Commentary: Courteous containment is not enough

Pippa Gough

This is not an isolated incident. Nurses as well as doctors are often faced with similar situations of racist abuse, which is often directed at them as well as other patients. Remaining courteous and passive in the face of these remarks is not enough; this will be interpreted by the racist as tacit acceptance of their views. Ultimately, some greater sanction, such as withdrawing the service, may be warranted where the abuse is persistent and intentional.

Nurses' professional practice is founded on their code of professional conduct.¹ This is premised on respect for the autonomy and privacy of individual patients. Our starting point is that we treat and care for our patients regardless of who or what they are, and whatever their attitudes, values, or beliefs. But this is insufficient in the case of racist abuse and bigotry. Where individual action encroaches on the mental and physical welfare of other patients, the response should be positive intervention of some kind, not just containment.

In the case described by Dr Selby, action took the form of creating "a 'caucasian' corner." This may have lessened the distress of the other patients, but did it imply acceptance of the abuse being perpetrated? Treatment continued once the environment had been modified to suit the racist view. A mini apartheid was created. Mere containment, with no expression of repugnance for the views being aired or more positive action, seems to be professionally and morally questionable.

What is the ethically acceptable way of responding? Is it too extreme to suggest that one way forward might be to withdraw care until the patient changes his (or her) behaviour. This action is not without precedent.

Nurses have withdrawn care where their own physical wellbeing or that of others is at risk, most frequently from drunken patients in accident and emergency departments, and this move has been given strong government support. Why should racial abuse, which is assault by any definition, be different? Moreover, doctors also have a right to expect a duty of care from their employer and from the organisation within which they are working. How much easier this doctor would have found the situation if there had been a clear organisational policy setting out the action to be taken in the situation described, and this was clearly displayed and publicised.

We cannot separate what is professional from what is personal in this situation. Such a position is too close to the unjustifiable notion of "only following orders." As health professionals our code of conduct does not allow us to condone tacitly the actions described, and as members of a civilised society we cannot be co-conspirators in the systematic oppression of minority populations. To contain racism without condemnation is arguably a failure of our duty to care for all of our patients (vulnerable and captive within a ward) who are subject to the assault, as well as our duty to society as a whole. We can remain courteous, while at the same time firmly rejecting the racist's views and taking action to prevent them injuring others. Although this might infringe the individual's autonomy and right to freedom of speech and action, it affirms our duty of care to the public at large.

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1 United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *The code of professional conduct*. London: UKCC, 1992.

A salutary lesson

Patients sometimes behave like our Snoopy

Hummingbirds need a lot of food in the evening. Then they roost and drop their body temperature. This bedtime calorie load and reduced metabolic rate enables them to survive the night.

We had just moved a few blocks across a suburb in the north of San Diego. Some young relatives of my German wife visited us almost immediately in a new house that was in chaos. An afternoon project was to obtain and install a new hummingbird feeder (I could not bear to harm the birds by removing the old feeder from our previous house, which was still unsold).

Hummingbird feeder technology is simple: a red apparatus with a yellow centre attracts the birds. A glass reservoir of 33% solution of granulated sugar provides the calories (running short of white sugar a few months before, I found that brown sugar is of no interest to hummingbirds). To the delight of our young guests, within five minutes of feeder installation, the first hummingbird arrived. Within two hours, five of them were competing for this new food source hanging under the eaves of our house.

Usually, hummingbirds are extremely territorial. A dominant male will vigorously defend, for hours on end, an artificial feeder, or even a single fuchsia plant. To my surprise, the dominant hummingbird at this new house had an entirely different strategy from the one who was king of the feeder at the old place. This new chap sat on top of the feeder, thus being dubbed Snoopy by our

young German guests, and drove off any competitor who attempted to feed three inches below. The boss at the old house perched and chirped in a nearby tree, and attacked his competitors at high speed, developed by diving from his sentinel position.

And then it happened. Just after sunset, the belligerent Snoopy permitted no fewer than five other hummingbirds to share the four feeding apertures. In a moment, the ingrained, reproducible behaviour of a unique hummingbird had changed into exactly the opposite.

Sometimes we are surprised by the choices that our patients make. People often request treatments which their doctors think are suboptimal. People who cannot afford yet another baby still fail to take precautions that they understand well. Some patients inexplicably withdraw halfway through a clinical trial. Well informed patients often take decisions that are not evidence based.

For some good reason, Snoopy, an identifiable individual hummingbird, suddenly reversed his ingrained, biologically predicated behaviour. Surely our patients deserve the same opportunity at a moment's notice, even if they mystify us.

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