Racism in the Chemotherapy Infusion Unit: A Nurse’s Story

LIDIA SCHAPIRA,a LEAH GORDON-ROWE,b ROSALBA MARTIGNETTI,b DEBORAH WASHINGTON,b MIMI BARTHOLOMAY,b DONNA GREENBERG,c CHRISTOPHER LATHAN,d JOANNE LAFRANCESCA,b THOMAS LYNCH,a BRUCE CHABNERa

aDepartment of Medical Oncology, bDepartment of Nursing, cDepartment of Social Services, and dDana Farber Cancer Institute, Massachusetts General Hospital, Boston Massachusetts, USA

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ABSTRACT

Shortly before his death in 1995, Kenneth B. Schwartz, a cancer patient at Massachusetts General Hospital (MGH), founded The Kenneth B. Schwartz Center at MGH. The Schwartz Center is a nonprofit organization dedicated to supporting and advancing compassionate health care delivery that provides hope to the patient and support to caregivers, and encourages the healing process. The Center sponsors the Schwartz Center Rounds, a monthly multidisciplinary forum where caregivers reflect on important psychosocial issues faced by patients, their families, and their caregivers, and gain insight and support from fellow staff members.

In this article a nurse relates her experience as caregiver for a patient who made repeated racially motivated comments. She reflects on her response and the support she received from her colleagues. The Oncologist 2008;13:1177–1180

DIALOGUE

Infusion nurse: Last year I was assigned the care of a gentleman with a diagnosis of small cell lung cancer. He was prescribed cisplatin and etoposide. He tolerated the cisplatin but reacted soon into the etoposide treatment. Immediately we gave him methylprednisolone and then diphenhydramine to alleviate the symptoms of the reaction, and after receiving diphenhydramine he started slurring his words and said, “Oh, I sound like I’m talking like a Puerto Rican.” At this point I realized he might become a challenge.

The following day he seemed anxious. He received premedication as he would for every subsequent treatment. He complained about the extra time this added to his treatment. It was around the third cycle that he was watching a TV court program featuring a white woman with her black male partner fighting. He said to me, “Does it bother you when white women are with black men?” It struck me as an odd question. Thinking that he may be curious, I responded: “No, it doesn’t really bother me. Actually my mother-in-law is white; my...
husband is half black and half white, so obviously it
doesn’t bother me.” He then asked, “But how does the
mother give the child culture?” and I said, “well I
would think like any mother would give her child cul-
ture.” He repeated the question two more times until I
finally responded: “I don’t know if you know, but I am
biracial, my husband is biracial, my mother-in-law
happens to be white. I think that my mother did a great
job giving us culture, my mother-in-law did a great job
giving my husband culture: ethnic, religious and
American culture.”

A few weeks later he made a comment about my hair, say-
ing “But Oprah doesn’t have hair like that.” I then
talked with my colleagues and they expressed support,
sympathy, and concern, and also wondered if he was
surprised at being in the hands of a competent black
professional. I turned to my clinical nurse specialist be-
cause I wanted to excuse myself from his care. Her ad-
vice was to set limits and remain involved and that I ask
an associate nurse to become involved. I was con-
cerned that I would not be able to put up with his jabs
and maintain my composure as a nurse. This was a
challenge I had never before experienced in my nurs-
ing career. I experienced intense anxiety for a few days
before his next scheduled visit and began to think of
him as “my racist patient.” He returned with more
questions and I handed him off to a colleague when my
shift ended.

At every step of the way, I was supported by colleagues and
senior leadership. For a person of color to be able to say,
when you look out here in a city full of people who
don’t really look like you, who might not understand
what you go through on a daily basis, “this happened to
me and I don’t really know what to do about this,” and
feel supported, was tremendous.

Clinical Nurse Specialist: As professionals, we do not get
to pick and choose our patients. We often have to take
care of patients who are difficult to deal with and know
how to push our buttons. There is probably not a nurse
or physician here who has not run into some kind of
prejudice during the course of their work. My greatest
concern for this nurse was that because of her skin
color, she would be subject to a disproportionate
degree of prejudice during the course of her career. I
wanted her to be able to stand up for herself and tried to
help her find ways to feel more empowered.

Second Infusion Nurse: I took over the care of the patient
for the day and went in to introduce myself to him. The
first question he asked me was, “Where are you from?”
Our last names indicated a common ethnicity. After
that he asked me if I knew what medication was in his
i.v. solution. I assured him that I knew his chemother-
apy regimen. He went on to ask me if I knew what hap-
pened the very first day he was seen in our unit and
proceeded to pick apart his nurse’s care from the onset.
He said that she should have given him premedications
before giving the chemotherapy and, in so doing,
would have avoided his initial reaction. I explained to
him that patients do not typically react to etoposide
and it is not standard practice to administer premedications.
I went on to reassure him.

He then asked about my cultural background and remarked
that we had the same ethnicity. He went on to make rac-
ist comments, which I found very insulting. I was un-
comfortable listening. His wife just shook her head and
I said, “You know, some things are better left unsaid,”
hoping he would take the gentle hint that his comments
were inappropriate.

The following day he resumed his repertoire of racially mo-
tivated statements. He asked if the “other colored girls
were registered nurses too because they’re usually
not.” I explained each person’s role to him and con-
fronted him on his use of the word “colored.” He re-
sponded angrily. I explained that we work in a
respectful environment. He did not back down. His
wife looked down, embarrassed, shaking her head.
Trying to make things lighter I asked, “How have you
put up with him all these years?”

He went on to ask me if I was married. After I answered no,
he then asked how old I was. Before I could respond he
stated, “Never mind. I met you. I know why you’re not
married.” I laughed although I was embarrassed.

Director of Diversity: What I find intriguing about this case
is the personal experience of the infusion nurse. Con-
versations about race and ethnicity are always nu-
anced. So if this nurse had not found colleagues who
understood and supported her, what would she have
done? It is very easy to explain away everything that
happened. When you have been insulted and someone
processes it with you in a way that explains it away,
your experience is dismissed.

How do you hear this story and build a response to it?
Within this story is the organizational message. The
next question is: “Who delivers that message?” The an-
swer has to be that we all do. The message of zero tol-
erance for discriminatory behavior can only flourish if it is delivered consistently and adhered to by everybody.

Comment from the Audience: Does the hospital have a policy on this?

Director of Diversity: Other than the expected social laws against discrimination, the organization has a strong commitment to diversity that deepens the intent of that social message. Within the context of our institution, we link that message with accountability to act and respond to coded language that implies racist beliefs. The most important decision anybody has to make is to speak up. Typically, in race-based conversations, it means speaking up on behalf of others who are not present.

Another Comment: He was provocative with you. Here he is dealing with a disease. It sounds like nobody really got at what was provoking him or tried to understand it on a different level.

Oncologist: I think the question of a zero tolerance policy is an unfair standard for health care professionals. We do not choose whom we take care of. We still have to care for the patient and seek our own supports to help us through.

Psychiatrist: This goes beyond race. This is a man who was abusive in racial terms and abusive in man-to-woman terms regardless of culture. He went for the vulnerability of the woman of this ethnic group and the woman of a different race. He is a terrified man who is facing the fight of his life, and I suspect he has always coped by lashing out in this way. Someone in authority needs to set limits. I would have gotten the oncologist who was responsible for his care to say, “This is unacceptable. I understand that you are very upset and that it’s difficult being ill, but do not be rude to the nurse who works with me.”

Physician Moderator: What would you have done in this situation?

Director of Diversity: My practice is to have a conversation in order to have the person declare himself explicitly. I think that we should not allow the implicit to go forward without a challenge. Illness is not an excuse for racism. If we allow this language to go unchallenged we become accomplices.

Clinical Nurse Specialist: If I were the nurse at the bedside and I had just had my emotional button pushed, would I be able to step back and say “that’s just unacceptable”? It is very difficult in the moment to do so.

Director of Diversity: We need to prepare for this in the same way we prepare to give medications appropriately. Addressing these situations is a learned skill. This organization has several courses available to the staff.

First Infusion Nurse: I was so focused on his care and still trying to help him see, “I’m okay, I’m good, I can take good care of you,” that when some of those comments started I was fearful and concerned. How do we say: “It sounds like you might be racist, let’s talk about it”? I want to see the good in everybody and I want people to see the good in me.

Second Infusion Nurse: Being angry at his cancer was not really the issue or the cause of his prejudice. This is the way he is and his experience of illness did nothing to change his views. My colleague’s diligent care, expert knowledge, and her multiple attempts to build a relationship with him accomplished nothing. As caregivers, we pride ourselves in providing patient-focused care. Addressing this directly with the patient would have made it about the nurse and not the patient. We need to support one another and respond to the situations at hand.

Psychiatrist: We are in professions of service and we want to be helpful. Diagnostic thinking and training allow you to recognize that this is an abusive man. He has you in his power as long as you are trying to please him and you do not understand that he is over the top. The minute that you feel belittled by a patient, you can stop and say, “This is a belittler.” Whatever the reason you are uncomfortable, you can pull back and do exactly what you just did: talk to your colleagues, get support, and think together about how to deal with a belittler, because he is an expert at making everybody uncomfortable.

Director of Diversity: The mission of Schwartz Center is to promote compassionate care and to develop healing relationships with our patients. This man made it impossible. It is important to say to a patient, “This is what’s going on, our purpose here is to get you well as effectively as we can. Does my color or does my style or my gender make that hard for you?”

Massachusetts General Hospital has a good reputation for care because we make sure that all of us who practice here are able to meet the same standards of competence. I see no reason to allow patients to take on the role of second-guessing us on that because of their reaction to skin color, hair texture, accent, or gender. Really, what does one thing have to do with the other?
COMMENTARY

Young professionals of color expect that their presence and competence will be respected in the same manner as that of their white colleagues. Confronted with bigotry time and time again, the protagonist of this story acknowledged her own pain and confusion. She sought advice, received support and encouragement, and first tried to diagnose and fix the situation by setting limits and educating the patient. When this failed, she removed herself from his care. In telling the story to a multidisciplinary audience at Schwartz Rounds, she reflected on the lasting impact of her exposure to this abusive and racist patient.

Diagnostic thinking helps us sort through the possible reasons or motivations of this patient. Was he feeling helpless, scared, or out of control? Appropriate responses can then be oriented toward putting the patient at ease by giving him choices on small matters, being consistent, adhering to professional etiquette, and acknowledging the difficulties of the patient’s predicament. Forming a therapeutic alliance remains our professional goal. We can always remind patients that we have a common purpose. If the behavior cannot be managed then it is important to obtain backup and think about more complex motivations or even serious psychiatric pathologies. This patient’s abusive treatment of the second nurse clearly showed his true personality. His wife was a silent accomplice in this story.

Racist behavior needs to be addressed as an institutional issue, not a personal one. If ignored, it threatens the care of the individual and serves as a distraction for the team. While little has been written about this specific subject [1-4], we conclude from the foregoing discussion that it is important for the multidisciplinary team to have a consistent and clear position and to set reasonable limits on racist or abusive behavior. The management of such patients should be a team decision, not the responsibility of a single individual. If the patient is unable to accept reasonable limits then he/she should be encouraged to seek care elsewhere. Isolating the patient or shifting his care to a nonminority caregiver has significant logistic disadvantages and sets a dangerous precedent. From an ethical point of view, accommodating racist behavior can be thought of as a breach of commonly accepted standards for society as a whole. We recognize that there is a spectrum of personal values and ethical mandates that influence the behavior and responses of individual nurses and doctors, and the presence of a life-threatening illness will likely influence how such confrontations are managed.

African Americans represent 12.3% of the U.S. population [5] and are dramatically underrepresented among health care professionals. African Americans account for 4.2% of registered nurses [6] and 2.2% of physicians and medical students [7]. We may expect or even accept a degree of surprise from patients who are not used to being cared for by minority professionals but should not excuse any hint of rudeness. Although we have no jurisdiction over beliefs, prejudices, or comments made outside our treatment facilities, we can enforce a culture of tolerance and civility within.

It is easy to dismiss this case as an example of bullying and focus on the need to train the staff to recognize and respond to a desperate man who repeatedly abused his caregivers. To do so would be to miss the real tragedy and ignore the toxic legacy of racism. Styron correctly identified racial anguish as the most profound moral dilemma in America [8]. For many years, the impact of racial discordance and prejudice in medicine was simply ignored. This case serves as a reminder of the multiple repercussions of our racial dilemma and the need to support both patients and professionals.

AUTHOR CONTRIBUTIONS

Conception/design: Lidia Schapira, Bruce Chabner

Provision of study materials: Lidia Schapira, Joanne LaFrancesca

Collection/assembly of data: Lidia Schapira

Data analysis: Lidia Schapira, Leah Gordon-Rowe, Rosalba Martignetti, Deborah Washington, Mimi Bartholomay, Donna Greenberg, Bruce Chabner

Manuscript writing: Lidia Schapira, Leah Gordon-Rowe, Rosalba Martignetti, Deborah Washington, Mimi Bartholomay, Donna Greenberg, Christopher Lathan, Joanne LaFrancesca, Thomas Lynch, Bruce Chabner

Final approval of manuscript: Lidia Schapira, Leah Gordon-Rowe, Rosalba Martignetti, Deborah Washington, Mimi Bartholomay, Donna Greenberg, Christopher Lathan, Joanne LaFrancesca, Thomas Lynch, Bruce Chabner

REFERENCES


