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Open to Being Different

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Open to Being Different …

In 1989, I was a second year nursing student doing my rotation in a trauma center in southeastern England. I was assigned the night shift. On my second night, the Accident and Emergency Department was busy. Staffed by a combination of staff nurses and second year student nurses, we were given specific areas to cover in the department. It was my turn in the observation area. A staff nurse gave me a brief report on a middle-aged man, Mr. Owens, who was brought in for paranoia. The patient was a known schizophrenic. The parting words of the staff nurse were simple: "Just watch him. He should be no problem."

I introduced myself as the student nurse on duty. I sat at the nurse's station quietly watching my patient who sat on a bed talking to himself. The lights in the observation area had been dimmed. Mr. Owens suddenly looked up and asked loudly, "Who are you? Why are you watching me?" He got up and walked towards me. My heart started to pound. I had not yet encountered a schizophrenic patient in my short nursing career. Mr. Owens asked why he was assigned a student nurse, "Am I not bloody good enough for a staff nurse? What do you know as a student nurse?" He was standing right in front of me with only the counter as a barrier. I could feel my heart racing. Even if I had screamed for help, the observation unit was at the farthest end of the department, separated by two ward doors.

I suggested he go back to bed to get some rest as it was 0130. He retreated to his bed still mumbling to himself. He was swearing quietly but I could hear angry words of dissatisfaction tinged with racial references, "…a Chinese student nurse...." I picked up the phone and called the charge nurse telling him I needed someone in the observation

area. He asked, “What’s the problem? We are really busy out here.” I did not want to reveal on the phone that I needed help for fear of escalating the patient’s behavior. I told the charge nurse to send someone in as soon as possible. I knew I was over my head and believed my patient knew that too.

Mr. Owens started to talk loudly to me about his family. He said he hated his father and that he would kill him when he saw him again. As he started to hit the mattress with his fist, I called the hospital Matron (the equivalent to the hospital supervisor in the U.S.). This time, I did not hesitate to tell her I needed help. After the longest five minutes of the night, the Matron arrived with the charge nurse. I was shaking visibly. I told them I wished to be relieved from watching Mr. Owens as I felt ill-equipped to manage an escalating psychiatrically ill person. As I said that, Mr. Owens started to gesture angrily with his arms as he swore loudly as us. The Matron ushered me out as the charge nurse took over.

In the Matron’s office, I sat crying as she encouraged me to drink a cup of tea. The English believed tea could sooth all anxieties. I learned to appreciate just that as tea has become a habit in my life. After 20 years, I can still vividly see the face of Mr. Owens. The experience of caring for him is forever engraved in my mind.

Student nurses in England were considered hospital staff during clinical rotations. Despite not being sufficiently prepared to take care of Mr. Owens, my clinical skills progressed very quickly. Since graduation, I have moved on in my career to nurse in the United States, Malaysia, and New Zealand. Be it in the streets of San Francisco’s Tenderloin, a challenging neighborhood full of life of both the legal and the illegal kinds, or in the comfort of a brand new Emergency Department (ED) in New Zealand, I have

learned to de-escalate potential violent situations. I have learned that by the cruel nature of being human, there will be name calling, insults and threats targeted toward health care providers or between patients.

In San Francisco during the mid 1990's, the urgent care center in the Tenderloin had armed police officers. The officers had a calming effect. The staff were street wise. On the streets, we would get trusted patients to accompany us as we looked for the homeless we knew were in need of medical attention. We separated patient populations with the potential for violence. For example, we had time especially assigned for high-risk women and for the high-risk transgender population to prevent these patients from being abused or attacked. We also allowed staff who were not comfortable caring for transgenders to work other shifts.

I was most comfortable nursing in Malaysia where I grew up. In this multicultural society, I did not experience any racial taunts. I spoke three of the four languages—Malay, Chinese and English. Malaysia had seen its share of racial strife with Chinese and Indian migration encouraged by the British in the 1900's. Racial differences have long since been accepted in this country as reflected in the many public holidays celebrating different religious holidays.

In New Zealand, I experienced so much name calling by the ED patients that I decided to end my 2-year contract early. My colleagues and I noted that in every situation where I was verbally abused, the patient or the accompanying members of the patient were intoxicated. Alcohol blunts inhibition, permitting people to release their suppressed racism, yelling out: "Don't you touch me, you f… Chinese;" or "Get this garlic eating bitch away from me;" or "Chink, chink, chink!" After I brought my

concerns to the attention of the hospital administration, they conducted a survey. Findings revealed that racism was widely experienced by a largely foreign staff. My colleagues were very supportive. With agreement from administration, I would be relieved from caring for patients when their discontent over race became situations of potential violence.

I learned early in my nursing career to appreciate how important it is to educate our nursing students on cultural differences. The new Standards of Practice for Culturally Competent Care by Douglas, et al. stress the importance of continuing this education.[1] Beyond a basic understanding of how different ethnic groups approach health, we need to teach students and staff nurses how to handle being verbally abused and how to de-escalate a situation. Administrators must support staff by relieving nurses from caring for patients in abusive situations.

Nursing must also start promoting an understanding of ethical principles that may differ from the dominant Judeo-Christian approach. I have seen angry Muslim families leave without receiving care when staff challenge the rights of traditional Muslim women around personal decision-making. I have witnessed the distressed transgender patient who walked out because she overheard a staff nurse refer to her as ‘a freak.’ Another situation involved a nurse, a strong believer of patient autonomy, who told an elderly Asian patient his terminal diagnosis against the wishes of the extended family. In addition to incurring their wrath, he also caused the breakdown of the strict Asian familial harmony when it was most needed. The elderly patient was angry that his family had failed to protect him from the painful news in his dying days.

As health care becomes more complicated by population changes, economic shifts, and social stresses, nursing must adapt. With the emphasis on culturally competent care by the Joint Commission,[2] the literature abounds with articles on educating health care providers on cultural competence. A model frequently cited is that of Dr. Josepha Camphina-Bacote, in which the education of cultural proficiency is described as a *process*.[3 4 5] A one time theory course on culture, as it is frequently taught now in nursing programs, is insufficient. The need for continuing education is thus emphasized by Douglas, et al.

We must, however, take the Standards proposed by Douglas, et al. a step further. Beyond *tolerance*, we must advocate for the *acceptance* of our cultural differences. In teaching and celebrating the wealth in our diversity, it is my hope that one day, cultural differences will become another impassionate factor in patient care where nurses know how to weigh the benefits of respecting patient rights and wishes, and to manage abusive situations. This paradigm shift will improve patient care, satisfaction and safety for all.

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