



Obstetrics and Gynaecology Cultural Factors of Care

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EDITORIAL

In this post, I'll look at how cultural variations can affect health outcomes and how understanding them can improve my interactions with patients and colleagues, as well as have an impact on the profession of obstetrics and gynaecology. Recognizing and embracing variations in individuals and groups of people is what diversity is all about. We have a natural need to be a part of a group. For our stone-age forefathers to survive, they needed to be a part of a group, and being left out meant certain death. We, too, want to belong and are afraid of rejection, and we have a natural preference for those who are similar to us. The 'fight or flight response' is triggered when someone is dismissed from a group. We may feel vulnerable, isolated, hurt, or have an acute stress reaction (negative or depressive emotions; disappointment in oneself; increased emotional reactions e.g. more tearful, sensitive, or aggressive; loneliness; withdrawn; loss of motivation, commitment, and confidence; mood swings) if we are rejected [1-3].

FACTORS OF CARE

Excluding a team member can result in internal conflicts and dissatisfaction, as well as a rise in personnel turnover, complaints and grievances, sickness, and stress reports. It may make it harder to recruit new employees, cause poor performance, and lead to consumer unhappiness and complaints. When our patients seek care, they may already be vulnerable, and feelings of isolation may compound this. We live in a multi-cultural society in the United Kingdom. This can be seen in both our patient population and our personnel. In obstetrics and gynaecology, maternal and perinatal deaths are two apparent examples of cultural differences in health outcomes. When comparing women from black and minority ethnic (BME) groups to women from white groups, the risk of

maternal death was considerably greater (2012e14) (RR 4.19; 95 percent CI 2.69 to 6.35). In the UK, white women have a 4.5 percent stillbirth rate (95 percent CI 4.3e4.7). Stillbirth is more common in black and Asian women, with rates of 9.2 (95 percent CI 8.3 e10.3) and 7.0 (95 percent CI 6.4e7.7) per 1000 births, respectively. According to a Danish study, ethnic variations in socioeconomic status or maternal education did not contribute to the increased risk of stillbirth in BME groups [4].

The prevalence and severity of endometrial cancer in different ethnic groups is one example of a variance in gynaecological outcomes among cultural groups that is not easily explained by biology. When it comes to endometrial cancer, South Asian women are eight years younger than their white counterparts. Black women are more likely to acquire the most aggressive histological subtype of endometrial cancer and, as a result, are more likely to present with advanced stage disease. Obesity rates do not differ considerably between ethnic groups; however diabetes is significantly more common in South Asian women due to lower insulin sensitivity [5]. Health disparities between cultural groups can be significant, explained, in part, by the challenges non-white women face in obtaining healthcare and interacting with government officials message on health. This is a multi-faceted issue, but communication issues and a limited understanding of how health and wellness work are two of the most significant factors. Health-care is seen differently throughout cultures and plays a significant role.

Finally, if at all possible, provide a choice of telephone or in-person interpretation. Inquire whether they have a preference for the interpreter's gender or religion, and if so, accommodate them. Remember that some communities are small, and women may need to be reassured about their privacy. Attempt to maintain the interpreter's consistency. During the consultation, keep an eye out for nonverbal signs. If all else fails, Google translate can serve as a last resort.

Received: 03-January-22

Manuscript No: IPGOCR-22-12411

Editor assigned: 05-January -22

PreQC No: IPGOCR-22-12411 (PQ)

Reviewed: 10-January -22

QC No: IPGOCR-22-12411

Revised: 15-January -22

Manuscript No: IPGOCR-22-12411 (R)

Published: 20-January -22

DOI: 10.21767/2471-8165.100004

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Citation: Joe M (2022) Obstetrics and Gynaecology Cultural Factors of Care. Gynecol Obstet Case Rep. Vol.8 No.1:4.

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REFERENCES

1. Walker KF, Gribbin C, Siddiqui F (2018) Cultural aspects of care in obstetrics and gynaecology. *Obstet Gynaecol Reprod Med* 28(11): 366-367.
2. Lazar JN, Johnson-Agbakwu CE, Davis OI, Shipp MP (2013) Providers' perceptions of challenges in obstetrical care for Somali women. *Obstet Gynecol Int* 2013(1): 1-12.
3. Giammarile F, Bozkurt MF, Cibula D, Pahisa J, Oyen WJ, et al. (2014) The EANM clinical and technical guidelines for lymphoscintigraphy and sentinel node localization in gynaecological cancers. *Eur J Nucl Med Mol Imaging* 41(7): 1463-1477.
4. Lai G, Rockall AG (2010) Lymph node imaging in gynecologic malignancy. In *Seminars in Ultrasound, CT and MRI* 31(5): 363-376.
5. Motoshima S, Irie H, Nakazono T, Kamura T, Kudo S (2011) Diffusion-weighted MR imaging in gynecologic cancers. *Journal of Gynecologic Oncology* 22(4): 275-287.