Race, Gender and Culture: My Personal Nursing Experience

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Abstract: This paper explores how race, class and gender intersect with ongoing practices of domination and oppression in the nursing profession, as highlighted by the author’s professional experience as an immigrant male nurse of color. Recommendations are also offered on how these issues could be constructively and openly handled to foster a socially, racially, and culturally harmonious health care environment.

The health care system in the United States is getting more and more diverse, both in specialty areas and, perhaps more importantly, in patient and staff populations. People of different race, class, and genders all expect and even demand, quality health care. However, stereotypical perceptions about each others’ differences can hinder the genuine effort to provide quality health care for all.

I work as a Registered Nurse (RN) in a staffing agency. On average I work in five different facilities every month. As residents in these facilities have virtually the same nursing needs, the work is familiar in every environment. As a social minority on at least three counts -- an immigrant, a male in a female dominated profession, and a person of color (black to be specific) -- my awareness of self, especially of the latter, plays a significant role in the day-to-day activity of my professional nursing career, as illustrated by the following examples.

1. I was mistaken by a receptionist for a Certified Nursing Assistant (CNA) when I went to fill an application for an RN position. As more than 90 percent of the facility’s CNAs were of African descent and spoke with an accent the odds that I was applying for a CNA position could easily be explained by statistical probability, especially considering less than 10 percent of the licensed nurses and administrators were non white.

2. I have had patient family members, doctors and other visitors, of at least four different races, walk past me looking for the nurse or nurse in charge. Upon realizing that I am the nurse in charge, and after I have offered my professional nursing opinion to their concerns, many still ask, bluntly, if there is another person whom they could consult with. Some people would rationally blame it on my accent and others would not bother to explain at all. I am always respectful and sincere in my responses but am proud to tell people that I am the only nurse -- the black immigrant male nurse.

3. As an agency nurse, I introduce myself to all my patients at the start of my work shift. Ten minutes after an introduction with a Caucasian patient, he called and said that he preferred a female nurse. He had been in the facility for at least four months and been cared for by male Caucasian nurses, who said such gender preference in receiving care was never an issue with him.

4. Nurses and patients, both white and those of color, including Africans, often ask how come I speak such immaculate English after living in the United States for only five years. Not knowing English is my official language from back home in Africa, some comment that I must have had very good instructors for my English-as-a-Second-Language classes; classes I never took. Some may argue that these people are simply demonstrating sincere social curiosity. However, for the person responding to them – who is usually from a lower end of the social spectrum - the encounter yields a much deeper outlook and meaning (Grant-Mackie, 2006).

My experience may not be the same as other immigrants or people of color, but there are philosophical similarities in these experiences. As Martinez puts it, whatever the differences, “these experiences cannot be attributed to xenophobia, cultural prejudice or some other, less repellent term than racism”
(2007, p.108), sexism, or classism. This may be due to people’s tendency to rationalize strong stereotypical inner feelings into plausible and supposedly acceptable words and phrases during conversations.

It is a realistic challenge for one to have to prove professional competence at work. However, with unnecessary supplemental challenges of having to prove that one is a legal immigrant, a caring male in a female-dominated profession or a person of color who deserves equal rights and treatment (Wilson, 2007) the challenge can easily transform into undesirable consequences. Such consequences may include poor work performance, increased stress, low self-esteem and self-worth, and a feeling of not belonging among others. It can also lead to “unplanned changes in career trajectories” (Nunez-Smith, et al, 2007, p. 50) in the pursuit of peace of mind rather than planned academic dreams. Unfortunately, these undesirable consequences have a direct effect on the quality of care we as health professionals render to our patients as well as the colleagues we work with. Additionally, the consequences of such experiences falsely validate a “mainstream” stereotype about minorities, especially those that are black -- being lazy, violent, and not as intelligent (Wilson, 2007). In effect, such stereotyping leads to a revolving cycle of a pathetic social reality in the minds of most minorities.

A point worthy to note in the wake of the ongoing practices of domination and oppression and the ways they intersect with race, class and gender is silence. Open discussion about race and racism, gender and sexism, immigration and legality is virtually non-existent in the healthcare workplace, where these issues are even more sensitive than they are in most other settings. Silence, suppressive or repressive, does nothing but help essential issues to get brushed under the rug and hence go unchallenged. This “accepted workplace silence on issues of race results in a normalization of race-based challenges, compounding the effect of discriminatory experiences” (Nunez-Smith, et al, 2007, p. 49).

As a start to recommendations that may help pave way for a socially healthier workplace in the healthcare industry, the issues surrounding race, gender and culture should always be openly discussed. This should be done with a constructively-oriented approach that gives minimal to no room for emotional labiality. Where possible, a specific board could be set up to tackle certain sensitive issues ranging from racism, sexism, to cultural stereotyping (Nunez-Smith, et al, 2007). Racial or other social minorities should also voice their experiences as both healthcare providers and receivers. This will help create more objective public awareness (Wilson, 2007). Rather than be inherently pinned to our stereotypic concepts, we as healthcare personnel should strengthen our similarities and build on the strength of our differences to foster a culturally and socially harmonious workplace. There also needs to be stricter enforcement of workplace policies that are already in place against discrimination based on race, culture, gender, disability, etc (Baptiste, 2007). As professionals we need to be able to hold multiple social perspectives without personal or group judgment (William & Rogers, 1993).

In conclusion, socially constructed negative theories of race, gender, religion and class still exist in the healthcare workplace. Many people are aware of their existence but choose to be silent about them for fear of sensitive and crude reactions from others. All healthcare professionals need to be able to share their experiences freely, constructively, and non-judgmentally. Only then can a healthier social work environment and quality health care be achievable both for us as health care professionals and for the patients we serve.
References


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