Chapter 12
Native-American Patient

Xi Damrell and Kevin Ferguson

Case Scenario

A 63-year-old Native-American woman, accompanied by her son, presents at an emergency room with complaints of dizziness, edema and pain in her extremities, shortness of breath, and a nonproductive cough. She is a practitioner of native traditional religion, is not seen by the Indian Health Service, and claims that she "avoids doctors." Her manner is alternately standoffish and joking. She states to the emergency room physician that she is not averse to Western medicine, however, and sees "traditional medicines" as "complementing white medicine." They both speak English, but, intermittently, the patient and son speak Lakota (their native language) to one another, which makes the physician uncomfortable. Both seem evasive about the patient's history and appear to avoid eye contact. The patient is nonadherent with previously prescribed and unknown diabetic medications, saying that she prefers to treat her condition with "bear root" and other herbs available to her seasonally or from friends. She displays an empty prescription bottle with most of the information worn off. She has tried an unspecified home remedy for cough, but it "won't work until the next moon." She wants the emergency physician to help her decide how to proceed with her cure. At the end of the exam, the son briefly takes the doctor aside to say that his mother is "a highly respected person and not as crazy as she sounds" and that he will make sure she does what she is told.

X. Damrell (✉)
Kaweah Delta Emergency Medicine Residency Program, Visalia, CA, USA
e-mail: xi.damrell@vituity.com

K. Ferguson
Touro University at St. Joseph Medical Center, Stockton, CA, USA
e-mail: kevinferguson@cep.com

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Review of Symptoms

The patient has increased shortness of breath lately and is unable to lie flat. According to her son, she gets tired easily lately and has been less active.

Past Medical History

The patient says she is diabetic but does not take medication and generally does not follow any dietary restrictions except according to her own beliefs and traditions, preferring wild game and plants to “store-bought” food. Her blood pressure has been high during office visits, but she is not on any blood pressure medication.

Family History

The patient’s father died of old age and was diabetic. Her mother died of a heart attack at age 50. Both of her brothers are alcoholics and living, and she is unclear about their medical conditions.

Social History

The patient is a member of a large, multigenerational family group and is considered by them to be an elder and a “medicine woman.” She is divorced and lives alone in her small home behind the family farmhouse. There is adequate food in the home, and the patient has children, grandchildren, and neighbors who will “look in on her,” although there “may be a problem if medication have to be taken at certain times.” The family is seasonally employed by local ranchers and farmers and also farms a small hay plot in addition to maintaining a garden and raising a few horses and chickens. The patient does not use alcohol, illegal drugs, or tobacco.

Physical Exam

Vital signs Temp, 98.3 F; pulse, 110, BP 180/90; respiration, 28, O_2 Sat 93% on room air.

General Obese Native-American woman.

ENT Pupils round, reactive to light, non-icterus sclera, mucous membrane moist, poor dentition.

Neck Jugular venous distention present, no carotid bruits.

Cardiovascular Tachycardia with irregular rhythm, no murmurs, equal palpable distal pulses.

Respiratory Tachypnea, rales in the bilateral lower lung fields.

Abdomen Soft, non-tender, non-distended, no organomegaly.

Extremities 2 plus pitting edema bilateral lower extremities up to the mid-calf.

Skin No rash.

Neuro Awake, alert, and oriented; no focal deficits.

Test Results CBC, normal; metabolic panel, elevated blood glucose of 480; normal bicarb; VBG showed PH is 7.38; BNP, 810; CXR, enlarged heart with bilateral interstitial infiltrates, Kerley B lines, small pleural effusions consistent with pulmonary edema; EKG, atrial fibrillation with V rate of 112, no acute ischemic change; first set of troponin is negative.

Questions for Discussion

1. Why is communication between the physician and the patient difficult?

Attitudes/Assumptions: The Physician

(a) Based on her statements, the patient mistrusts "Western medicine."
(b) She doesn't act educated or well-informed about her condition.
(c) Patient is delusional and has difficulty talking to the physician.

Attitudes/Assumptions: The Patient

(a) I believe in the medicine and the practices of my ancestors. The spirits have answered me in the past and cured my other illnesses.
(b) I know the doctor thinks I am crazy. I saw his facial expression when I told him my medicine will not be ready until the next moon.
(c) White people have always thought we are stupid.

2. What are some cultural issues?

Attitudes/Assumptions: The Physician

(a) Why are they speaking in a Native-American language?
(b) What are they saying that is not translated to me?
(c) What does it mean that the patient considers herself to be a "medicine woman"?

Attitudes/Assumptions: The Patient

(a) I am trying to show the white doctor that I am capable and not uneducated.
(b) I am proud of my native heritage and my bilingual abilities.
(c) The physician may have gone to medical school, but I have learned from the elders during my lifetime.

3. What are some factors related to trust and respect?

Attitudes/Assumptions: The Physician

(a) Even though the patient verbalizes her distrust of medicine, she has communicated that distrust (communication is good).
(b) The patient has offered the doctor an opening by saying that Native American and "white" medicine can complement one another.
(c) Lots of patients are nervous around physicians, and the joking, etc., may simply be this patient's reaction to the situation.

Attitudes/Assumptions: The Patient

(a) I will show this non-Indian doctor that my ways are as valid as his.
(b) I will follow the doctor's advice, so long as it seems to fit with my own beliefs.
(c) When the doctor shows me a little respect and doesn't treat me like I am uneducated, uncultured, or a child, I will reciprocate.

Gaps in Provider Knowledge

(a) The provider may not understand the following: Native-American elders are considered autonomous. They make their own decisions, including medical decisions, although the group (e.g., family and extended family) might weigh in

on minute details. Health beliefs are not fixed but are subject to "testing" and "contextualizing" [1]. Western medicines are often sought in addition to native healing (including the use of herbs, ceremonies, sweat lodge rites, and extensive dietary practices) to restore a patient to health. Causes of disease include malevolent spiritual forces and other unknown causes "beyond our understanding" [2].

(b) Owing to her age, the patient has no doubt experienced discrimination by white authorities (including, perhaps, medical providers). She might be using both English and Lakota to "prove" to the doctor that she is competent and capable and also to communicate her autonomy [3, 4].

4. Which components of Emergency Medicine Milestones of the ACGME competencies are incorporated in the case?

(a) *Professional values:* Providers often encounter patients with different cultural beliefs and practices that may conflict with the provider's personal values or beliefs. Respect the different beliefs and establish the therapeutic environment.

(b) *Patient-centered communication:* A professional and nonjudgmental approach is the key when obtaining the history. Understanding the patient's view of her health and likelihood of her compliance will determine her disposition.

(c) *Patient safety:* The provider needs to address psychosocial issues as well as medical emergencies. This patient has no established medical care and will need a primary care physician with cardiology consultation. This could be managed with close follow-up as outpatient.

Case Outcome

Diagnosis Pulmonary edema, new onset atrial fibrillation.

Disposition The patient is admitted to the regular floor with telemetry, and she improved with IV furosemide. Blood glucose improved after 10 units of IV regular insulin in the emergency department. Blood pressure improved with 10 units of IV hydralazine. Serial troponin was negative. A full cardiac workup was done, which included an echocardiogram that showed the patient has a reduced ejection fraction at 40%. The patient's congestive heart failure symptoms improved, and she was discharged home with a multi-medication regiment for heart failure and Coumadin for her atrial fibrillation. There were several long discussions with the patient and her family members. The patient agreed to take her medications as described, and she was given an appointment to follow up with the cardiologist in 2 weeks. The patient also had a primary care appointment scheduled in 2 weeks.

References

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