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

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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 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

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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.

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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 chemotherapy regimen. He went on to ask me if I knew what happened 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 racist comments, which I found very insulting. I was uncomfortable 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 motivated 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 confronted him on his use of the word “colored.” He responded 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. Conversations about race and ethnicity are always nuanced. 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 answer has to be that we all do. The message of zero tol-
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.

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REFERENCES