagnostic impression was consistent with unspecified trauma or stress-related disorder, likely acute stress reaction in context of sudden infant loss. Patient was at increased risk for development of a perinatal mood and anxiety disorder (PMAD) during the postpartum period and thus should also be included on the differential. Of note, the social work team was still attempting to complete assessments with the patient in Spanish. ACS and law enforcement had become involved and were attempting to conduct investigations while the patient and her husband were transitioning the infant to comfort care, arranging for baptism, and preparing for a palliative extubation.

DISCUSSION

There are several opportunities for improvement in the case described above, as well as in the provision of care during the peripartum period. We shall highlight some areas of improvement using the lens of person-centered maternity care (PCMC). PCMC emphasizes respectful, holistic, responsive maternity care and has been recommended as a framework to provide quality equitable care for maternal and newborn health. In 2017, Dr. Patience Afulani developed and validated a tool to objectively operationalize this vital yet largely abstract aspect of maternity care.[4,5] Her work defined 10 domains of PCMC, including dignity and respect, communication, stigma and discrimination, and autonomy.[4]

Person-centered maternity care plays a role in the health and well-being of both mother and newborn. In a study of the association between PCMC and newborn complications, women with high PCMC scores were significantly less likely to report newborn complications than women with low PCMC scores.[6] In the same study, the PCMC domains of respect/dignity and supportive care were associated with fewer newborn complications and a willingness to return to a facility.[6] The study concluded that PCMC could improve the experience of the mother during childbirth, the health of her newborn, and the mother's future health-seeking behavior.[6] Unfortunately, care that implements the framework of PCMC can be difficult to find; one study found that just over 50% of women felt they were treated with respect all the time while receiving maternity care.[5]

In a world where vast disparities exist in maternal and child health outcomes, PCMC has been proposed as a way to

make perinatal care more equitable. The World Health Organization (WHO) defines quality care as care that is safe, effective, timely, efficient, equitable, and people centered.[7] In a paper looking at the WHO's vision for quality care for pregnant women and newborns, the authors recommended balancing evidence-based practice and functional systems with optimizing patients' experience of care, via effective communication, respect and dignity, and emotional support.[7] The authors describe that within the critical perinatal period, quality of care improvement efforts could have a significant impact on maternal, fetal, and newborn survival and well-being.[7]

Using the PCMC domains, we shall review aspects of this case that fell short. The three main subscales identified in Afulani's PCMC tool include dignity and respect, communication and autonomy, and supportive care.[4] The couple were denied dignity and respect when hospital staff assumed the patient's emotional response to the pending death of her child was "inappropriate," and interrupted the couple's grieving process with accusation and interrogation.

In the subscale of communication and autonomy, the patient was "counseled against" and effectively denied an abortion procedure, a violation of her autonomy. "Rarely" having an abortion at 24 weeks versus not legally being allowed to have an abortion at 24 weeks are two separate issues, and the way this case was handled seems to be a matter of provider comfort rather than an objective, well-informed decision made by the patient herself. One question used to measure PCMC is "did the doctors, nurses, or other staff at the facility speak to you in a language you could understand?"[5] This correlates with the recommendation of the American College of Obstetricians and Gynecologists that health care teams provide access to interpreter services for all patient interactions when the patient's language is not the clinician's language.[8]

Quiché (K'iche') is a subgroup of the Mayan family of languages from the western highlands of central Guatemala. It is the second most widely spoken language in Guatemala, after Spanish, and roughly 8 million people worldwide are estimated to be native speakers, including increasing numbers of speakers in the US. That said, there are limited interpreters available for this language. At the hospital at which this patient delivered, there is one over-the-phone Quiché interpreter, who is not always available.[9] It is the second most widely spoken language in Guatemala, after Spanish, and roughly 8 million people worldwide are estimated to be native speakers, including increasing numbers of speakers in the US.[10] Prior to the birth of her child, important health care information was provided to the patient in Spanish, a language that she did not speak or understand. A Spanish-speaking interpreter was provided to the patient so that she could communicate with her treatment team. Assuming that Spanish was 'close enough' to the patient's language, as well as using her husband as an interpreter, was inappropriate.

One could also argue that this patient was not provided supportive care as defined by Afulani.[4] Aside from the isolation experienced by the patient in the hospital due to the language barrier, the patient experienced a significant lack of compassion from the health care team. Implicit and explicit biases were evident from the perceived inappropriateness of the patient's grief reaction, and the insensitivity towards the patient in questioning her for suspected neglect or ill intent, hours after learning of her baby's death.

Grief is a person's emotional response to loss and is a natural and universal response.[11] The range of 'expected' reactions to loss is vast, and it is critical to validate patients' experience in its entirety. This patient was criticized for a 'flat affect' towards learning of her loss, possibly indicative of shock, dissociation, or denial.

In addition to the language barrier and isolation, the patient's cultural differences may have created discord between the patient and her care team. McLemore et al. used focus groups to understand the experiences of pregnant, birthing, and postnatal women of color within the health care system during the peripartum period.[12] Participants described disrespect during health care encounters, including experiences of racism and discrimination, stressful interactions with all levels of staff, unmet information needs, and inconsistent social support. For the women in the focus groups, prenatal health care was a largely disrespectful and stressful experience, and they recommended changes such as better communication among multiple health care providers and more careful listening to patients during clinical encounters.[12]

Many propose cultural competency as a solution to bridge these culture gaps. Cultural competency focuses on the idea that individuals can attain a certain set of skills and knowledge to address health inequities. However, this assumes a finite process, rather than a changing system of beliefs and values.[13] Further, the expectation that a provider should be fully versed in all cultural customs from different ethnic groups is unrealistic. The concept of *cultural safety* shifts focus to the power differential between provider and patient, and encourages self-reflection on the part of the provider on the implication of said power and privilege on our health care systems and practice.[14] Similarly, *cultural humility* refers to an orientation towards caring for one's patient that lends the provider to admitting when one does not know and is willing to learn from patients about their own experiences, while being aware of one's own embeddedness in cultures.[13] Cultural safety and cultural humility recognize that the power differential between provider and patient presents the risk of reinforcing stereotypes, which worsens patient outcomes rather than improves them.[13]

Although tragic, this case illustrates the need to improve the provision of equitable perinatal care. A focus on upholding the core tenets of PCMC would have provided this patient with appropriate interpretation services so that she could participate as a full partner in her health care. It would also have provided the patient with better support and understanding of her reactions in the wake of the death of her newborn. Finally, prioritizing a shift in how caregivers understand culture and treat those with different cultures is vital to providing equitable care now and in the future.

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