

**PROFESSIONAL INTIMACY: AN ETHNOGRAPHY OF CARE IN HOSPITAL
NURSING**

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The global nursing shortage severely impacts the health care crisis in the United States and around the world. Nurses are overworked and under recognized and patients feel frustrated and neglected. Nurses professionalize their labor to increase recognition of their contributions to medicine, but these efforts focus on individualism and deemphasize the intimate nature of their work. Nonetheless, experienced bedside nurses know that intimate interactions help patients feel safe and comfortable during illness, which contributes to their healing. These interactions require specialized knowledge and skill, which contradicts the popular idea that whether or not one is caring is a personal attribute.

In this dissertation, I found that nurse-patient interactions are in large part shaped by perceptions and constructions of race, gender, sexuality, and nationality. I offer the term professional intimacy to characterize how nurses negotiate intimate care and learn this specialized knowledge and skill set over time. I argue for collective recognition of professional intimacy, that it can and should be taught to nurses, and that hospitals can better accommodate this labor. Allowing nurses to conduct professionally intimate work will ensure better medical care for patients, which ultimately increases both nurse and patient satisfaction.

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1.0 PROFESSIONAL INTMACY: INVISIBILITY AND INDIVIDUALISM

This research names and analyzes professionally intimate labor from the perspectives of hospital nurses. At first, professional work and intimate encounters may seem a strange analytic combination; however, care work in nursing requires a mixture of compassion, specialized knowledge, and skill. To understand intimate labor in nursing, I studied how nurses explain, organize, and negotiate emotional and sexual behaviors from patients and family members. I focused my study on interactions between patients and family members because scholars understudy these interactions and their relationship to institutional and social meanings of care. In addition, patients, family members, and hospital administrators do not see or understand the dynamics of this labor because nurses conduct this work in patient's rooms, when other clinical staff members are absent and behind closed doors.

I define professional intimacy as intimate exchanges between nurses, patients, and family members in which the nurse must balance the patient's emotional and physical needs in a turbulent work environment. Professional intimacy encompasses more than physical and emotional connection. Unlike intimacy in families and in other personal relationships professional intimacy is work that requires skill, experience, and strategy. Professional intimacy manufactures and sustains trust that is necessary for quality care of patients and families. Acknowledging the importance of professional intimacy in organizational processes of care work will help nurse recruitment and retention because it values labor that nurses identify as crucial

for patient care. Recognizing professional intimacy also contributes to increasing the social value of care and interdependency.

Social scientists, feminist scholars, and individual care workers know that care work is invisible; it is misunderstood, taken for granted, undervalued and when paid, it is underpaid. The complexities of care work remain unnoticed by family members, employers and social and economic policy-makers (Folbre 2001). Care work stays invisible in part because it is still seen as either a private act or a paid public act. This dichotomy is false as care is motivated by love and money on both fronts: in families and in markets (Hochschild 2003; Meyer 2000; Zelizer 2005). My explanation of professional intimacy will help make visible the skill and experience required when one “gives care” in a professional work setting.

Professional intimacy is invisible but it is important to patients and family members. Patients and family members need and want nurses to be gentle, kind, and attentive. When patients write memoirs about their illness, most focus on the role of nurses as gentle and kind, rather than as skilled in critical care (Gordon 2005). Patients define care as a gift, rather than a skill set (Gordon 2005). This reinforces the idea that giving care is an individual attribute, not work that is taught and learned over time. Patients and family members expect nurses to be competent and define basic care tasks as part of this competence.

The expectations of patients and family members have of nurses conflict with those of hospital administrators who track nursing work through charting and other standardized documentation that record medications, orders, procedures, and vital signs. Even patient satisfaction forms, completed by patients after they returned home, fail to record information about care work. Most nurses report that they would rather spend more time with patients but they are required to extensively spend time on their charting (Gordon 2005; Weinburg 2003). As

nurses try to balance patient care with institutional demands, they experience a time-bind because there is simply not enough time to accomplish all tasks (Hochschild 1997).

In this chapter, I first discuss current definitions and experiences of care work, how I use intersectionality as a theoretical framework, and how naming professional intimacy will contribute to a social revaluing of care and interdependency. In the next section, I discuss the economics of intimacy, including the commodification of care work, the global nursing shortage, and current debates on paid care.

1.1 DEFINING AND EXPERIENCING CARE WORK

Professional intimacy secures the bridge between nurses' professionalization activities and their commitment to quality care of patients. Although nurses strive for professional recognition for their labor, administrators and the general public discuss care labor without specifying the skill and specialized knowledge necessary for intimate encounters with patients and family members. I use the term professional intimacy to avoid definitions of care as a moral value or an inherent gift. Rather, professional intimacy is a set of strategies and skills that necessitate specialized knowledge and training and that changes according to perceptions and constructions of race, gender, nationality, and sexuality. Revealing the meaning and practices of professional intimacy in nursing thus challenges neo-liberal ideas of individualism by emphasizing interdependency and mutual need in professional work.

1.1.1 Professional Intimacy, Invisibility, and Naturalized Care

The concept of professional intimacy helps define the complex circumstances nurses face as part of their caring labors. Nurses struggle to define their labor so that it is duly recognized as work that is indispensable to health, well being, and saving lives (Gordon 2005; Melosh 1982). Professionalization has been one way that nurses have promoted the skill and complexity of their labor. Nursing used to be considered “sacred” work, “a calling” for white middle class women, or the only job accessible to women other than teaching; now it is a career path viewed as suitable for men and women of various races, classes, and ethnicities. One only need visit the Internet website of the American Nurses’ Association or peruse the shelves in any university health sciences library to see concrete evidence of the professionalization of nursing. Nurses conceptualize, develop, test, and practice medical and, increasingly, technical knowledge. They create and maintain sustainable venues for research, publication, and teaching in academic degree programs. The nursing profession maintains ethical and “best practice” standards for education and research, illness assessment and diagnosis practices, delegation of roles and responsibilities, and documentation.

Alongside the professional recognition of nursing runs a deeply instilled philosophy that prioritizes compassion for patients above all other tasks. The ideology of care operates as the conscience of nursing with values that include providing faith and hope, sensitivity to self and others, and a supportive, protective, and healing environment. For example, many of the nurses I studied told me they entered nursing because they wanted to honor and heal the sick and care for the ill and injured. Even nurses who did not enter nursing for these reasons found patient care to be one of the most satisfying aspects of their work. Nurses value care as a foundational premise in nursing yet few recognize it as professional labor.

Nursing straddles a dichotomy: it is seen as either nurturing or rational. When discussed as nurturing, nursing is viewed as based on natural traits inherent in certain individuals. When discussed as rational, nursing is regarded as a set of medical or technical skills that can be taught. This false duality – virtue or skill – precludes an assessment of how these function simultaneously in nursing since professional intimacy requires both skill and caring. The nurses I observed combined gentleness and shrewdness to respond to the changing needs of patients and family members and the schedules and resources of other clinical staff. They made decisions in fast-paced and rapidly shifting environments. Nurses were as skillful in their medical knowledge and decision-making as in managing emotions and drying tears. To say that nursing is either intimate or intellectual loses sight of the work conditions that nurses must face every day (Davies 1996).

I offer the term “professional intimacy” as a way to analyze the intimate labor conditions of nurses. I incorporate race, gender, nationality, and sexuality because of the increasing diversity in nursing and because work and other everyday life experiences are constructed by these and the intersections of these social factors (Collins 2000). Professional intimacy includes emotion, physical touch, and intense feelings, but it differs from other types of personal intimacies in that it also requires long-term study and the mastery of specialized knowledge. Professional intimacy is a set of labor skills and strategies that are learned on the job through trial and error and from the knowledge of more experienced nurses. It is another layer of professional skill, after technical and medical skills are mastered.

Although the public perceives nursing as women’s work (Abbott 1998; Melosh 1982), it is useful to distinguish women’s work from feminine work (Connell, 1987). Women’s work (typically occupied by women) and feminine work (work that is gendered as feminine) are

different, even though women often do feminine work. The phrase “women’s work” draws attention to the tensions in nursing that accompany a predominately female labor force. The phrase “feminine work” draws attention to traditionally feminine tasks in nursing such as nurturing, serving, and cleaning bodies and spaces. Unlike women’s work, feminine work is invisible because good care and service are often assumed to be characteristics that are inherent to femininity and natural to women who work in these jobs (Ehrenreich and Hochschild, 2002; Hochschild, 1983; Misra, 2003). It is not formally counted as part of professional labor; it is taken for granted by employers and employees; and it is typically unpaid. Even when men do feminine work, their care and service labor is defined as outcomes of their personal characteristics or ambitions (MacDougall 1997).

The concept of professional intimacy acknowledges that care workers are expected to provide love as well as labor (Cancian and Olicker 2000). Professional care work, such as bathing, feeding, moving, and emotionally attending to patients, requires intimacy (Faugier 2006; Williams 2001). I define intimacy as interactions that are private because they occur “in the space of just two or a few bodies producing knowledge and attention that are not available to most others in that moment of time” when knowledge includes “body information, awareness of personal vulnerability, and embarrassing situations” (Zelizer, 2005: 14) and attention comes in the form of kind words, body service, and emotional support. Nurses and patients produce intimacy in part by degrees of trust that they create between them.

The ideas that care comes naturally to women and that nursing is additionally racialized as “white women’s work” result from ideological and structural influences of race, gender, sexuality, and nationality. Ideologically, the iconography of Florence Nightingale has naturalized nursing as a calling for respectable white middle and upper class American women (Choy 2003).

The Nightingale version of a nurse based on puritanical femininity and whiteness, defined nurses as pure, innocent, ready to help, and available to serve. The image of Florence Nightingale persists today; it informs how patients, administrators, and the general public mystify the provision of nursing care (Gordon 2005). My field notes show that even nurses view their skilled care work as something that “just happens over time” rather than as a product of training. For example, many nurses could not say exactly how they cared for patients, saying instead, “I don’t know” or “I just do it.” When I asked how they learned to do specific tasks or handle intimate situations, nurses said they learned from experience or from other nurses. Nurses also used personal characteristics, rather than labor activities, to define nursing in different units of the hospital. For example, they described themselves and others who work in oncology as “kind,” “soft,” and “patient,” nurses in intensive care as “quick-thinking” and “intelligent,” and nurses in the ER as “tough” and “able to handle anything.”

In addition, women of color are stereotyped as inherently better care givers than white women (Ehrenreich and Hochschild 2002; Hondagneu-Sotelo 2001). For example, in 1999 recruiters in the United Kingdom justified the Philippines as the “natural” place to start recruiting nurses since Filipinas are inherently caring (Choy 2003). In the United States, white employers, patients, and families often view Black and Latina women who perform care work as naturally hyper-caring and ultra-loving (Collins 2000; Ehrenreich and Hochschild 2002; Hondagneu-Sotelo 2001).

The ideas that women are “natural” care-givers and white women are expected to be nurses also stem from structural influences: historically women traditionally have provided the bulk of care work in and outside of the home (Kittay and Feder, 2002; Meyer, 2000). White women comprise the majority of degreed and licensed nurses in the United States, Australia,

Great Britain, and other western nations (U.S. Department of Health and Human Services Health Resources, 2002; Whittock and Leonard, 2003). Indeed, before WWII, hospitals and training programs excluded women of color from nursing (Hine, 1989). Racial diversity within nursing began when hospitals changed from charitable organizations to for-profit businesses, and, as a cost-saving measure, began to distinguish “practical” from “skilled” labor. Employers hired practical nurses for routine care tasks, leaving professional nursing to RNs (Reverby, 1987). Moreover, a racially-tiered nursing education system added a racial dimension since white hospital employers ignored graduates from majority-Black nursing schools (Hine, 1989). Professionalization activities including licensure, credentialing, and education requirements aggravated a racial divide between white skilled and non-white unskilled nurses (Glazer, 1991; Scherzer, 2003).

In recent years nursing has also diversified by gender. Scholars explain the steady increase of men in nursing several ways. Some men actively decide to become nurses and pursue this career. Some men enter female dominated occupations like nursing as a fallback when they fail to secure male dominated and traditionally masculine positions (Simpson, 2005; Williams, 1995). This is especially the case for men from working-class backgrounds (Lupton, 2005). In any case, employers promote male nurses more often than female nurses and pay them higher wages (Bradley, 1993; Davies, 1996; Williams, 1993; 1995). Women take more leave from work and work part-time more often than men, which results in men gaining seniority at a quicker pace than women (Brown and Jones, 2004). Even when family-friendly policies are in place, more women than men take advantage of these policies. As a result men are promoted more quickly in the workplace (Whittock et al, 2002). Men also argue that they do a more professional job than women when they are in non-traditional jobs. This reinforces masculine

traits, which in turn promotes their career opportunities relative to women (Cross and Bagilhole, 2002).

Although the numbers of men and people of color working in the United States nursing industry increased in recent years, white women still dominate nursing both in numbers and in the public imagination. Stereotypes of whiteness and femininity help maintain ideas that care – defined as pure, selfless, and effortless – is a natural trait primarily found in white women. These stereotypes negate the skills that are necessary for feminine work (Bolton 2005) and also reinforce social constructions and stereotypes of gender, race, ethnicity, and sexuality.

1.1.2 Intersectionality

Recent scholarship on care labor explains how social and economic systems interconnect to reinforce and challenge inequalities of gender, race, class, and nation. Intersectionality theory is useful for such analyses because it studies how discrete social categories work together to create unique experiences of privilege and subordination. Intersectionality theory contributes to explicit meanings of care work because it reveals the experiences of individuals and groups that differ from mainstream knowledge.

Intersectionality theory is based on the study of social structures; it conceptualizes social categories as material and social behavioral patterns that influence and are influenced by institutions and ideologies. A structural analysis study of race, gender, nationality, and sexuality reveals relations of power that exist beyond individual interaction. It shows how institutional practices and ideologies impact the norms, expectations, opportunities, and barriers of individuals and groups. Structural analysis also shows how social categories change over time and space.

Intersectionality theory demonstrates how gender, race, nationality, and sexuality impact experience, identity, culture, politics, and power by highlighting the experiences of oppressed and privileged groups (Collins 2000; Crenshaw 1991). For example, scholars used intersectionality to analyze how women of color suffer constraints rooted both in sexism and racism (Crenshaw 1991). Intersectional studies also show how whiteness traditionally acquires a social meaning as purity, goodness, innocence, that becomes a category against which other experiences are judged to be deficient (Rothenberg 2002).

Intersectionality theory avoids universal and essential characterizations of gender. In late 1970s and early 1980s, women of color, lesbians, and working class women revolutionized feminist theory when they theorized about the differences among women across race, class, sexuality, and national boundaries. Collections such as *This Bridge Called my Back* (Moraga and Anzaldua 1979) and *Home Girls: A Black Feminist Anthology* (Smith 1983) challenged mainstream definitions of sisterhood, which universalized white, middle-class, heterosexual women's experiences to all women's experiences (Davis 1981; hooks 1984; Lorde 1984), while works like Gloria Anzaldua's (1987) *Borderlands*, on the experience of mixed ethnicities and nationalities, demonstrated the importance of challenging the epistemological construction of structures themselves.

Intersectionality theory asserts that systems of power interconnect so single forms of oppression and privilege cannot be prioritized over one another. It avoids additive explanations, which choose one structure, such as gender, as the primary explanatory factor of social phenomena, and considers how other structures, such as race and class, alter the original gendered phenomena (Anderson 2000; Collins 2000; Crenshaw 1991).

A leading scholar of intersectionality, Patricia Hill Collins (2000), uses the notion of

“matrix of domination” to analyze oppression, privilege, and resistance by revealing the salience of social categories and showing how power circulates between individuals, groups, ideologies, and systems in specific times and places. On an individual level, the matrix explains how individuals accept, use or reject multiple identities in interpersonal interaction. On a group level, the matrix analyzes the multiple features of groups that exist beyond singular descriptions, such as “women” or “the black community.” On a structural and disciplinary level, the matrix shows how social institutions, such as the law, education, policy, and the media, shape, manage, and resist oppressive practices and ideologies. Individuals, groups and institutions use and reinforce what Collins calls “a hegemonic domain of power” to maintain their social dominance. Hegemonic ideologies and cultural practices connect “social institutions (structural domain), their organizational practices (disciplinary domain), and the level of everyday social interaction (interpersonal domain)” to normalize social inequality through “common sense” beliefs and values (2000: 284).

The matrix of domination does not merely describe systems or situate them along side each other as separate entities; it generates new knowledge about how, when, and where individuals, ideologies, and systems participate differently to support domination or resistance. Because it is grounded in experiential knowledge, the matrix locates power dynamics in specific times and places, which helps avoid universal, additive and fixed definitions of oppressor and victim. Thus, the matrix explains simultaneous privilege and marginalization that can occur on the site of one body, e.g. a white woman or a black upper-class community, and how one form of oppression, such as sexism, can be reinforced through social and cultural tolerance of another form, such as homophobia (Pharr, 1988).

The theory of intersectionality informed both my methodological design and my

conceptual analysis. Methodologically, I designed my research to ensure that I had opportunity to study nurses who varied by gender, race, nationality, and sexuality. Conceptually, I situated my study in an analysis of the global dynamics of the transnational nursing shortage to consider how these shape local practices of intimate care, *how and when* race, gender, nationality, and sexuality shape meanings and experiences of professional intimacy, and how this analysis might inform global recruitment and retention strategies. I analyzed precise relationships as they emerged in the data to avoid conflating the factors and effects of distinct social constructs, for example, I found that the intersection of gender and sexuality significantly construct meanings of professional intimacy between male nurses and patients (Biesel and Kay 2004; McCall 2005; Welsh 2006).

1.1.3 Social Value of Professional Intimacy

Naming and explaining professional intimacy challenge neo-liberal ideologies that often accompany globalization discourse on labor and opportunity. Neo-liberal frameworks promote false notions of individualism and liberty, which influence how we think about human nature, our desires, and our motivations (Kittay and Feder 2002; Quillen 2001). For example, most mainstream definitions of globalization offer an account of economic systems as streamlined, efficient, and mobile. These focus on multinational corporations, technological advances, or transnational, usually male, professional workers but gloss over the specific practices of workers and the localized economies in which they labor (Sassen 2002). They also do not consider the economic impact of care work around the world (Folbre 2001; Hochschild 2002; 2000).

Understanding professional intimacy could contribute to an increase in the valuation of care work and values of collectivism, rather than valuing only individualism (Held 2002). For

example, according to an individualistic ideology, nurses who migrate from India to the United States are seizing the economic opportunity to obtain better employment abroad. Although true to some extent, this fails to acknowledge the relationships and obligations that nurses must leave behind (Kingma 2006). Neo-liberal ideologies that are premised on the “free human” ignore individuals’ desires and needs to give and receive care. They obscure the inter-dependency we all face at some point in our lives in work or family (Garland-Thomson 2002).

The concept of professional intimacy provides an analytical space to value care and interdependency. Combined with intersectionality theory it is possible to analyze the skill, strategy, and specialized knowledge that are necessary for care work in nursing experienced by a diverse nursing staff. Since care is a critical commodity in modern global economies, understandings of professional intimacy is important for broader discussions of care work on both a local and global level.

1.2 ECONOMICS OF INTIMACY

One way to challenge the hyper-visibility of neo-liberal ideologies of freedom and the invisibility of issues of inter-dependency is to emphasize how and under which conditions professional intimacy is negotiated and exchanged in the purchase of hospital care. This fits recent scholarship on how caring behaviors contribute to the social political economy as well as to civic society (Folbre 2001; Herd and Meyer 2002; Hochschild, 1983, 2003; Misra 2003).

In *The Purchase of Intimacy*, Viviana Zelizer challenges readers to avoid separating economic life from the intimate since intimacy is often framed as too soft, too feminine, or too sexual to be taken seriously by economists and other story-tellers of public life (2005). In

contrast, Zelizer points at the combination of intimacy and economics that are seen in divorce obligations, struggles for the rights of same sex couples, and professional and unpaid care work. Zelizer argues that money does not necessarily degrade intimate activity and, more relevant to nursing, that the work of intimate care does not make economic activity inefficient. She suggests it is the “grip,” the resilience, of intimacy that makes it a necessary part of economic exchange. Even though nurses I studied were overrun with balancing multiple technical, administrative, and medical tasks, they displayed significant compassion when caring for patients and families. In Zelizer’s words, they “employ the skilled practices of personal intimacy – joking, cajoling, consoling, and sympathetic listening” (2005: 187).

The resilience of intimacy in nursing helps patients and family members. Hospitals also benefit from the exchange of care because it is an inexpensive commodity that results in satisfied patients and families. National governments benefit too; western nations lure nurses from poorer countries and developing nations receive financial assistance for training and education efforts. Even nurses benefit as they experience satisfaction in their care work. For this reason, increased wages cannot alone resolve the global nursing shortage since although increased wages benefit individual nurses, they do not address the invisibility yet necessity of intimate care work in this profession.

1.2.1 Commodification of Care

In her landmark study of flight attendants in the U.S., Arlie Russell Hochschild (1983) coined the phrase “emotional labor” to explain how employers appropriate the emotions of workers to ensure customer satisfaction and to accumulate profit (1983). According to Hochschild, emotional labor alienates workers from their “true selves” which prohibits possibilities for

worker resistance to exploitative conditions.

For two decades, scholars confirmed Hochschild's theory of emotional labor, expanding it to include employee negotiation of emotions and resistance to employer dominance (Bolton and Boyd 2003; Lopez 2006). In his study of care work in nursing homes, Steven Lopez found that the level of organizational support for genuine emotions at work varied across three institutions (Lopez 2006). He argued that "organized emotional care consists of self-conscious institutional interventions that encourage relationship building and emotional honesty" and supports the development of "caring relationships between service providers and recipients" (2006: 137).

Emotions are not the only human commodity in care labor. In her study of Korean nail technicians in New York City, Miliann Kang (2003) reveals how race, class, and gender intersect in what she calls "body labor." Body labor includes both physical and emotional management. It reflects race and class inequalities between women that capitalizes on race stereotypes of Korean immigrants (i.e., docile and more adept at paying attention to detail) and enforces the privilege of white customers. In the case of some care work, employers commodify the entire body. In her discussion of global domestic work, Bridget Anderson (2000) distinguishes between the body as personhood and the body as property. She asserts, "with particular reference to the caring function of domestic labour, that it is the worker's personhood, rather than her labour power, which the employer is attempting to buy, and that the worker is thereby cast as unequal in the exchange" (2000: 2). When the body is regarded as property, employers can dehumanize and feel entitled to this body. Miliann Kang and Bridget Anderson, extending Chandra Mohanty's earlier analysis of lace makers in India and Asian factory workers in the United States (1997), claim that feminine work naturalizes race and gender hierarchies and serves the interests of capital. Like

other products, the production of care occurs in a series of phases at different locations in different parts of the world (Hochschild 2000; Moody 1997). Surplus value accumulates at each phase of production generating profit. Imported and exported on a global scale, emotion and care labor thus form a chain of production that contributes to capitalist wealth but receives little acknowledgement in mainstream social and economic arenas (Ehrenreich and Hochschild 2002; Folbre 2001; Hochschild 2000; 1983; Kang 2003; Misra 2003; Sassen 2002).

1.2.2 Global Nursing Shortage

Nursing is a transnational enterprise. Currently health care is characterized by a focus on profit and a shortage of nurses (Weinburg 2003). Care work is exported and imported, bought and sold in local hospitals, and transformed in global systems all over the world. Developed nations such as the U.S., UK, and Canada recruit nurses through formalized “managed migration” agreements from developing nations or “nations in transition” such as India, Cuba, and the Philippines (Kingma 2006). Nursing migration results both from push and pull factors, from employment shortages in exporting countries and nursing labor shortages in importing counties (Kingma 2006).

The nursing shortage in the United States is well documented. The U.S. Department of Health and Human Services (DHHS) reports that 44 states and the District of Columbia will face serious nursing shortages by the year 2020. In 2002, President Bush signed the Nurse Reinvestment Act. This legislation provides federal funds to hospitals, universities and other health organizations to recruit, educate, and retain nurses and nursing students in the U.S. In July 2004, DHHS granted \$15.5 million to expand the nation’s supply of qualified, minority nurses. Although these efforts aim to remedy the shortage, they fall short of what is needed. Another

proposed solution to the nursing shortage is magnet hospitals (Satterly 2004). Inspired by efforts of the American Nurse Association to create better work environments for nurses, magnet hospitals recruit and retain nurses by reorganizing work environments and decision-making processes. They formalize decision making processes that include all levels of staff, expect nurses to continue their education and share knowledge with other nurses, and support nurses' autonomy.

But the major solution to the nursing shortage in the United States has been the training, recruitment, and immigration of foreign-born nurses. Catherine Choy (2003) shows how the U.S. established hospital training programs in the Philippines in the early 1900s as a way to establish low cost labor and acculturate the Filipino population to American standards. Several recent nursing relief acts (from 1989 through 1999) provided migrant nurses special status and consideration, extending their visas to accommodate health care crises in the U.S. These acts stem from the Immigration and Nationality Act of 1965, which liberalized immigration from formerly restricted areas such as Korea and the Philippines. Filipinas took advantage of the U.S. Exchange Visitor Program that was developed to improve post cold war relations but also provided the U.S. with low cost labor by paying work stipends for two years with the requirement that visitors would then return to their home countries. This residency requirement was waived for "certain" nurses in 1970 prompting the Philippines government to actively promote nurse employment contracts with the U.S. Because the Act opened up opportunities for immigration from formerly restricted countries, it became more likely that governments – especially those in debt – would respond and become more dependent on human and other product export oriented economies rather than focus on their own internal development.

In 2003, The International Council of Nurses (ICN), a federation of 125 national nursing

associations representing millions of nurses worldwide, initiated the Global Nursing Workforce Project to examine the global nursing shortage and nursing migration patterns. In March 2004, the Project produced its first report, “The Global Shortage of Registered Nurses: An Overview of Issues and Actions” (Buchan and Calman 2004). This report named international migration as one of three critical challenges faced by policy-makers, personnel, and advocates who work to provide access to safe, adequate and affordable health care in all regions around the world since large-scale recruitment drains needy countries of nurses and nurses do not always personally or professionally benefit from migration (Kingma 2006; my field notes). The ICN advocates for an increase in wages among other solutions to help with nurse retention and recruitment.

1.2.3 Paying For Care

Basic supply and demand logic suggests that increasing wages for nurses will remedy the nurse shortage. While administrators in my study insisted that nurses should be happy with wages that increased over time, one new nurse told me that if she divided her hourly wage between the numbers of patients she had, she received less than \$3.00 per hour for each patient. Research shows that care workers generally experience a decline in wages when entering care work and an increase when they leave the field (England, Budig, and Folbre 2002). This suggests that collective mobilization is needed to increase the social and economic value of care (MacDonald and Merrill 2002).

Not all care workers agree that money measures good care. In her study of professional care workers, Deborah Stone (2000) argued that caring in the public sphere clashes with the care ideals held by workers. Professional care workers want to care for patients in ways that mirror good family relationships; that is they want to spend time with patients, talk with them, and treat

them like loved ones. Despite organizational systems that stifle these relationships, professional care workers resist over-management of care and find ways to intimately connect with their patients (Stone 2000). Philosopher Virginia Held (2002) also argues against applying market values to care work because doing so encourages individualism and minimizes the potential of relational moral ethics, which support healthy, meaningful caring relationships. This logic assumes that money corrupts caring and that patient care will suffer as a result (England 2005; Zelizer 2005), yet she, like other scholars, assume that better care occurs when work relationships replicate mutually genuine caring relationships, such as those found in families (Lopez 2006; Stone 2000). Paying for care may increase patient satisfaction because it gives recipients a sense of control over the quality of care they receive (Ungerson 2000), but increasing wages is a partial solution to the nursing shortage and devaluation of care. It might help recruit new nurses, though many new nurses leave bedside care due to poor work conditions (Kingma 2006).

Public and private arenas merge in care work. Care is simultaneously commodified and taken for granted (kept invisible). It is important to conceptualize care work as both work and caring. Too tight a focus on the work of caring may detract from the benefits, joy, and satisfaction given and received in care work (Misra 2003). On the other hand, an overemphasis on care can lose sight of essential labor practices. Equally acknowledging care and work moves toward the kind of analysis that is required to understand the interdependency of global societies.

1.3 CONCLUSION

Rather than privilege virtue or skill, the concept professional intimacy recognizes both nurses'

professionalization and their commitment to caring. Professional intimacy reveals how intimacy, typically seen as a private issue, pervades professional nursing and the salience of race, gender, nationality, and sexuality. The following chapters use the concept of professional intimacy to analyze the practices of hospital nursing in one Phoenix hospital. I describe my methodological design and research methods in chapter two. In chapter three, I use the experiences of nurses to show how intimacy improves patient care. In chapter four I analyze the relationship between professional intimacy, patient entitlement, and conflict between nurses and patients. I discuss how nurses manage and negotiate boundaries with patients and family members during intimate conflict in chapter five. In chapter six, I turn my attention to theoretical and practical uses of this concept, professional intimacy. I begin by discussing how professional intimacy in nursing exemplifies connections between social and economic values of care. I then discuss how using intersectionality theory to study everyday life challenges universalized definitions of what it means to be caring. I conclude by discussing how hospital nursing might be restructured to better accommodate professional intimacy and offering suggestions for the continued theoretical development of professional intimacy in other industries.

2.0 RESEARCH DESIGN AND METHODOLOGY

In this chapter, I explain the methodological and conceptual trajectory which shaped my dissertation. I changed the focus from sexual harassment to intimacy in professional nursing, largely in response to nurses' understandings, and changed the location from New York City to Phoenix, Arizona. I detail issues of entrée, participant protection, and ethics. I discuss my data collection, analysis, and dissemination plans. As a feminist sociologist, I close this chapter with my thoughts on feminist research.

2.1 PILOT STUDY

My dissertation pilot study compared waitresses' and nurses' experiences and definitions of sexual harassment. Based on the research literature, I expected nurses and waitresses to have similar descriptions of sexual harassment on the job. Instead, I found that while both groups described what they considered uncomfortable or inappropriate sexual situations as part of their work, waitresses labeled these sexual harassment and nurses did not (see also Giuffre and Williams 1994; Hanrahan 1997). I argued that this difference results from work norms about intimacy, perceptions of clients' intentions, and levels of power in the workplace (Huebner 2005).

I conducted twenty-one in-depth interviews for this study. In 1994 I interviewed ten

waitresses who were diverse by race, sexual orientation, and age. I purposively sampled waitresses from three types of restaurants to ensure variance in workplace culture: i.e. price of meals, atmosphere, and clientele. In 2003, in partnership with 1199P/SEIU, Pennsylvania's chapter of Service Employees International Union, I interviewed eleven nurses diverse by gender, age, and work area at one large urban hospital in Pittsburgh, Pennsylvania. Eight nurses were female and three were male. All were white, U.S. born, and heterosexual. They worked in different areas of the hospital: i.e. emergency room, operating room, intensive care, and obstetrics and gynecology. Their ages ranged from twenty-one to fifty-two.

For waitresses, I asked mostly open-ended questions about work culture, interactions, and meanings of sexual harassment and inappropriateness. I also asked some categorical questions from a list of behaviors I defined as sexual harassment: i.e. touching, crude remarks, etc. If an informant responded "yes" to any of these behaviors, I later asked if they would define those behaviors as sexual harassment.

When I began interviewing nurses, I constructed an interview guide that relied on open-ended questions. Since I sought nurses' understandings of sexual harassment, I did not want to impose prescribed categories in the interview. I found, however, that when I did not include some of the prescribed categories that I used with waitresses, many informants were vague and did not address sexual harassment at all. In an attempt to garner more specific data and allow a better comparison with waitresses, I then asked nurses about specific behaviors. In later interviews, I noticed that I did not need to rely on this prescribed list if the informant led the interview. I coded discussions of behaviors conventionally thought of as sexual harassment, even if informants did not define these scenarios as such, including jokes, crude remarks, and requests for sexual favors. I also looked for references to behaviors not conventionally defined as sexual

harassment but those that informants defined “inappropriate.”

My pilot suggested that cultural understandings, including those shaped by work norms, are important to understanding sexual harassment (Huebner 2005). The relationship between meanings and culture questions whether traditional avenues for recourse against workplace sexual harassment are appropriate in caring professions. My analysis also pointed to the need to understand how nurses’ lives outside of work might impact how nurses distinguish between appropriate intimacy and sexual harassment. This suggested that nurses’ cultural belief systems shape understandings of work dynamics. This fit recent scholarship by labor sociologists who found that the private lives of workers affect their work lives (Clawson 2003). Finally, my pilot study suggested that relying exclusively on interview data, especially structured interviews, limited my analysis. Several nurses offered only vague responses when asked directly about sexual harassment; they were more forthcoming in later interviews with more open-ended questions.

2.2 DISSERTATION RESEARCH DESIGN

Since my pilot study showed that interview data alone was insufficient to explain why nurses responded in particular ways to sexualized interactions, why these responses changed over time, and how different work contexts impacted their responses, for my dissertation I decided to conduct an ethnography, situated in global circumstances (Burawoy 2000). Global ethnography attaches globalization processes to everyday life (Burawoy 2000). It is “grounded globalization”; which connects local ethnographic research on hospital nursing, for example, to discourses about the global nursing shortage and commodifications of care.

I draw from standpoint theories, which explain the everyday world by prioritizing subjective world-views and experiential knowledge. This does not suggest that any knowledge is superior; rather it is a method of inquiry that focuses on the relations between knowledge and power in three ways (Harding 1997; Hartsock 1997; Smith 1997). First, standpoint theory emphasizes the role of authoritative documents and texts in constructing and normalizing everyday experiences and meanings (Smith 1990; 1987). Second, standpoint theory focuses on how social locations vary by material resources and realities that reflect oppression and resistance (Hartsock 1985; 1983). Third, standpoint theory points to the need to analyze how multiple subjectivities and experiences create knowledge (Collins 2000; hooks 1984). I used these features of standpoint theory to analyze experiential knowledge from the standpoint of nurses to reveal the everyday world of interactions between patients and nurses. Incorporating knowledge from a position that is “bottom up” provided a fuller analysis of intimate and sexualized interactions between nurses and patients than would more conventional “top- down” analytic approaches.

2.3 DATA COLLECTION AND ANALYSIS

From October 2005 to May 2006, I immersed myself in the culture of a hospital in Phoenix, Arizona. Arizona faces one of the worst nursing shortages in the United States and, Phoenix, as a rapidly growing, uniquely diverse urban region, was an appropriate site for this study. I observed, conversed with, and informally assisted nurses and other clinical staff during the day and night hours (800) on four units: oncology, progressive coronary care unit (PCCU), med-surg, and orthopedics. I interviewed 45 nurses; 10 (22%) were male, 16 (36%) were people of color;

and 10 (22%) were from other countries. I also interviewed 10 administrators and educators.

Table 1 Nurse Demographics

FEMALE							
	OVER 40 years			UNDER 40 years			TOTAL
	U.S.	NON-U.S.	ALL	U.S.	NON-U.S.	ALL	
WHITE	7 70%		7 46%	11 73%	3 60%	14 70%	21 60%
BLACK	3 30%	1 20%	4 27%	1 7%		1 5%	5 14%
LATINA				3 20%	1 20%	4 20%	4 12%
ASIAN		4 80%	4 27%		1 20%	1 5%	5 14%
TOTAL	10	5	15	15	5	20	35
MALE							
	OVER 40 years			UNDER 40 years			TOTAL
	U.S.	NON-U.S.	ALL	U.S.	NON-U.S.	ALL	
WHITE	3 75%			5 83%			8 80%
NON-WHITE	1 25%			1 17%			2 20%
TOTAL	4			6			10

2.3.1 Study Site

I conducted my research in a hospital with a diverse nursing staff in Phoenix, Arizona, which offered me both a mid-size hospital and a nursing staff diverse by race, age, gender, and nationality. I chose Phoenix because, although nursing is still a predominately white and female occupation (93%), in Phoenix I could partner with a mid-size community hospital with a racially, gendered, and ethnically diverse staff and patient base. Although Phoenix was the 8th fastest growing city in the nation and located in a state that was one of the fastest growing too, it faced

one of the worst nursing shortages in the country and actively sought to recruit minority and male nurses.

Phoenix has clear divisions – and tensions – along race and class lines. It is in a border state with a significant proportion of native Spanish-speakers. Its Latino/a population grew from 19% in 1990 to more than 1/3 of the population in 2003. At the time of the study, Arizona was home to twenty-two Native American tribes. Real estate and financial planning were booming industries that served affluent individuals who moved there to retire, but there was also a significant homeless population. There were very poor neighborhoods and, also, wealthy pockets.

The hospital I studied was in a poor neighborhood, with a significant homeless and drug-using population. It was one of the few trauma hospitals in the state well known for its excellent nursing care and a mid-size hospital that served community residents. Its patient population was mixed: some wealthy, some poor, some homeless, some were year-round Phoenix residents, some visited during the warm winter months, and some were undocumented families who had traveled from Mexico and other South American countries. Most trauma patients were younger. Older patients were battling cancer, heart disease, and other illnesses.

Administrators in my study site struggled with providing enough nursing staff to meet patients' needs. The winter I conducted my study was especially challenging with the highest ever recorded admissions to their inpatient surgery department; the number of inpatient surgeries in January and February increased 17 percent from the year before. During the Christmas holidays, management team suited up and provided bedside care, staff converted office space to bed space, and employees came in to work on their days off. Administration struck a partnership with a registry service so that nurses from this registry would be trained on hospital policies.

This was in addition to a float pool of staff nurses originally designed to fill shifts by nurses who called in sick, not to fill permanent positions. In early 2007, the hospital planned to employ immigrant nurses from India to help fill their ranks.

2.3.2 A Typical Day

Nurses practice in close quarters. A typical day in a hospital unit was busy; nurses, doctors, social workers, case managers, secretary, and dietary and housekeeping staff shared work space but worked independently: each saw different patients at different times and completed their own documentation. Half of the patient rooms I observed were semi-private. Workspace in the nurses' station was at a premium, shared with doctors, case managers, pharmacists, physical therapists, patient care technicians, and other nurses. Still, nurses interacted intimately and privately with patients and family members in public spaces – in patient rooms, in the halls, and in nurses' stations. Workers moved up and down halls and in and out of patients' rooms easily and quickly. They also moved through the nurses' station quickly, often without saying "hello." They stopped in the nurses' station to make phone calls, receive phone calls, and chart. People generally did not talk to each other unless it was specifically about patients' progress. Multiple conversations occurred simultaneously: about individual patients, about discharges, phoning pharmacy, phoning doctors, paging doctors, paging nurses, handling calls with families, talking to the social workers about after or long term care, phoning the emergency department for a new admittance, technicians asking nurses to unhook IVs or provide other care, nurses negotiating breaks, prosthetic and other equipment representatives coming in, and family members asking questions.

Clinical staff members discussed patient progress but could not monitor the process of

their work. They did not discuss patient care in their meetings, which primarily attended to policy changes and institutional goals. They lost charts, moved charts, took charts, and spent precious time looking for charts. Staff called on the intercom for nurses who were five feet away in the medicine room or just on the other side of the divider in the nurse station. Nurses discussed their practice in individual terms but they needed each other and relied on institutional policies for patient care.

Unlike in some hospitals, where groups of staff members wear the same color uniform and all staff members wear visible name tags designed to help patients and family members distinguish among their caregivers, staff in the hospital I studied wore uniforms of their choosing that varied by color and design. They wore nametags, but often these were partially hidden or turned around, which made them difficult to read. Allowing staff to wear uniforms of their choice inadvertently equalized workers and made physicians, nurses, housekeepers, and patient care technicians indistinguishable from one another. This enabled patients and family members to use gender, race, and nationality stereotypes when they assigned various levels of authority to hospital staff.

2.3.3 Gaining Entrée and Developing Rapport

As someone new to studying nursing, I consulted many nurse researchers and practitioners while conceptualizing, designing, revising, and implementing this study. I conducted formal meetings (both in person and by phone), informal conversations, and attended meetings in Pittsburgh, PA, (University of Pittsburgh School of Nursing, UPMC, Shadyside Hospital, Allegheny General Hospital, 1199P/SEIU) New York (Mt. Sinai Medical Center, North General Hospital in Harlem, NYU School of Nursing, and Long Island School of Nursing), Idaho (Boise State University

School of Nursing, Idaho State University School of Nursing), and Oregon (Kaiser Permanente Medical Center, Clackamas Community College School of Nursing and Workforce Improvement Program for International Nurses, Oregon Chapter of the National Hispanic Nurse Association, and the University of Portland School of Nursing).

In June 2005, I contacted the Arizona Health Care and Hospital Association. They immediately referred me to several hospitals in the Phoenix area that would benefit from nursing research. I called all of them and scheduled visits with two hospitals in August 2005. The first hospital was a large urban center with 650 beds. The Director of Nursing expressed interest in my project. She invited me to the site, gave me a tour, and introduced me to the human resources director. However, my study, particularly its emphasis on sexual harassment, proved to be too risky for the organization. The Director of Human Resources rejected the study, saying “now is not a good time.”

The Director of Professional Practice at the second hospital scheduled me first with several clinical directors who expressed interest in the project. Many staff nurses were not trained to understand the importance of qualitative research. This was one of the reasons the director of professional practice and other administrators were interested in my study. They hoped to expose staff nurses to the qualitative study of nursing. In addition, this first meeting gave me an opportunity to explain my intention to be as little work for them as possible. I took time and great care to express how I would defer to them and their staff to be sure that I would not disrupt patient care or the flow of work. I also met with the Vice President of Clinical Care to share the project goals, methods, and my plans to approach ethical concerns. I left my August meetings with an informal approval from the Director of Professional Practice. She gave me an application to complete to secure formal approval. In September 2005, I received a letter stating

formal approval and commitment to work with me and gained theirs and the University of Pittsburgh IRB approvals.

In late September I moved to Phoenix and held a second meeting with clinical directors in early October. In this meeting I shared my research plan, asked for feedback and questions, determined the order of units I would study, and scheduled individual meetings to discuss particular issues and concerns for each unit. I asked questions about how to introduce the study to staff, the physical space I could access, the documents I could see, and meetings I could attend. The clinical directors expressed two concerns to me. The first was my use of the term “sexual” when I described my project to the nurses. The second was the possibility that I might interrupt patient care. The directors were very protective of their nurses and did not want them to feel uncomfortable with my presence in their unit. I avoided using the word “sexual” in initial descriptions of the study in response to the directors’ concerns that workers would not take me seriously. In addition, I brainstormed strategies with directors on ways to keep my observation focused but still as inconspicuous as possible. For instance, during my observations and conversations I learned the power of “knowing nothing” while on the floor. I told nurses I was simply there to follow them. I let patients think that I was a nursing student. I did not correct patients until they asked me to provide care, at which point I explained that I was not a nursing student and that I would need to get their nurse. When I explained my project to staff and patients, I made statements such as “I do not know about nursing” and “I am not a nurse.”

After I received permission from the hospital and guidance from the clinical directors, I began observation. Before observing each unit, I attended staff meetings to introduce myself, explain my study, answer questions, and initiate rapport. Following Mary Beth Happ’s (1998), study of interactions between nurses and patients in a critical care unit, I encouraged nurses to let

me know if there were particular events, days or patients that they would not want me to observe. Also, like Happ (1998), I posted notices of the study in communication books in each area, in the family waiting rooms, and in staff restrooms.

I consistently gained more *entrée* with nurses, patient care technicians, and other clinical staff. In addition to the preparation I completed, I explained the study on an individual basis with nurses, continuously emphasized that participants would be protected from harm, that participating was voluntary, that I would only follow them on their daily rounds and observe their interactions with patients and family members with their permission, and that I was only there to observe their work, not evaluate it or answer questions. I also emphasized that I would not disrupt patient care. I told nurses that I would observe their interactions with patients and family members, but would not interview patients or family members or access patient records.

Gaining *entrée* was affected by my status as a researcher who did not need to comply with institutional norms. Although my observation and inconsistent schedule breached the routine and fast pace that organized nursing work, it gave me a chance to identify these norms (Garfinkel 1967). For example, I often attended meetings and staff in-services as they happened during my observation because they were opportunities to meet staff and build rapport. I learned from nurses that my “coming and going” and that “folks never know when I am going to slip in and out” was “kind of creepy.” Looking like I did nothing during observation was a second breach in a very busy environment. For instance, a unit director said to me that she “wished she had my hours” not understanding that hours of work waited for me after I left a four or five hour observation “shift.” Other nurses joked with me when I stood or sat during my observations. To appear less conspicuous, I moved in and out of chairs, from one side of the station to another, up and down halls, out of the way of other personnel, and I took notes.

2.3.4 Protection of Participants

I kept the names of participants confidential throughout and after the study in my findings, reports, and papers. I did not include patient identifiers in my field notes, interview transcriptions, or analysis. I encouraged nurses to avoid using patient names or other identifiers during in-depth interviews. I did not include names in transcriptions when nurses disclosed this information in interviews. I also consistently reminded nurses that they could ask me to cease observing at any point in the process. I sought to be as unobtrusive as possible to ensure that participants were comfortable with my presence in their workplace. This meant that I was hyper-aware of my presence and how I appeared to staff and patients.

2.3.5 Ethical Concerns

As a socially responsible researcher, I continuously interrogated how my research process affected research participants and their work environments. Taking responsibility for these effects was especially important in ethnographic field work because ethnography presents more opportunities for intimacy, disclosure, and feelings of familiarity between researchers and informants (Stacey 1988). With this in mind, I incorporated ethical research throughout all phases of my research. I considered ethics an ongoing dialogue and set of questions and concerns specific to each new situation, rather than as a problem to solve or a list of rules to check off. Rather than ask “when do I care about my informants” and the “fairness of my study”, I asked “how do I appropriately care for each participant” in each specific moment.

Ethnographers need to consider ethics in the experiences of participants as well as how we engage with these experiences. During my field work and analysis, I used auto-ethnography

as a mode of data collection to ensure self reflection, my accountability, and my tracking of my own emotional work. Auto-ethnography begins with one's personal life, documents moment to moment, and incorporates systematic introspection and emotional recall (Richardson 2003). It extends beyond mere social inquiry and becomes a moral and ethical practice; it exposes vulnerabilities and subjectivities honestly and openly. For example, incorporating auto-ethnography early in my study helped me acknowledge the various contexts in which intimacy occurs at work, rather than limited my scope to meanings of sexual harassment. Conceptualizing intimacy as a process that changes over time and space helped me remain open to nurses' experiences rather than impose my own categories.

My academic and professional experience helped me consider my role as a researcher/advocate and how this role related to my work, my studies, and my interactions with hospital staff on a daily basis. Participant protection did not stop at maintaining confidentiality, it also included being sensitive to the changing work load for nurses and the subtle power dynamics between me and hospital staff, including those dynamics affected by my identity as a white woman researcher with no medical background. For example, my respect for nurses and their labor superseded any sense of entitlement to data. I was just as concerned with conforming to the norms of the field and as I was with attending to any potential pitfalls from my privileged status as a white researcher in others' work environment. Many times I conformed to the environment, such as not interacting with patients, dutifully following nurses, eating when others ate, and arriving when others arrived on shift.

I continuously attended to my changing location as an "insider/outsider" in the work environment of others (Collins 1986). Although nurses' discomfort with my outsider status as "researcher" and "student" somewhat shifted to insider status over time, my status as a medical

outsider remained intact throughout the study. Some researchers who studied the dynamics between nurses and patients are trained nurses. For example, one nurse researcher talked to me about “crossing the threshold” from researcher to caregiver when observing patients’ rooms. When she conducted an ethnography in a critical care unit, she provided care, i.e. turning patients over in their beds or assisting with an IV (Happ 2005). I expected that my chances to participate as observer would lessen due to my lack of medical training. This did not happen. Although I focused my efforts on cultural and social meanings of care, nurses asked me to assist them, by, e.g. holding equipment for a nurse or offering a drink to a patient. I was never in a patient’s room without an accompanying nurse so when patients asked me for assistance I deferred to the nurse. I expected to constantly negotiate my presence to avoid disruption of patient care at all costs. This was true. I negotiated the boundary between researcher and practitioner differently because I am not a trained nurse. In this way, my outsider status was an asset. However, my outsider status wasn’t always an advantage since it meant that I connected less to some nurses. For example some nurses did not trust me to follow them because they did not understand my “true” intentions. Similarly, some nurses expressed concern that human resources hired me to evaluate them or that I spied for managers.

The intersection and level of visibility of my race, gender, sexuality, and class affected how my status switched between “outsider” and “insider” with nurses. Gaining entrée to my research site was made easier because I am white and people expect researchers to be white (Warren 2000). Since all the hospital administrators were white, I did not have to negotiate expressions of shock or disbelief, nor discuss my race with them. For example, in her hospital study of Caribbean nurses, Afro-Caribbean scholar Natalie Bennett (2000) describes repeated encounters of surprise from hospital administrators and assistants who expected her to be white

on first meeting. In addition, Bennett's race became a topic of discussion during a meeting with unit directors to discuss how data collection would coincide with patient care. During this meeting, the Vice President of Nursing – a white woman – asked the other directors, in front of Bennett as if she was not there, “if her being West Indian could make a difference” (pg 107). In contrast to Bennett's experiences, my race was never a subject of discussion. No staff member or administrator seemed surprised when they learned that I was a researcher.

My race also affected interactions with nurses on the floor. I noticed that white nurses sometimes made racist remarks about patients and other nurses in front of me. On occasion, white nurses were explicitly racist in interviews. The access my race afforded me in these situations was pronounced; these overt expressions of racism likely would not have occurred – and therefore I could not have included them in my analysis of professional intimacy – if I was not white (Blee 2000). This conjecture provides only some comfort to what I feel was my complicity in racism through silence. I also know that my job was to observe and understand a racist situation so that I effectively address it (Becker 2000).

Most of the people of color I approached agreed to participate and seemed especially curious when they learned of my interest in race and ethnicity. This does not mean that there was no effect of race. My whiteness and my status as researcher might have afforded me privilege through what Jonathan Warren (2000:161) calls an “imagined superiority of whiteness” from participants. Only two nurses refused to participate in my study. One nurse was African and one nurse was Caucasian. While the African nurse's decision could have resulted from racialized distrust of white women and of the research enterprise (Zinn 1990; 1979), race-matching does not guarantee trust (Twine 2000).

My status as a woman may have afforded me greater access to my mostly female

population; however, shared gender does not always result in trust (Riessman 1987). While female informants of diverse races and ethnicities told me I was “easy to talk with,” no female informant explicitly said that this was due to our shared gender. It could be that female nurses assumed, without stating, the stereotypical benefits of shared gender, in part, because they were accustomed to a work environment that took female bonding for granted (Dellinger and Williams 2002) or it could be that our shared gender had no effect. In either case, I did not assume that my interviews with women would proceed smoothly because shared gender can also impede conceptual development. Many times female informants of all races made statements such as “you know what I mean” instead of stating their meanings explicitly. This type of assumed meaning that comes from bonding, or an assumed shared experience, can lead to confused or lost meanings (Blee 1998; Schwalbe and Wolkomir 2001). I paid particular attention to the potential of bonding problems with my informants and interrupted them as they occurred. Although I usually affirmed their sentiments when bonding occurred, I also asked informants to clarify their meanings in their own words.

Women interviewing men can also cause problems specific to gender. In contrast to other reports of women interviewing men, none of the men flirted with me, touched me, or denigrated women during the interview (Arendell 1997; Lee 1997). Early in the study one man suggested that we meet for dinner after he got off work at 11:30 p.m. I suggested that we meet one day before his shift began. He readily agreed. The rest of my male informants suggested I interview them at the hospital or at a public coffee shop, which meant I did not struggle with issues of safety or assumptions that we were on a “blind date” (Arendell 1997; Lee 1997).

Although male nurses seemed forthright with me about their experiences of gender in nursing, my gender could have affected our interactions in other ways. Male nurses may have

perceived my interviewing them as particularly threatening to their masculinity (Schwalbe and Wolkomir 2001). This could explain why one male nurse in particular repeatedly refused my requests for interviews. He was amiable during my observation and often volunteered his interpretations of events on the floor; thus, I opted to informally ask questions during observation. I also deferred to his experience and asked questions about acts I witnessed but did not understand (Schwalbe and Wolkomir 2001). I did this with all nurses, which likely helped me build rapport and avoid power conflicts. Some male informants were minimalist at first, keeping their answers short and curt. In these cases, I referred to what other male informants shared, for example being perceived as gay, as a way to help men feel more comfortable in the interview (Schwalbe and Wolkomir 2001). Male nurses may have also exaggerated their rationality, autonomy, and control when discussing their labor as a way to preserve their masculinity, which may have altered my findings on perceptions of leadership and authority in chapter four (Arendell 1997; Schwalbe and Wolkomir 2001).

I did not calculate in advance how I would address issues of my sexuality while conducting field work. Being lesbian is not new for me. I am “out of the closet” and also well aware that I often “pass” for straight. I tend not to discuss my private life in general, but will refer to my sexuality at work if it is productive, for example, if it contributes to teaching or to gaining research access. Because I did not foresee any benefits to disclosing my sexual identity, I decided to be non-committal as much as possible; however, marital status can be a problem in the field (Lewin and Leap 1996). I wear a wedding ring because although I am not legally married, my partner and our families and friends participated in a commitment ceremony four years ago. As far as my partner and I are concerned, we are married. Expressing concern for me in an unfamiliar city, many nurses noticed my ring and asked if my husband was in Phoenix with

me. Most often, I avoided these questions by changing the subject or just said “I have family here.” Occasionally, however, I mentioned that my partner was conducting her research or that she moved to Phoenix part way through my study. Only a few times nurses caught on and asked about my relationship or expressed shock that I am gay. Two nurses told me in confidence that they thought I “might be a lesbian.” Although each woman identified as straight, my sexuality seemed to build rapport with them because they talked about their gay and lesbian friends and family. Although most nurses assumed I was heterosexual, I had no reason to believe that my sexuality affected my interactions with participants. I also did not know this for sure because heterosexual privilege – even gained from passing – is invisible, assumed, and hard to measure.

I found that my assumed heterosexuality afforded me access to some participants. During my interview with Nadine, she expressed how some homophobic nurses on her floor care less for gay and lesbian patients. Although she emphasized her support for gay people, she admitted her discomfort with patients who were part of a lesbian couple because she did not always know how to approach them. Later, when I told her I am a lesbian, she seemed a bit embarrassed at first, but visibly relaxed when I reassured her that I was not offended by her sentiments. I found them quite important to my analysis. After this exchange, Nadine told me that another nurse would never have talked with me had he known I was gay. These comments helped me realize the impact that my perceived sexuality had on data collection efforts and the privilege I experienced because I passed for straight (Goodman 1996).

I do not know if my current class status as an advanced graduate student with a full-time research fellowship factored into my research. Many nurses expressed concern to me about walking alone to my car at night in a neighborhood fraught with high crime, homelessness, and drugs. These concerns could have resulted from their perceptions of my class status, i.e. that I

never lived in a neighborhood with high crime, was never around homeless individuals, or did not know drug addicts and alcoholics. It was hard to tell, however, because these concerns could have stemmed from a general concern for my safety and/or could have also resulted from my white race or female gender – both of which need stereotypical protection from “dangerous” neighborhoods.

2.3.6 Participant Recruitment

I recruited nurses for interviews over time in different ways. I introduced myself and the project repeatedly: at staff meetings, over email, and on the floor. During my observation, I developed rapport with nurses in the nurse station and in the staff room. Occasionally I ate lunch with nurses but many nurses did not take lunch or official breaks. I specifically sought out nurses who were male, non-white, trained in other countries, and new. I asked permission to follow nurses on rounds and then scheduled interviews. In some cases, I scheduled interviews without observation to ensure that my sample was diverse. Some nurses approached me asking to participate; most people were comfortable with my presence and very interested in the project. Two nurses (one on two different floors) expressed concern to me. In these cases, I was very careful and did not intrude on their work. In all cases, I respected nurses’ feelings and boundaries.

2.3.7 Sample of Units

With 20 beds, the oncology unit was the smallest unit in the hospital. There were four to five nurses on staff who cared for four to five patients during the day and four on staff during nights.

Half the patients were oncology and half were med-surg. Oncology was the least diverse floor. Most nurses on this floor were experienced, white women. I interviewed two men and two people of color from this floor. The progressive coronary care unit (PCCU) was the second smallest unit but it had a faster pace than oncology. Patients were older, needed to be moved more often, and some families dealt with end of life issues. There were four to five nurses on shift, many of whom were recent hires. I interviewed three male nurses and three people of color from this floor. With 36 beds and seven nurses per shift, the med-surg floor was the largest unit of the hospital and turned over more patients than any other floor. This unit had the most racially and ethnically diverse staff; many nurses were trained in other countries. I interviewed two men and seven people of color from this floor. With seven nurses per shift, orthopedics was the second largest unit and, also, moved at a fast pace. Nurses on this floor saw two kinds of patients: trauma patients, who were typically younger and alcohol-related and orthopedic patients who were older. I interviewed three men and four people of color from this floor.

I selected these units because each attended to different kinds of illness and varied in size but experienced similar nurse-patient ratios, involvements with family members, and lengths of patient stays. They also had similar control over who could come on and off the floor and all units cared for med-surge patients. Early in the study, other units expressed interest and willingness to participate. I considered including units such as the intensive care unit, emergency department, operating, and labor and delivery, but I discovered that these units had distinct work features and cultures that made them too different from the other units for a fair comparison of meanings of intimacy in care work. For example, the emergency department moved at an urgent pace with an open door, so that nurses watched for unknown or uncontrollable circumstances. As the director of the emergency room explained, “it is a very different place” and it is “part of the

culture” to deal with stress by talking and joking about sexual and intimate matters. She said the line between appropriate and inappropriate behaviors blurred and could bias my findings. Similarly, the intensive care unit worked with acute illnesses but had a very low patient-nurse ratio compared to the other units in the hospital. Patients were not alert and interactions with family were much more intense.

2.3.8 Observations

On both day and night shifts, I observed nurses in the nurses’ station, joined in conversations in the staff room, and walked the halls. I attended staff meetings and received policy updates, unit-specific correspondence, and all-hospital emails. When able to do so without disrupting their work, I informally talked with nurses and followed them on their rounds, observing their interactions with co-workers, patients, and patients’ family members. I followed nurses on their rounds for approximately seventy-five percent of my observations. Within one month, I learned it was most useful to follow one nurse consistently for three hours rather than move from nurse to nurse. Also over time, I learned to nuance my requests for permission. Nurses were always thinking about their next decision, their next move, and their next task. I found I interrupted their train of thought if I consistently asked if I could follow them. My questions forced them to think about yet another decision. Instead, I became less hesitant and observed with confidence I did not always feel (Becker 1993). Similarly, although I felt awkward keeping a distance while immersed in the situation, I tried not to offer my help with simple tasks such as getting linens or water for patients because I did not want to disrupt what I knew was a systematic process of care. For example, when I grabbed the linens to help the nurse took time to explain where they went and reminded me to go wash my hands, because I was not wearing gloves. I became another

factor to account for in her work.

After each observation I wrote a log of events. I recorded physical setting, key participants, equipment used, types of physical and emotional interactions, and responses to and consequences of these interactions.

2.3.9 In-depth Interviews

In order to understand how nurses perceive and explain intimate care in nursing, I conducted 55 in-depth interviews. I interviewed 45 nurses, three nursing professors, and seven hospital administrators. The administrators included three unit directors, the Director of Human Resources, the Director of Magnet Research, the Vice President of Clinical Services, and the CEO. All administrators were white women except for the CEO, a white man. I approached nurses for interviews while conducting my observations. I purposively sampled to obtain variance on gender, age, race, ethnicity, country of origin, and hospital unit. I asked open-ended questions in my interviews about personal background, work history, and intimate behaviors at work with patients and patients' family members.

I revised my interview schedule twice while in the field. I designed my initial interview schedule to elicit a broad range of information on multiple factors – within and outside the workplace – that impact nurses' distinctions between normal interactions in caring and intimacy in nursing from acts of harm. Informed from my initial observations I later included questions about nurses' personal ethics and belief systems affecting care, the impact of charting and other document responsibilities, the specific impact of families, and meanings of intimacy and conflict. I conducted each interview in the setting of the participant's choice and each lasted one to two hours. These settings include offices, coffee shops, and nurses' homes. In my interviews with

administrators, I asked about how the emotional work of care affected them, staff, and the hospital at large. I also asked how the changing patient population contributed to changing nurses' work. I asked how much of nurses' work was providing care and how the hospital evaluated this work. I conducted interviews with administrators in their offices. These interviews were shorter than those with nurses; averaging 30 minutes. I audio recorded and transcribed each interview for analysis.

Following Weiss (1994), I set a collaborative tone from the beginning of each interview to help avoid positioning myself as the "expert." As I suspected, some participants generalized their responses rather than provided details. I avoided general remarks by looking for concrete instances, spoke in present tense, and inquired both on descriptions of events and how informants felt about these events. I used phrases to encourage the informant to speak, i.e. "How did that start?" and "Could you walk me through it?" and "What did you mean by _____?" rather than try to anticipate what my informant would say. I returned to passing events that felt important and to let the informant lead the interview. In my first interviews in my pilot study, I noticed that I talked too much, especially by self-disclosing in an attempt to make the informant feel more comfortable. In retrospect, I realize that I felt uncomfortable and nervous. My fear of imposition was needless and if left unchecked, could have cost me opportunities to learn more about the situation I was studying.

2.3.10 Data Analysis

In the tradition of qualitative research, I conducted ongoing data analysis to focus my data collection efforts. My observations focused on interactions between nurses and family members and patients, nurses and other clinical staff, and the general process of care. I typed my

field notes and transcribed my interviews in Microsoft Word. I sorted and coded data along analytic themes. While some of my analyses were deductive, many categories also emerged from the data.

Throughout the project, I organized memo-ing as discussed by Strauss and Corbin (1990) for multiple levels of analysis: 1) code notes to identify concepts to explore; 2) theory notes in the development of my explanations discovered in the text, and operational notes for practical matters. I added “reflexive notes” to organize my own thoughts and reflections during the research process (Richardson 2003). This helped me remain accountable to my own potential biases, fears, and concerns. Tracking the role of my emotions in the field and in my interviews impacted my interpretations of nurses’ understandings of intimacy at work (Blee 1998). By tracking my emotions in my pilot study I found that initially I was hesitant to “hear” that nurses really didn’t feel sexually harassed by behaviors and interactions that I considered to be sexual harassment. In retrospect, I realized that my understandings of my own experiences with harassment and assault were interfering with the ways that I was analyzing these “alternative” experiences. I overcame this “block” in my thinking by writing and talking – essentially revisiting – these experiences. Doing this work separately from my analysis helped me avoid conflating my experiences with those of my informants.

I coded themes from my field notes and my interviews both deductively, based on those derived from my pilot project and inductively, from analytic categories that emerged in the course of my observations and interviews. Deductive codes included 1) work environment, behaviors, and definition of sexual harassment; 2) explicit discussions of sexual harassment; 3) behaviors conventionally thought of as sexual harassment, even if informants did not define these scenarios as such including jokes, crude remarks, and requests for sexual favors; and 4)

behaviors not conventionally defined as sexual harassment but those that informants defined as “inappropriate.”

Inductively, I opened coded my notes and interviews line by line, underlined key phrases, and constructed systematic comparisons i.e. using free lists and cognitive mapping in order to find thematic patterns among short words or phrases. I performed in vivo coding, especially seeking categories and terms that my informants used to describe the intimate conditions of their labor. I read my notes and interviews multiple times, back and forth, with these conditions and relations in mind constantly asking, “When, why, and under what conditions do these themes occur in the text?” I used the conditional matrix as described by Strauss and Corbin (1990) to check and order different levels of interactions, influences, and consequences of events. As new themes emerged, I coded and recoded these patterns and worked through remaining notes and interviews again to test these ideas. I continually checked my developing ideas and explanations against competing explanations and negative cases. I adjusted my data collection to check these contrasting explanations. I used NUD*IST and NVivo software to help organize my coding efforts.

2.4 DISSEMINATION OF FINDINGS

In January 2007, I returned to Phoenix to give what Michael Burawoy calls a “valedictory visit” (2003) to nurses as a part of their educational series, Nursing Grand Rounds, on meanings of professional intimacy and how these meanings are impacted by race and gender. Although I returned to provide final results to participants, not to collect more data, the visit offered opportunities for study participants to engage with me and debate the findings. As Burawoy

suggests, “this is the moment of judgment, when previous relations are reassessed, theory is put to the test, and accounts are reevaluated” (2003: 672). To ensure maximum attendance, I presented early morning to catch nurses leaving night shift and later in the day for day shift workers. Nurses’ responses varied. Many nurses, especially women of color, affirmed that I validated their work experiences especially that their extra labor is taken for granted. Two administrators commented that they misunderstood the impact of nurses’ and patients’ race and nationality on intimate care before hearing my presentation. Most evaluations stated they wanted me to return to share more findings and they look forward to reading the report.

2.5 CONCLUSIONS

At first glance, my research choices seem classically feminist. For example, I chose to study the invisibility of women’s work for my master’s thesis, my pilot study, and my dissertation. I bridged theory and praxis by choosing Phoenix, in part, because hospitals in this rapidly growing region needed research on nursing. I focused my research on the lived experiences of nurses to help nurses positively change their work environment. I prioritized the concerns of participants throughout the study. I avoided disrupting the already burdensome work days of nurses. My data collection, analysis, and dissemination included plans that responded to the needs of my participants – as identified by them. I obtained a sample that was diverse by race, gender, age, and ethnicity. Did these choices make this research feminist and me a feminist researcher?

Standpoint and intersectionality theories are not in and of themselves feminist (Smith 1997). By using standpoint theory and intersectionality as methodological guides, I focused on the experiences of my participants in this research. I considered how relations of power impacted

public knowledge about their experiences. I listened to my informants, even when their statements seemed antithetical to my feminist ideas. When nurses dismissed the idea of sexual harassment at work, I considered other explanations for sexualized behaviors from patients. I did not, however, always take their advice. When nurses and administrators suggested that I should not bother studying the sexual harassment of nurses by patients, I did it anyway. Similarly, I persisted in studying the impact of race even though some administrators suggested it would not matter to my findings, i.e., “Most nurses are white anyway.”

I am a feminist, but I do not consider this identity sufficient to define my research as feminist or to label me a feminist researcher. I define my research as feminist, and not simply because I chose to conduct participatory research that highlights diverse experiences or that I hope people outside of the academy find my work relevant to their lives. I define my research as feminist because three historically feminist ideals ground my work: safety, accountability, and empowerment. I strove to protect the participants. Hence, I maintained confidential data, but also consistently remained sensitive to the vulnerabilities and fears of all participants involved, including myself. My research was accountable, not just because I reported back to participants but also because I chose topics that affect everyday individuals and groups. My research was empowering because it revealed and challenged social inequalities.

I take social constructions of race, gender, class, ethnicity, and sexuality seriously because I know that these constructs and the intersections of these constructs have very real material and social impacts for people. Through my use of an intersectional methodology, I sampled to consider individual and group experiences of race, gender, and ethnicity. Intersectionality, as both a methodological and conceptual framework, helped me maintain my commitment to examining social and structural power dynamics in participatory research. By

focusing on my identity and the impact of my presence as an outsider I remained aware of how my identity impacted my research.

These research decisions are not necessarily *only* feminist; it is true that my intentions are shared by researchers whom do not identify themselves or their research as feminist. This makes my statements all the more necessary – I choose to *claim* the label of feminist for these positions. I assert feminist both to acknowledge feminist scholars' rich history doing public and activist research that cares for its participants and because naming – a historically feminist act – requires one to stake claim, to discuss, and to enter dialogue. It is in the spirit of continued dialogue that I claim my research and my researcher identity as feminist.

3.0 LABOR AND SKILL IN PROFESSIONAL INTIMACY

In this chapter I show how nurses perceived and experienced intimate care in nursing. I explain how nurses create and develop professional intimacy to build trust with patients. Trust does not occur naturally between nurses and patients and their families. “Trust work” requires experience and develops over time. Nurses negotiate professional intimacy with patients and families and across boundaries and perceptions of gender, race, nationality, and sexuality.

3.1 CONDITIONS FOR PROFESSIONAL INTIMACY

Nurses in my study felt a tension regarding meanings of intimacy in their professional work. Although nurses know that intimacy benefits patients and family members (Faugier 2006), they did not always use the term “intimacy” when they discussed their labor. Some nurses, especially those new to the profession, expressed discomfort with intimacy as part of their work. Other nurses were clear that they did not consider nursing personally intimate but said that patients perceived care as intimate. Still others defined intimacy as necessary to patient healing. Regardless how nurses identified or felt about intimacy as an idea, all nurses discussed how they used intimacy in their professional practice. Individually and collectively, nurses built a culture of intimacy to increase the comfort of patients during their stay. Producing intimacy required skill that was learned over time. New nurses expressed shock at the amount of intimacy in their

work. Experienced nurses described how they developed these skills throughout their careers and how important these practices were to quality care.

3.1.1 Producing Intimacy

Nurses worked hard to facilitate a culture of comfort on the floors. They wanted family members and patients to feel as though they were in their homes. Nurses took care of patients and family members in private and less visible places, like patients' rooms, behind curtains, behind closed doors, and in patients' bathrooms. Nurses also provided care in less private areas, such as in the nurses' station and in the halls of the unit. Family members and patients also roamed the units, floors, rooms, and the nursing station. They got coffee and water, put food in the refrigerator and took it out, and sometimes, sat in the nursing station to visit, process emotions, or discuss next stages of care. In all of these places, nurses were hyper-visible to patients and family members who perceived them as accessible.

To nurses, intimate connections contribute to healing. Carey, a new nurse, described her thoughts regarding intimacy and patient care,

You are here in a bed. I'm here. You have to touch them. It's what to do. It's part of the healing. And you don't want to touch people like, "Ooh icky. I can't touch you." If they feel that way, how are they going to get better, heal? The bottom line is you have to touch them; you have to put your hands on them. It can be intimate, I think it should be. I don't think it should be so strict and rigid.

Professional intimacy requires providing physical touch in a sensitive manner. Nurses emphasized patients' feelings of closeness, trust, intense emotions, and bodily interactions in their discussions with me. They thought that working on people's bodies

and with people's fears, comforts, pains, and hopes created intimate circumstances in their labor. Mia, an experienced nurse, said, "Well, they get close to you. You care for them. You want them to get better. You bond with them. They know you." When I asked Tonia, a nurse with a few years of experience, if nursing was intimate, she said, "Most of it is intimate. I mean you're touching other people's body parts. It's intimate. You've got to touch the person. You know how uncomfortable is it for a stranger to touch you?" Carey agreed, "And you have to be able to show compassion and love to a total stranger that, you know, you don't know. You don't know these people." Tonia and Carey framed their discussions of intimacy as a form of empathizing with patients. They saw intimacy in nursing as not entirely personal, although incorporating personal aspects.

Even nurses who did not define care work as intimate built intimacy into their professional work because they wanted their patients to heal. Jason described how intimacy in nursing was necessary for patients to feel better.

You know, even though you're looking at people's bodies, I see it as a job. I see it as work. Even though I'm getting intimate with them because they're in a gown or their pajamas, I've never even thought of it as that, oddly enough. It's the professional distance that is the difference. I'm doing this to help you, and not because I want to arouse you or make you want me, I'm doing it so that you get better.

Jason made clear that intimacy in nursing was professional because its goal was to move patients towards healing. To him, maintaining professional distance helped manage perceptions and experiences of intimacy with the patient. Bill also emphasized the need for professionalism during intimate work.

They're looking at you as like a professional; that you're not leaving the room talking about their body that you just viewed, and the things that you just did. You're not degrading them when they leave the room. During my observations, I watched experienced nurses balance distance with closeness. This work did not come naturally; it required skill that was developed over time. Building trust requires both familiarity and professionalism.

3.1.2 Developing Knowledge

New nurses were astonished at the level of intimacy that was part of their work. They did not feel academically or personally prepared to handle the depth of emotion that resulted from intimate circumstances at work. As a consequence, some new nurses avoided intimacy when working with patients. Joyce described her fears and discomfort when she was too close to patients. She explained, "Like, if I'm really tired or something, while I'm talking to a patient, I'll lean against the wall. I don't sit on patient's beds. That to me is just something I'm not willing to do. And I've seen nurses do that. That's too close to me. That's too intimate. I don't like patients touching me, as terrible as that sounds [laughs]." Joyce's laugh was ironic. These feelings were true for her but they contradict an ideal of caring. When I asked Joyce why she thought not wanting patients to touch her was terrible, she explained that other nurses viewed her as a "bad" nurse, as uncaring. Joyce's story illustrates a dilemma in nursing. As a part of their labor, nurses must balance their discomforts and fears against patients' needs and, in some cases, demands.

Balancing patients' intimate fears and discomforts with their medical needs required professional experience. Many experienced nurses talked about "getting back to basics" with care after they learned and practiced their medical and technical skills. Elizabeth, an experienced

nurse, described her routine as one that new nurses did not know right away and “came with experience.” Helen, also an experienced nurse, grew accustomed to working with bodies over time. She said, “That part of it, that doesn’t seem intimate to me anymore. I remember when I first did it. Yeah, it was like, whoa, this is uncomfortable. Now it’s not an issue. Now it becomes more intimate when you’re dealing with the feelings and emotions of it.” Another experienced nurse, Jody, told me that over time nurses learn how to connect with and set boundaries with patients. She said,

You just have to learn how to talk to them. It just comes with time. You know. They like to talk about their family. They like you to talk about your family. And I don’t mind doing it up to a point. But I don’t think they need to know where you live.

Experienced nurses knew that patients will emotionally and physically connect with their nurses as a result of receiving care. To them, professional intimacy meant keeping the patients’ desires in mind, balancing these against their medical needs, and protecting themselves against harm.

Experience – perceived and real – is symbolic capital in professional intimacy. Nurses knew that experience helped patients and family members feel safe. Nurses also identified having experience as important when negotiating authority in patient care. Helen discussed how patients need to feel safe with nurses and one way to feel safe is to assess levels of experience. She said, “I think sometimes they’re trying to gauge how long you’ve been a nurse. So they think you’re competent or know what you’re doing.” Tammy, an experienced nurse in her forties, told me that she “feels bad” for young nurses who “go in there with no experience and take care of somebody twice their age.” She said,

If I was sick I wouldn't really want a young nurse taking care of me. Well, I'd want somebody with a little experience because there are a lot of things you can't teach people. I go in the room and I talk and I'm joking around with people, but you're looking at little tiny, insignificant signs that an old nurse can pick up on, and treat, and it won't become an issue. Whereas a new nurse might not catch it until it's much more of a physical manifestation, more of an issue to deal with.

Learning what "old nurses" know and how they assess patients while keeping them emotionally and physically comfortable is critical for nurses who need to maintain authority while providing intimate care. Other experienced nurses told me they wanted an older nurse taking care of them because they knew they needed to look confident even if they did not feel confident. Joyce, a new nurse, told me that patients did not question her authority if she appeared confident. She said, "I think if you come off at the beginning as confident and in control, they do not question you because they assume you know what you're doing. They have no reason to think otherwise. If you're not sure and you're hesitant and stuff, then they have more [reason to worry]." Looking experienced, even if you were not experienced, helped nurses establish authority.

Race affected perceptions of experience. Eva, a mature and experienced African American nurse, described how a patient asked her questions about her qualifications, but then automatically assumed that the white patient care technician was the nurse when Eva left the room. She told me,

They try to get confidence in you. They will watch and then they'll say, "How long have you been a nurse? Oh! That's why you are doing it that way. And you

seem to know what you're doing." And they'll still ask you. I have some patients that I tell them I'm their nurse and then when I leave the room they say to the PCT, "are you my nurse?" And the PCT is white. So that tells me that oh, they don't think I'm the nurse, they think she is the nurse. And they start asking her questions!

Leah, a Filipina charge nurse, also noticed that patients and family members assumed that white housekeepers, certified nursing assistants, and patient care technicians were nurses. She expressed her shock when patients and family members assumed that her white nurse assistant had more experience and education than she. She said,

For example, Ann and I – Ann is red haired and white and I am short, dark haired, and Asian. I'll go into the room and [they would see] Ann as the RN, and I would be the aide. Because how could I get my education [to be a nurse]? And there were two of us that this would happen to and I would think, "My God, this is a different world!"

Leah described how a common stereotype, that women of color are less educated than white women, affected how patients and family members reacted to her. In her view, patients and family members saw a white woman and a woman of color both entering the room to care for them and they assumed that the woman of color was less educated and therefore should have less authority than the white woman. They also assumed that the woman of color would defer to the white woman. This undermined the authority of the nurse and reinforced racist ideologies.

Mary, an older and experienced African American nurse, explained how being African American affected her work. She said, "Sometimes when they question you regarding your training and how long you've been a nurse, they ask it in a very nice way (laughs). They just try

to ask if you are qualified.” Patients consistently asked older women of color, but not white women of the same age, if they were properly trained to do nursing tasks such as listening to lungs, taking care of wounds, and administering intravenous fluids and medications. Nurses of color experienced patients’ and family members’ disbelief that they were nurses.

Angie, a very experienced immigrant black nurse, agreed that patients and family members assumed that she was not qualified as a nurse. When she was younger, she experienced overt discrimination. Angie told me about the first time she applied for a job as a nurse: her potential employer almost turned her away, saying the housekeeping jobs were taken. Angie said she still experienced such treatment today. Patients and family members ignore her and seem surprised when they realize she is the nurse. Even when she introduced herself by saying “I’ll be your nurse today,” patients and family members looked for someone else. She explained,

Not everybody. Some of them. I’ll go in and say, “My name is so and so and I’ll be your nurse today” but then once I leave the room the PCT comes in and they think she is the nurse and they start asking her questions! The techs are nice. They are polite to say, “No I am not the nurse. The lady that just left *is* the nurse.” So I’ll go back in and say again that I’m the nurse and check to see if they have questions: “What kind of questions do you have?” And then they’ll ask me.

Angie repeatedly had to assert her professionalism to patients, despite her significant nursing experience. As Angie’s experience shows, race affects perceptions of nursing experience. Race constructs meanings of professional intimacy by influencing how patients perceive the experience of nurses and how patients perceive nurses shapes the relations of professional intimacy.

3.1.3 Foregrounding Patients' Perspectives

While intimacy was present in nursing labor, nurses did not necessarily experience nursing as intimate. Amy, an experienced nurse told me, "Nursing is fast paced. You are not spending a long time with each patient – well not on days [shift] where we're usually running around in and out of five rooms." Developing personal intimacy requires time. Jason, an experienced nurse, acknowledged that although patients and nurses were emotionally accessible to each other, he did not consider this to be intimate.

I think [patients] let you in and you let them in for hours or days. And that's the difference ... If is intimacy, it's so brief that I don't even feel like I miss them when they're discharged home. And, to me, intimacy is almost forming a bond where you could potentially miss that person in the future.

Jason did not feel the "bond" that one might develop in a personal relationship. Nonetheless, as he talked, Jason decided there is a relationship between intimacy, time, and quality care. He explained how patients become more open with nurses as they confirmed their skills during their hospital stay. He said, "I think that a patient seeing your competencies becomes comfortable with you and then you can become intimate with them. As they open up and you open up, you start letting down these professional obstructions." Other nurses who did not think their labor was intimate agreed that patients and family members might experience nursing care this way. Jill, a new nurse told me,

Intimate is a strange word because there are so many different meanings, but I guess it would be a good way to describe patient care. Yes, I do think it [nursing] is intimate because you are dealing with people's bodies and that's the most – that's personal space. We're dealing with health information which can be

embarrassing. So yes, it's very intimate. It's very special, sacred stuff.

Jill used "intimacy" to mean different things in different contexts. Initially, she hesitated when I asked her if she thought nursing work is intimate, likely because she defined intimacy in terms of personal relationships and sexuality, rather than work. She quickly reconsidered when she framed the idea of intimacy in what she imagined to be her patient's experience of nursing care.

Many nurses told me that they never thought that their work was intimate until they thought about it from their patients' point of view. When I asked Lori, a new nurse, if care was intimate, she explained that it was not intimate to her but it could be for the patient. She said,

It's not intimate, but you have to respect the patient, and you have to respect their privacy. And that's the intimate part of our job, but at the same time I don't think it's intimate. And if the patient has been in the hospital before, they know about it [lack of privacy]. If not, you know, they're a little more private. In that way it is intimate.

Individuals respect the privacy of others in their homes and in their neighborhoods. In public we might step away from what we perceive to be a private conversation between two individuals and when we do so, we assume that the individuals know each other well. The act of respecting privacy is usually reserved for the private realm. Respect of privacy is an act of labor that considers intimate interactions from the patient's perspective. It helps to distinguish professional intimacy from other intimacies and, also, from other professional labors.

Keeping the patients' perspectives first and foremost in mind may seem an obvious act in professional care work but it was often what seemed most obvious that was most invisible; what nurses could not articulate (Zerubal 2005). Unlike other professional labors in nursing,

professional intimacy is effective when it is understated. It is sometimes *not* talking, not acknowledging familiarity. Mary agreed that nursing care was intimate in the ways that it was subtle. She said,

You are sharing something with the patients that nobody else gets to see. You're caring for them when they are in excruciating pain. I think that is most intimate because people do not want others to see them at their lowest point. And it's so funny, that's why even when you care for people if you see them out often you will not really talk. Because you see them at a time that no one wants to acknowledge that you saw. I took care of an employee here. He appreciated the care, talked wrote a nice note. But afterwards he would not acknowledge me at all. And I would think does he just not see me. But it is because I took care of him at his lowest point.

In the hospital, professional intimacy required nurses to keep painful and other intense interactions muted to preserve the dignity of patients and family members. Yet this exacerbated the invisibility of professional care labor. The needs and desires of patients changed during their hospital stay. Nurses constantly re-framed intimate conditions to best care for their patients, even when it deemphasized their labor.

3.1.4 Trust in Professional Intimacy

Quality care of patients requires that patients trust their nurses. Professional intimacy fosters this trust. Unlike personal intimacies, trust between patients and nurses does not occur naturally. Patients and family members are scared when they first enter the hospital. Patients wear hospital gowns that sometimes do not cover their entire bodies. They feel physical pain and mixed

emotions – fear, anxiety, depression, and hope. At times, they have no control over their bodies or emotions. Nurses know that patients feel emotionally and physically exposed.

In my study, nurses expressed their sympathy with the fears and vulnerabilities that prompted patients to need to feel close to them. Carey, a new nurse in coronary care, described how she reassured a patient who felt fearful about his heart surgery the next morning. In addition to explaining the procedures and processes that he could expect, Carey said she also “stayed with him and massaged the back of his hand.” She told me, “You can’t really say he’s going to be fine because you don’t really know that. So I just stay there and let them [patients in general] talk and let them talk about all their fears and get it all out.”

Intimate situations, such as touching bodies, also provided a way for nurses to consistently reassure their patients. Anna, a new nurse, explained how she used professional intimacy to provide reassurance and establish trust. When I asked Anna if nursing is intimate, she responded, “Yes, because you are touching bodies and I know this is private. This is why I reassure them, because caring for them is intimate. I want to make them comfortable.” Jason also explained this connection, “And I think your intimacy grows as they trust you. And trust is a huge word, you know. There are some patients who trust these three nurses to do this particular painful procedure. Someone else comes in, they could be even better [have greater technical skill] but it doesn’t matter. They don’t have a rapport.” Reassurance from a familiar nurse could make a private, embarrassing situation more comfortable.

Although nurses maintain a routine to keep their work organized and efficient, they constantly shifted this routine to prioritize the needs of patients. Educators do not necessarily encourage nurses to share their routines with patients. Although patients consistently asked her when she would return to them, Carey told me she learned to avoid telling patients when she

planned to go back to their rooms. “And that was something we learned in nursing school. Don’t give them a timeline. Don’t say, “I’ll be back in five minutes.” Guaranteed they are looking at their watch, and at five minutes they’ll be on the call light.” Although this might save them time and potential conflict with patients, experienced nurses disagreed with this advice. They felt that this accountability to patients fostered closeness and trust. When I asked Mary, an experienced nurse, if she informed patients of her routine, she replied,

I do. I know when patients are in pain I have to go down the hall to get their meds and then back up the hall to bring it back. That time frame is so long to them. So I do, I try to make a point of letting my patient know that I am taking a little longer and I will be in as soon as I can. This is how I show care. I am considering their feelings.

Professional intimacy required nurses to take time to inform their patients of any deviations in their routine or “plan for the night,” telling patients that they were having a busy shift and apologizing for not seeing them sooner. This demonstrated their care for each patient and prevented patients from feeling neglected. They rushed to meet their patients’ needs, sympathized with their patients, and encouraged patients and family members to talk about themselves to gain their trust. Nurses saw trust as critical to patient care. Angie, an experienced nurse, described the relationship between trust, time, and healing:

And when they call me I really try to get there as soon as I can because I don’t want to lose their trust. By the afternoon if I don’t come quickly, they’ll say, “Oh how come she doesn’t come? She said she’d come.” I try to keep my promise to my patients. And I find that it is this trust. The patients know that when they call me, when they want to go back to bed, they call me and I’ll be right there or I’ll

send someone right there. And that trust that really helps. If nobody came, they wouldn't want to get up out of bed again.

Angie knew that healing required her patients to become ambulatory. Negotiating their movement required her to create a pact or a “promise” to patients. Whether patients would move after a painful experience depended on whether they trusted their nurses. Nurses knew that because patients depended on their nurses, they needed to believe them and they needed to believe *in* them. Experienced nurses, like Angie, learned that trust is fluid. While trust contributed to the speed and ease of healing, nurses could lose or gain trust at any time.

Professional intimacy requires attention to patients beyond medical and physical care. In my study, patients paid attention to the frequency that nurses entered and left their rooms. They usually knew when their medications were due. They often watched the clock closely, keeping track of time. They noticed their nurses' facial expressions. Mary described an interaction with a patient, “She [the patient] noticed I was focused, I was truly focused on doing something else in another room, and I came into the room and I had to do a task, maybe hang a patient IV and [the patient] said, ‘What is wrong? Are you mad at me?’ It was because I was focused on something else. It was my facial expression.” Nurses who were professionally intimate with their patients knew that patients, who felt needy scrutinized nurses' words, touch, tone, and body expression. They worked hard to account for their behaviors, personal expressions, and changes in their and other staff members' routines.

Many nurses – both new and experienced – discussed the importance of taking time first thing in the morning to “set the day right.” To “set the day right” meant that a nurse would approach each patient cheerfully, say good morning, introduce her or himself and ask how the patient is doing. Trixie, a new nurse, told me, “That's why when I go and see them in the

morning, like I have a conversation with them and see, and try and build, even if it's little, you know something. So that, you know, instead of just going in there and just like, 'OK here's your meds. OK, bye.' [Laughs]." Elizabeth, an experienced nurse, explained, "I start when you go in and introduce yourself. Right from the get-go I try to ask them basic need things. 'What can I do to make you feel more comfortable at the moment? Do you need a drink of water? Do you need a blanket? Would you like a wash cloth to wash your face?' It is the simplest little things." Attending to the "simple things" helped nurses ease into what they knew was a private moment for the patient. It also built confidence in their care. Mary, another experienced nurse, considered families when she provided what many nurses called "basic care."

Nobody wants to see their loved one soiled. That says to them that you don't care; the little, basic, daily needs. It's the little things they notice, not the big things – that they are getting all their medications – how are they situated in bed? Are they clean? Is their mouth clean? It's all those little things that tell the families that you care.

During their exchanges with patients, nurses took note of physical and medical matters such as breathing, facial expressions (to assess pain), skin coloring, and warmth of skin. While nurses were also conducting medical assessments the patients only saw expressions of concern. "Setting the day right" helped build trust and confidence and helped ensure that overall care progressed without difficulty.

The work of establishing trust includes ensuring that patients develop confidence in their nurses. Nurses know they need to act with confidence so patients felt safe, even if they feel insecure. Carey, a new nurse, considered the importance of patients having confidence in her. She told me that it was her job to be sure that patients "know they're safe and that people care

about them and won't hurt them." Speaking as if she was a patient, she added, "If they care about me, then I think I can trust them, I don't think they would lie to me or mislead me." When they perceive nurses to be competent, patients feel secure and are open to a professionally intimate relationship with their nurses. Many nurses discussed the importance of a neat appearance and skillful presentation to develop rapport with their patients. Brett, a nurse with five years experience, asserted, "Anything that looks like you're incompetent will destroy the intimacy between you and your patient." Nurses needed to professionally achieve intimacy with their patients to present a competent self that would simultaneously sustain familiarity and professional trust.

3.1.4.1 Gender, Sexuality, and Trust

Gender affects trust. Normative masculine stereotypes suggest male nurses cannot be invested in giving good care. Academic literature suggests that men enter female dominated occupations either for quicker advancement or as a fallback when they fail to secure male dominated occupations (Williams 1995; 1993). On the contrary, the men in my study said they became nurses because they valued the importance of care and wanted to help people. As Roy, a male charge nurse, explained,

I have no regrets of being a nurse. I get satisfaction out of making people feel better. You know it's rewarding. You know it's always nice when patients come back after having surgery and stuff and say hi and give you a card, a thank you card. It kind of makes you feel like a hero for that short time, you know. It's kind of neat.

Like Roy, nine of the ten male nurses chose nursing because they wanted to be in a helping profession. The remaining male nurse said that he later realized that in addition to good

pay and hours, nursing left him feeling personally satisfied because his work made a difference in people's lives. Male nurses not only enjoyed the caring components of their work, they also wanted to do it well.

I observed male nurses provide gentle, thoughtful, compassionate care to patients and families on a regular basis. Like their female colleagues, and contrary to stereotypes about masculinity, male nurses handled physically and emotionally intimate or potentially intimate encounters with ease, such as rubbing lotion on patients' body parts, holding a family member's shoulders while they grieved, and patiently listening to descriptions about bowel movements. Moreover, when bodily contact was necessary, male nurses discussed how they felt a greater imperative to be more sensitive and cautious than female nurses. They used quick and precise movements because slow movements might have been perceived as lingering. They demonstrated concern through kind words and compassionate facial expressions.

Male nurses were also conscientious about care, often anticipating needs before patients and family members asked. For example, one evening I observed an elderly female patient in Tom's care express a fear of needles and "getting stuck by more people." She was slightly disoriented and anxious. To prevent additional stress, Tom asked a lab technician to check with the unit secretary to see if there were additional orders for blood work before he drew blood from his patient. This way, Tom told me, his patient was only stuck once. In another example, a patient care technician grabbed Tom to say that an elderly female patient's oxygen level was low. When the tech left to get a machine to assist with breathing, Tom calmly observed the patient. He noticed that she was not panicking and her demeanor was calm. He considered her negative MRI and angiogram results. After a minute, Tom simply moved the tube from the patient's nose to her mouth. The patient's oxygen level returned to normal. "She is a mouth

breather,” Tom told me as he ordered a mask to cover her entire face.

Brett explained how nurses knew that patients who felt comfortable with them will trust them more easily and care will proceed more smoothly. He said, “There is an intimate relationship when you’re caring for a patient. When I say that I mean that there’s a sense of compassion and trust but if you feel disconnected from patients then you’ll be providing care that’s not really, not necessarily bad, but not necessarily the best, maybe more mediocre.”

Despite their skills and professional demeanor, male nurses feared that patients and family members could misunderstand their efforts at professional intimacy. Masculine intimacy – especially in professional settings – is often socially coded as violent, aggressive, or simply inappropriate. Tom explained, “It’s harder for males because, this day and age, people touching other people inappropriately. Oh, I wear gloves all the time. You have to kind of be sterile and let them know that it’s a procedure.” Roy echoed Tom’s sentiments to explain his fears that female patients would misread his professional intimacy as inappropriate sexual behavior.

It’s scary. It’s scary being a man. I don’t know how the women feel, but it is scary being a man in this field because, you know, being with female patients and stuff. You know, being alone in the room, it is kind of freaky. I know a [male] nurse, just recently, had a complaint. A lady patient came in to the ER and she was like totally drunk and they had to restrain her. And she complained that the charge nurse touched her inappropriately and stuff like that. You know, it’s like, geez, you know, anything like that could happen.

Due to masculine and feminine stereotypes of care, nurturing, touch, and intimacy, male nurses sometimes chose to compromise professional intimacy and err on the side of providing standard or what I call “sterile” care. This solved the problem in the short run and may have prevented

uncomfortable feelings, but the professional distance resulted from “sterile care” did not afford the same benefits of professional intimacy.

Many times female patients, especially older female patients, refused male nurses outright. Sometimes male nurses sensed that female patients were uncomfortable with them. In these cases it was easier to give a patient a female nurse than to address deeply held beliefs and or fears. Reassigning patients and nurses was a strategy that nurses used to deal with difficult and awkward situations. Roy explained, “We get little old ladies and I got to flip up their gown or give them a bath and it kind of freaks them out. They’re a little uncomfortable. I’ll go get a female. It’s all part of team work.” Nurses incorporated reassignment into the team work of the unit. It met the immediate desires of the patient but required the new nurse to establish professional intimacy.

When masculine intimacy is not assumed a threat, it is assumed abnormally feminine or, in other words, gay. Regardless of one’s sexual orientation, feminine behavior from men is often perceived by others as gay (Pharr 1988). Since nursing is considered inherently feminine, it is a common stereotype that male nurses must be gay. Nick, a male nurse confirmed this stereotype. He said, “And I get that, too. That’s another misconception, actually. People, they think males that come into the nursing profession are gay.” Indeed, questions of sexual orientation played an important role in, borrowing from Judith Butler (2004), the “undoing” of gender for male nurses. All male nurses I interviewed commented on the regularity with which their sexual orientation was questioned – both overtly and covertly – by patients and their families who inquired about their marital status and children.

Male nurses experienced questions about their sexual orientation from colleagues too. Brett explained how other nurses asked similar questions about his sexuality.

Yes, I think they [other nurses] do in a very subtle way. They'll start kind of pulling information from me. 'Are you married? Do you have a girlfriend? Any kids?' And when I first started here, nurses had assigned someone to try to kind of pull some information from me."

These examples demonstrated the relationship between the assumption of gay sexual orientation, masculinity, and professional intimacy. Like Tom and Brett, male nurses were not necessarily heterosexist, but because they were men in a normatively feminine profession, they experienced – and then named – this subtle, yet false, connection between professional intimacy, gender, and sexual orientation.

Male nurses responded to these comments in various ways depending on the situation and on the patient – but always in a way to build trust with the patient. Often male nurses confirmed they were married because they knew it increased the comfort level of their patients. Sometimes, especially with older female patients, male nurses purposefully acted more feminine. For example, when giving patients baths, Jared took great care in acting what he called "neutral." He avoided gruff language and vocal tones. While his voice was not effeminate, it was soft – softer than when he spoke in the nurses' station or when he interviewed with me. I observed Jason "playing up his feminine side" with patients he knew or assumed to be gay. He purposefully acted more effeminate. Bill told me that *he* was comfortable knowing that his gay patients might assume he too was gay and patient comfort was his primary goal.

Male nurses were in a bind. They worked hard to disentangle the ways that others conflated gender with sexuality in the process of care. They worked differently – some argue harder - to prove they were caring – intimate - in a way that was not sexualized – gay or straight. Male nurses demonstrated that care coded masculine can be safe but only when provided in a

way that cannot be perceived as sexual. They needed to be hyper caring – yet professional – in their intimacy.

Ideologies and practices regarding sexuality also mattered to the process of professional intimacy, not just to the perception of one's individual identity. When nurses felt uncomfortable caring for same sex partners, the process of professional care was diluted. Partners of gay patients did not receive the same attention and information as heterosexual spouses. Even empathetic nurses felt limited in the scope of their care because of concern for their patient's privacy. They avoided "outing" the patient if the patient or partner did not disclose their relationship. They hoped to preserve as much dignity and comfort to their patient as they could. Nonetheless, this sensitivity still meant that same sex couples might not receive optimum care. Nadine explains,

Same sex couples become more of an issue than race or religion because you can't tell, sometimes it's harder. You might walk in that situation and not realize it. Sometimes the significant other is there and sometimes she is a "friend." You can't always tell. And then how do you deal with the privacy and confidentiality? You don't know how to approach that person. Husband-wife, you know you can share information, it's much easier. But if they disclose themselves as a friend you have to treat them as such. And they are very cautious, too, about how they present themselves until you let them know that you are ok with it. It is a delicate line. You want to let them know that you are ok, but they say "friend" and never "partner" and you want to respect their privacy. When they say, "This is my friend" that automatically puts them in another position. It gives them no power to know any information, medical information. And certain nurses are not

comfortable at all. So they will not go out of their way to make that person feel at home, part of the care and that person is very much a part of the care, when they go home they are going to be the ones caring for that person and they don't get the same information.

Nadine was extremely sensitive to the plight of same sex partners but her hands were tied because heterosexist norms interfered with optimal professional intimacy. Nurses uncomfortable with gay and lesbian partners could not obtain the same personal information from their patients as they could from patients with whom they were more comfortable. The opposite was also true. Even sympathetic nurses did not connect with gay and lesbian patients because these patients did not feel safe disclosing their sexual orientation. Yet, nurses needed to feel connected to their patients in order to engage in professional intimacy necessary for quality care.

3.1.4.2 Race, Nationality, and Trust

Race and nationality affects trust. When I asked Bill, a white nurse, about the ways that race affects care; he discussed how whiteness informs the trust process for white patients. He said, "You know, I think the white race is the least threatening of people, and that you can come across as very neutral, and I think it does help you in some respects with some people." Asserting that whiteness is safe implies that nurses of color are dangerous, which reinforces racist stereotypes and affects how white patients interact with nurses of color. Moreover, by not specifying the race of patients, Bill generalized all patients to white patients, which privileged the perceptions of white patients over patients of color. Finally Bill suggested that white nurses are unbiased, which support both that professional labor should be unemotional and that white nurses are more professional than nurses of color.

White nurses were less comfortable with their competence when I asked about patients of

color. Nadine, a white nurse, discussed her relationships with patients of color. “I don’t know how they see me. I think they might not interact with me as quickly as they would with their own race.” Jody, a white experienced nurse, agreed that patients of color may feel more comfortable with nurses of color. She said, “I wonder how much some of these black patients like us taking care of them. Quite frankly, I think they would prefer somebody within their own race.”

Male and female nurses of all races contended that some complaints about bad nursing care were rooted distrust from racist and xenophobic attitudes. Tammy and Patsy, both experienced white nurses, described how patients falsely complained to nurse supervisors as a way to refuse care from women of color. Tammy explained, “I’ve worked with black nurses that had patients that were really, really racist, and one patient actually wrote a letter to the nursing director. And it was totally a racist situation, but everybody knew that.” When I asked Patsy how she knew that patients’ actions were racist, she replied,

They’ll request another nurse. And then others will make remarks. You know, they’re passive-aggressive, saying, “She didn’t do a very good job,” or “She didn’t seem to know what she was talking about.” And I know that they [nurses in question] know. But because they [nurses] have an accent, they’re [patients] not willing to get the idea across to them.

As Tammy’s and Patsy’s statements illustrated, nurses noticed covert or “passive aggressive” racism and xenophobia from patients even when it did not affect them directly. Sonia, a white nurse, described patients’ relief when she entered their rooms after a Chinese nurse cared for them. She described how patients of nurses with different accents complained to her about their care. She said, “I think people do not respond as well to foreign nurses because culturally they are different.” That all nurses who work in the U.S. must demonstrate standard

knowledge of nursing through the required licensure and examinations and many countries adopted their training from U.S. models further suggests that patients are responding from fear of cultural difference, rather than actual bad care (Choy 2003; Takahashi 2004).

Patients who inquired about the race of nurses or who outright refused nurses who were not white also evidence racialized distrust. Charge nurses, team leaders, transport nurses, and other nurses who saw patients first described how patients asked about race. Roy told me,

We do have patients that are racist, “Make sure it’s not a black nurse.” Or, you know, “Is the nurse white?” You’re kind of like, “wow.” But if they absolutely don’t want a black nurse, you got to change it. I just wouldn’t know how else to – I could tell the patient that she’s very good, or this and that, but if she doesn’t want a black nurse touching her, then you have to make the changes.

In an attempt to provide optimal professional intimacy, nurses complied with racist requests. Respecting the beliefs of patients and family members was central to professional intimacy. It was practically much easier to accommodate the patient and get someone else to take care of that patient than to argue on behalf of a nurse. Moreover, these actions demonstrate that ways that professional intimacy is constructed by race, nationality, sexuality, and gender as well as how it reinforces existing forms of structural and social inequalities.

Nurses noticed that race, nationality, and language affected negotiations of trust with their patients. Female nurses of color consistently heard questions about their race, accent, language, and country of origin. Lydia, an Indian nurse, told me, “There are sometimes I get comments like, where are you from? Do you speak English? Is there anyone around here that is American and that speaks English?” Patients’ questions ranged from innocent, conversational, and distrusting. Female nurses of color knew when patients were uncomfortable with them as

nurses. They sensed when patients distrusted them. Mia, a Filipina nurse, explained,

When I would go into a room and I would introduce myself, and then the patient, maybe a white, older lady would say, “Well, where are you from?” And I could see that she was uncomfortable. I felt it. They say some stuff that you know it is because of your race, because it is a trust issue.

Black and Latina nurses felt their race and ethnicity afforded them opportunities to care for underserved patients and family members. An African American nurse, Carey, told me she felt the presence of her darker skin tone most with Latina and Black patients and family members who responded to her, pulled her in their rooms, brightened up when they saw her, and generally seemed more relaxed in her presence. She described a situation that involved a Latino patient who reached out to her. The patient was assigned to a white, experienced nurse. He was bleeding and did not use the call light. She was down the hall on the other side of the unit when she noticed that family members sought her out. She stated,

They kept coming out of the room looking for someone to talk to, you can tell that look. They were searching and looking. He saw me and he came over and said, “Come help us. Come help us” and I said, “No habla Espanola” and then one of them said, “Help my friend. Help my friend.” And I knew his nurse would help but I think they just become so distrusting. I think they look for a brown face, a friendly face, you know, “We can trust this person.”

Carey knew her skin color afforded her trust with this family. Moreover, even though the charge nurse had not assigned her this family; she went out of her way to respond to them. Female nurses of color discussed how they felt called to help patients of color because they believed a nurse who “looked like them” would make them feel more comfortable.

Mary, an African American nurse, described a special connection with an African-American female patient. “And this one lady said to me ‘nothing against the other nurses but you take care of me differently.’ She was a black woman talking to another black woman. It means so much more.” Similarly, Carey, an African American nurse, described a connection she felt with an African American diabetic patient. Nurses reported him as “difficult” the entire two days he was on the unit because he would not talk to anybody or smile. She explained why he became more positive when she entered the room. She said, “He’s trusting, because he sees someone that looks like him and then he was scared. He was thinking they were going to cut his leg all the way up and he felt that they didn’t even care. And a lot of older black men feel that way. They’ll cut this off and cut that off but they don’t care about me as a person.” In a society structured in part by race, trust manifested through similar skin tones. The fact that this patient only spoke to Carey or that Mary’s patient connected to her as another black woman exemplified that race and skin tone mattered deeply to a patient’s sense of safety and security.

English-speaking nurses were concerned that Spanish-speaking patients trusted them less than they did Spanish-speaking nurses and thus could not provide the same care as Spanish-speaking nurses. Nadine, an English-speaking nurse explained,

We have a Hispanic population and I can’t speak Spanish worth crap. So a lot of times, I’ll call a Spanish interpreter and I definitely feel like it’s not fair because they can’t speak the language and they don’t want to ask questions. And they definitely feel more comfortable with someone of a Hispanic race. We have a tech, she goes in there and they talk a mile a minute. When I go in there they don’t talk very much.

Nadine knew that Spanish-speaking patients interacted with her differently because she

spoke only English. She regretted that her patients asked her fewer questions and spoke to her less than they did with Spanish-Speaking nurses. Another English-speaking nurse, Helen, expressed concerns about language but, unlike Nadine, she admitted that she does not give extra care.

And if I have a Spanish speaking patient, and the family doesn't stay at night, I can't say I don't give good care, because they will always get their medications. If they can communicate that they need something to drink or eat, they will get it. But do I go extra? No. I can't communicate with them. So they probably see me hardly at all at night.

Both nurses acknowledged that sharing the same language with your patients is critical to professional intimacy. Helen distinguished between good care and "going extra." As a professional, she provided good care to all her patients; yet, she also acknowledged that she failed to "go extra" with patients who did not speak English. But the labor of "going extra" built closeness and intimacy, that led to better care. Celia, also English-speaking, explained how she spent less time with Spanish speaking patients. She said, "I don't speak Spanish, I don't spend as much time with them, I can't educate them because I speak English." Like other nurses, Celia was explicit about the ways that language barriers negatively affect quality care. Simply put, speaking patients' language increased professional intimacy which improved the quality of patient care.

Spanish-speaking nurses often spoke Spanish with Spanish-speaking patients as a way to connect with them and to foster professional intimacy. Alicia, a Mexican-American nurse, told me she felt a special connection with a young Mexican man new to the U.S.

I went in there and I asked if they explained to him that his toe would be

amputated. And he said, “Not really.” I told him what to expect. He asked me for my phone number. He said, “I don’t really know a lot of people here.” And I said, “I am so sorry, I am not allowed. I could get in trouble.” He didn’t understand. I honestly think he was scared. He only had his uncle.

Competent, full-time, paid translators were available for nurses to use at any time at this hospital. The translation office was on the first floor of the hospital, designated to serve all medical units. Three or four translators were usually available for consult at any given time. To request a translator, nurses on each unit stopped their work to make a phone call. I observed nurses use a formal translator on occasion, usually for a new patient intake. Typically, however, most translation needs were spontaneous, unplanned interactions. It was simply more efficient to ask nurses (and patient care technicians) who were known on the floor as Spanish-speakers to stop what they were doing to perform translation. More experienced nurses who were accustomed to this routine volunteered to perform translation, but newer nurses who “looked Latina” were also asked to translate.

“Looking Latina” was reduced to skin tone. Not all Latina nurses got asked to translate immediately. Alicia, a new Latina nurse, had a pronounced Mexican accent and a light skin tone. For two months, none of Alicia’s colleagues knew that she spoke Spanish. She described a family member who thought the unit secretary spoke Spanish because she had dark skin. The family member was very surprised to learn that Alicia spoke Spanish fluently. He focused entirely on her skin tone. She described,

I’ve only been there a couple of months, since October. So they are getting to know me, and a lot of them don’t realize that I speak Spanish. So they call a translator, which is fine with me because I am busy with my patients, but, now

that they know, they go and get me. A lot of them are surprised. They say, “You speak Spanish too?” I know I have an accent! I know I do! A family member came in and started talking Spanish to the secretary. The secretary was dark-skinned with Spanish features but spoke absolutely no Spanish and instead of looking at me she started looking at her and she was like, “I don’t speak Spanish.” And I said, “How can I help you?” And she said, “Oh my God! I would’ve thought she spoke Spanish and you were white!” And I said, “Yeah it’s funny, huh.”

Alicia explained to this family member, as she later did to me, that most people assumed that she was white and therefore could not speak Spanish. After observing the difficulties that arose on the floor due to language barriers, she began to offer her help. She soon became overwhelmed.

I get frustrated. I do. They don’t pay us extra for speaking Spanish. I thought they would. They don’t. When I have time I don’t mind, but when I’m that busy and they don’t care... For a while they would just volunteer me! Somebody would be speaking Spanish, and she [a nurse] would call me away from my work so that I could pick up the phone. I get so frustrated. Transfer the call or do something. Don’t take me away from my patient. This is your job.

Latina, Spanish-speaking nurses reported more mixed feelings about translation. They enjoyed translation because they knew that although it made Spanish-speaking patients and family members feel more comfortable and increased professional intimacy, leading to better care, it also required extra labor that did not get counted on an already busy shift. Anna, a young and new Latina nurse, was frequently asked to translate for patients and their family members.

Like other nurses, Anna wanted Spanish-speaking patients because she knew it comforted them to have a Spanish-speaking nurse, but was concerned about how often she would “get pulled” to other nurses’ rooms to translate.

I get pulled a lot. And I feel that sometimes I don’t get my work done, and I just have to tell them, “Look, I’m, I’m so sorry, but I have my work to do.” And, and I just wonder sometimes, why didn’t they give them to me in the first place?

Anna’s frustration was exacerbated when another nurse asked her to translate when the paid translator was already there. Her frustration lessened slightly when she realized she was communicating more successfully with the patient than the paid translator since she understood the patient’s dialect and slang. She told me, “So he understood me and was asking me questions. And I don’t know if the other translator was getting mad. So that’s another thing. I’m pretty good at it, especially medical stuff, I’m good at it. I’m pretty good at translating.”

Not only did Anna know that she was good, she saw herself as “one of the translators” when she referred to the possibility that the “*other*” translator was getting mad. She identified her skill – translating difficult and complicated medical jargon into a particular Spanish dialect. Although she used this skill at work regularly, she was neither recognized nor compensated for it. Since hospitals often need immediate translation – the kind that cannot wait for a translator to be summoned from another floor – nurses like Anna were regularly expected to meet this need. Hospitals reap benefits from this form of convenient and unpaid translation, such as better and more efficient communication, increased trust, and the saved expense of formal translators.

3.2 THE ROLE OF PATIENTS AND FAMILIES

Patients and family members contributed to the establishment of professional intimacy by seeking an intimate environment to feel safe. They drew on their own understandings of nursing to ease their tensions and fears. Patients and family members disclosed personal information about themselves to nurses as a way to ensure a connection. They talked about their families, their past loves, their troubles at home, and how they became ill. They discussed their hobbies and favorite television shows. They shared their views on spirituality and their fears about death. Patients and family members talked to me, too. One patient's wife took me aside while the nurse assessed her husband and began to talk to me about how she and her husband met and fell in love. I knew she shared their love story as a way to cope with her fears about her husband's illness.

Many patients asked nurses personal questions during the course of professional intimacy. Questions ranged from benign to extremely personal. Patients and family members commented on nurses' choices of uniform, earrings, or hairstyle. They also asked nurses about their personal experiences with illness, their married lives, and children. Nurses responded to these questions in a variety of ways. Nurses knew when patients felt vulnerable and kept this in mind when they were asked about their private, personal lives. Some nurses provided brief answers, some ignored the question and redirected the conversation, and some disclosed quite a bit of information about themselves. Nurses with common experiences with patients disclosed more information about themselves than if their views or experiences differed from those of patients. Nurses knew that disclosing information about themselves to make them seem similar to patients was one way to connect with them, to build trust, and to help patients feel at ease. Nadine provided an example, "If I notice that they [my patients] were in the military, I will share

that my dad was in the military.” Disclosing personal and family information was something that nurses did to make patients comfortable.

Nurses provided less information about themselves when their experiences or backgrounds differed from patients because professionally intimate interactions and circumstances depend on the ways that nurses are perceived according to gender, sexuality, race, and nationality. Male nurses and female nurses of color in particular negotiated the ways that patients and family members perceived them to ensure trust and rapport with their patients and to build professional intimacy.

Nurses provided care to families because they believed it increased the comfort level of patients during their hospital stay. I asked nurses how they worked with families to ensure quality care. Many referred me to the hospital’s patient advocacy program (PAL) that permits family members to help meet their patient’s needs. Jason explained to how he works with family under PAL.

With the PAL program I believe we tell them, “This is what you’re able to do. You can go get linen, you can get water.” And basically tell them they’re welcome to do this, but letting them know that we’re also more than willing to do it. We give them options and let them choose.

The PAL program did not ease the amount of labor for nurses – indeed, it likely added to it – but the program helped ensure quality care and patient satisfaction because it involved families in care.

Although the PAL program was a hospital-wide project, I most often observed and heard nurses describe how they work with families outside of PAL. For example, Jill explained how her ethics of care extended to families. She described working with families by being honest and

open.

I am factual, honest, ease up the mood, I just deal with families the best way that I can. I answer their questions. It's kind of like case by case. Depending on the person and what their needs are and what they want you to do for their patient. Oh definitely, I take care of them and it's also a team. Families expect something from the doctor, the nurse. You all have to work together to get it right so that everyone is feeling comfortable.

Nurses told me that working with families was necessary to ensure that patients received quality care. They imagined how they would feel if they had family in the hospital. Josie explained that she involved families in care.

I think they're part of the healing process for the patient. Their family's going to get them through everything. And why shouldn't they be involved? If my mother was in the hospital I would be involved in everything. So, yeah, you know, it's something I would like to do. I'm not against it in anyway, unless the patient doesn't want them involved.

Sometimes nurses disagreed with patients' family members on how to best care for the patient. I observed Helen reassure a patient dying from AIDS. His family refused hospice care and he was nervous about going home with his parents. When she asked him why he was nervous, he told her he did not think his mother could take care of him. She said, "Are you fighting [the disease] for your mom and dad because you don't have the fight in you?" The patient burst into tears and said, "You are right I don't, I don't want to do this anymore." She said, "I know your family refused hospice and I don't want to step on any toes but there are alternative programs with hospice. It doesn't mean end of life." After this conversation, the

patient asked for information on counseling programs. Although Helen explained hospice programs, including outreach programs for his family, she only noted the hospice referral in the patient's chart. There was no place to recognize her counseling labor.

Helen identified and considered the family's needs in her care work, but she ultimately prioritized the needs of her patient. Nurses skillfully negotiated the needs of patients with the needs and demands of families and doctor's orders. Helen risked intimacy with her patient to ensure that he was getting the best care. She opted for familiarity, sitting next to him in his bed and gently but firmly discussing how his family's grief and fears might be interfering with his care. Helen's care extended beyond basic care. In addition to providing medical care and ensuring her patient was physically comfortable, she assessed how and when she could approach an intimate matter – the balance of her patient's well being with that of his family. Jason also explained how and when he prioritizes patients and families needs, strategically sharing his knowledge in a way that maintains the agency of patients.

I give family choice and I go over what I think should be done, but the patient is ultimately the boss. If it's [sic] a confused patient or a minor, it's going to be the family who makes the decision. So you can't just cut them off. But I think it's very important to give the patient choices, give them the final decision.

Even when patients were unable to make the final decision over care, Jason found ways to preserve their dignity. One way was to consider how and when he offered choices to patients, such as how to take medication (via pill or liquid). Jason also simultaneously valued patients and families and shifted his attention accordingly to preserve their agency.

Although including families in direct care contributed to healing, nurses rarely had extra time to assess whether or not families wanted to participate in direct care, demonstrate the

specific care routines they used during illness and injury, and monitor family involvement. Chrissy explained, “If the family member is willing to do it, then we have to show them how. If it’s back surgery, we’ll teach them proper routine so they don’t injure themselves or the patient. Then we watch them to be sure we’re comfortable that they are doing it right.” Josie expressed frustration because, “it’s so hard to find the time. I don’t know when I will do a specific thing with a patient and then I have to make sure that the family’s going to be there. If they’re there, yeah, I tell them [what I’m doing]. But do I go out of my way to find them and make sure they’re a part of it? No. I just don’t have the time.”

3.3 CONCLUSIONS

Quality nursing requires professional intimacy. Nurses work in and around “intimate settings” and with patients and family members who have “intimate ties” to each other (Zelizer 2005). Nurses alleviate patients’ fears by building trust and familiarity through strategic interactions with patients and family members. Defining professional intimacy from the perspective of the patient, providing consistent reassurances, addressing disclosures and biases, and balancing individual needs against a turbulent work environment necessitates skill, strategy, time, and practice. Although a critical part of nursing care, it is invisible labor; not all new nurses know that intimacy will be part of their work.

Professional intimacy challenges dichotomous framings of nursing, that it is either professional or nurturing, labor or love, skill or nature, and altruistic or paid. Naming this work “professional intimacy” demonstrates that nursing is all of these things and that professional

intimacy is dialectic; a tension produced from the need for and the result of intimacy in professional work. Professional intimacy results from and affects care interactions between nurses, patients, and family members. These exchanges are affected by the intersections of race, gender, sexuality, and nationality. Depending on identities of individuals involved, these interactions both reinforce and challenge dominant ideologies that care occurs naturally, people are either inherently caring or they are not, and altruism is a pleasant experience. But care work in nursing is not a natural process; it requires specialized knowledge and experience. Moreover, people successfully do care work whether or not they consider themselves inherently caring individuals, and altruistic interactions sometimes result in conflict.

4.0 CONFLICTS IN PROFESSIONAL INTIMACY

In chapter three, I show how professional intimacy relaxes emotional, physical, and sexual boundaries between nurses and patients. In this chapter, I explore the conflict that emerges as part of professional intimacy due to relaxed boundaries and, also, because the trust they develop with nurses makes patients feel entitled to constant care. In general, professional labor is defined through maintaining emotional, physical, and sexual boundaries, for example, formal policies that prohibit physical and sexual interactions in professional work. Professional workers also maintain boundaries at work by caring for clients publicly while keeping their own emotions private. Yet, in nursing, the development of professional intimacy requires nurses to encourage familiarity and trust with their patients. Relaxed boundaries and a sense of entitlement sometimes encourage patients to express anger and sexual desire toward nurses. As a result, nurses feel discomfort, tension, and that they are harmed.

4.1 ENTITLEMENT TO SERVICE

As a result of developing a sense of familiarity and trust with their nurses, some patients feel entitled to attention and service from them. Patients view special and extra food and drink, extra blankets, extra attention, and other acts of service by nurses as acts of caring, which contributes to their feelings that they are entitled – as hospital patients– to constant satisfaction and comfort.

Patients and family members also conflate care and service when they describe their hospital experiences; for example, they acknowledge acts of service, such as getting special food, more than they do medical care or technical expertise in patient satisfaction reports.

Nurses have a different perspective. Although nurses do not consider service in their scope of care practice, they provide service because their patients value these acts. Nurses also know that simple acts, such as giving warm blankets, make patients feel special and safe and also, build trust with them. Many nurses assert that, although it is not necessarily in their scope of practice, providing service to patients is central to providing care because patients expect service – the kind of service one might expect in a hotel or restaurant – while in the hospital. This results in a vicious cycle where nurses' responses to the demands of patients increased patients' sense of entitlement to service, care, and attention. Moreover, when patients did not feel satisfied by nursing care, they became frustrated, which resulted in conflict with their nurses.

In my study, patients sometimes expressed feelings of entitlement and frustration through verbal and physical confrontation. Jane expected this kind of conflict from patients; she explained that patients wanted to ensure that their needs were met.

I think it is part of their care. You never know why patients act the way they act.

You know, sometimes it can be something emotionally, and sometimes they can be ruder. I don't mind, because I think it's a need. I think they feel they need to have the hospital satisfy how they feel.

Nurses assume that patients would feel entitled to attention from them. As a result, they take responsibility for these needs and include them in their care of patients. But privately, they feel disrespected and frustrated when patients express inappropriate needs, make excessive demands, or manipulate them.

Some nurses express discomfort with what they feel is expressions of excessive and inappropriate gratitude from patients. For example, patients and family members gave nurses gifts like food, candy, and stuffed animals to thank them for their hospital experience. Some patients even offered extra money or “tips” to nurses for good care. Jody explained, “They just appreciate their care and they want to express it, but, you know, we already get paid [laughs].” While patients only intend to show gratitude, offering gifts and tips recognizes the relationships produced from professional intimacy, more than skilled labor required to produce it, although both are necessary for quality care.

Nurses also express discomfort with patients who make requests that, to them, seem beyond the scope of quality care. Depending on their circumstances, patients felt entitled to additional food, a longer stay in the hospital, increased medication, and increased attention. For example, patients sometimes complained about food preferences or the timing of their medications. Before each meal, dietary staff helped patients select their food choices. After patients received the meals, they complained to nurses, “Well I didn’t order this” and asked questions such as, “Well, what’s this?” “Can you get me skim milk?” “I want apple juice, not orange juice.” “This is too hot.” “This is too cold.” As Amy explained, “if patients didn’t get exactly what they wanted, or if it was hot or cold or whatever, all they had to do was call the nurse and you just kind of got the brunt of it.” When nurses perceived that patients had an unfair sense of entitlement to service, they became frustrated. Amy explained,

I don’t like... rude family members, demanding patients, patients who treat you as if you are a waitress or their housekeeper. It’s the tone of voice that they have. And then you have six patients, blood transfusions, this one needs pain medicine; you need to start an IV over here. I mean you’ve got other stuff going on that is

much more a priority than juice.

Nurses become frustrated when their professional labor is reduced to service, but they also react to the circumstances of their labor, which result in a constant time crunch – too much work to do in too little time. Nurses feel devalued when patients focus on service rather than their professional and medical expertise. Nurses become increasingly and understandably frustrated when they feel simultaneously devalued and overworked.

Nurses described how patients also expected them to take care of patients' family. Leah described feeling conflicted about a patient who expected the hospital to pay for her husband's meals.

One month ago, an American Indian who lived up north was transferred here because there was no hospital where she lived. Her husband had no place to stay so he stayed in the room with his wife. And she expected us to feed her husband. He didn't have any money or any place to go. See, we were caring for the patient and not the husband. But she expected us to serve the husband. When I was working one day she asked me if I could get her husband something to eat. I just said "I, we have a cafeteria. He can go downstairs and get some food but I cannot give him a tray." But then I said, "What I can do is give him an extra tray if no one needs it but I can't give him a tray every meal." Patients expect their family to be fed at the same time as them. And you just have to get the boundary there.

We will care for you but we can't care for your family.

In the beginning and the end of her quote, Leah said that service was not part of nursing. However, Leah also offered to get a plate for her patient's spouse if an extra tray was available. Even though Leah and other nurses insisted that service was not in their scope of practice, they

still practiced service to try to best meet the needs of their patients. In this sense, nurses negotiated requests for service as part of professional intimacy.

Nurses negotiate requests for service, but they also feel that their efforts are taken for granted. When I asked Josie if service was part of care, she said,

I do service. But does the patient know I have so many things to do that are more important? I think I've said, "I'm not a waitress. This isn't the Hilton." I need to make sure they're drinking, but do I need to make sure that they have the exact drink that they want and they desire on the floor at all times? I have to go out of my way to call dietary and make sure this drink comes up. Or I've gone down to a pop machine because they just insisted on a diet sprite.

Like Leah, Josie felt tension between providing service to patients and, also, resenting patients for requests that seemed unreasonable. Josie knew that meeting patients' requests for a particular food or drink extended outside her scope of practice, a practice that was already overburdened with paperwork, coordination activities, and care. She tried to meet these needs, however, because she, like most nurses, knew how patients valued this attention and strategically incorporated meeting these requests into her routine.

Although nurses are willing to serve patients, it is more difficult for nurses to alter their routine and approach with patients when patients are dishonest with them. Chrissy felt betrayed when she discovered a patient had lied to her about his food.

The way he was telling me, he was complaining of the food being so bad. We ordered another tray and he ate the first tray. Why in every meal [would you] complain about food and then eat both of them? At first you feel for them and you believe. Order another tray and another tray. And I realized then that he was lying

all along. I said, “God he is manipulative.”

Chrissy believed her patient when he complained that his food was spoiled, but soon realized that he was lying to her so that he could get more meals. She was frustrated because he wasted her time and the time of other staff members, but more so, because she needed him to honestly express his needs so that she can most effectively perform her job. Nurses depend on their patients to honestly communicate their needs. When they fail to communicate honestly, patients interrupt the potential for optimal professional intimacy and needlessly overwork their nurses.

Nurses’ feelings of disrespect are aggravated when patients seem impossible to satisfy. Celia explained that some patients and family members expected constant attention but were never satisfied.

The rude ones, overtly rude, who are overtly demanding; the ones who call every five minutes and no matter what you do you’re not going to make them happy; the family who thinks my whole purpose is to take care of their mom. You spend all of your time on this patient [so] that all the rest get neglected.

Leah also described demanding patients as those who “can’t be pleased.” Demanding patients and family members treated nurses “rudely” and “unreasonably.” They treated nurses with disrespect and acted entitled to them. Demanding patients can quickly turn into abusive patients.

Lydia explained,

No nurse has to be in an abusive situation, we have patients who are coming off the drugs and they get very hungry. And they’ll say “I want a steak and potatoes,” and the best we can do is get a hamburger and fries and one patient was eating so much ice cream that she emptied our supply for the whole night. And then when I told her that I didn’t have any she told me I was lying and that I was being rude. It

got so bad that my nurses could not continue their work.

Depending on the patient and the circumstances, a simple request for food could escalate to abusive or unfair treatment. Conflict like this occurs in part because patients feel a sense of entitlement with their nurses.

Nurses expect patients to need. Needy patients ask questions, express pain, press the call light, and want to talk. Moreover, because professional intimacy is an exchange, nurses *need* patients to express their needs in order to do their jobs. In my study, both patients and nurses sometimes conflated service with care. In part from the familiarity and trust they gained from professional intimacy, patients felt entitled to good service. Most nurses felt that providing service to patients was part of care, although some found it slightly annoying. Yet, nurses identified difficult patients as the hardest part of their jobs. They distinguished entitled patients from needy patients by describing entitled patients as “difficult,” demanding, and disrespectful to them. All patients are needy patients but entitled patients, nurses said, “Acted out.” When entitled patients feel frustrated or express pain, stress, or fear, they can become angry and hurtful.

4.2 TYPES OF CONFLICT

Nurses experience angry patients and family members as part of professional intimacy. Nurses also experience sexual advances from patients and witness sexual interactions between patients and their guests due to relaxed boundaries and patients feeling entitled to their nurses. Although nurses told me that they rarely experienced violent or sexual behaviors from patients, I observed patients sexually interacting with nurses and with guests, patients stepping outside of their rooms

and yelling for nurses down the hall, patients shoving or kicking nurses, and patients and family members yelling at nurses out of pain or frustration.

4.2.1 Angry and Abusive patients

Patients exploit and abuse nurses to alleviate their feelings of fear and powerlessness. While some of these interactions resulted from drug and alcohol detoxification or involved patients who were mentally unstable, many resulted from ordinary patients who felt pain, stress, fear, and entitlement. These interactions included extreme violence, such as yelling at nurses, grabbing them forcefully, and threatening to harm them. Brett asserted, “We as nurses take a lot of abuse in general. Just, actually two nights ago, a male patient came out of the room screaming and yelling at his nurse. He walked up to the nurse’s station and was very vocal using abusive language.” Eva also said, “They holler, scream, and they’re scared. They’re scared. They’re really scared, you know.” Nurses “took abuse” because they understood that patients and family members expressed anger out of fear, pain, and frustration.

Angry interactions affect how nurses care for patients because they stifle professional intimacy. Jackie said, “They have anger, [they get] frustrated, sad, and that can affect how they treat you and react to you.” She described an interaction with a white, male patient who became very agitated, making racist remarks when she asked him where he would like his IV for his pain medication.

Then he just got so upset, and then he called his daughter saying, “Take me home now.” He moved his arm and I realized it was a pick line (permanent IV for medication). I gave him the medication and then I said, “Do you have anything

you want to tell me?” He said, “I want my daughter to send me to a hospital with only white people.” And I said, “Why?” And he said because, “I cannot trust a person who even doesn’t understand English.” And I say, “I understand English.”

This patient focused his fear and anxiety on Jackie’s ethnicity, accent, and language. Jackie knew “patients don’t like me just because I am an Oriental girl.” Although Jackie and other nurses of color tolerated racism to maintain professionalism, remarks by these patients undermined trust and familiarity. Mary described a patient she thought felt comfortable with her by drawing on a familiar, racist and sexist stereotype, the mammy (Collins 2000).

Since I am an African-American, I remember very vividly the one patient who told me that I was like his mammy that used to care for him. He was an older gentleman. I think he was feeling cared for. I’m like, “please not while I am cleaning you up!” But he was feeling cared for. As an African-American, black woman, did he feel like I would take offense? I don’t know.

Mary told me she felt subservient and “like a slave,” but she tolerated these feelings and her patient’s behavior because she knew that open acknowledgment of her race would increase his comfort.

Nurses understand that, many times, patients express anger because they do not understand their illness or their treatment and feel scared and powerless. Nurses simultaneously empathize with patients’ feelings of powerlessness and endure unfair treatment from these same patients. Mary explained that “patients tend to get angry” when they get conflicting information about their care. Nurses in my study thought that patients rightly expected consistent information from their health care providers. They understood the frustration of patients when they were limited in how much information they could provide. Mary explained, “Like if a patient has a

couple of physicians on the case telling him conflicting information and they look to the nurse to clarify the situation. As a nurse I think you feel limited in your powers and how much you can say because you don't always have the ok." This "ok" referred to the physician's decision about care as well as the approval to share information with the patient.

Nurses are more likely to tolerate difficult, even violent, interactions when they think that their patients feel particularly vulnerable or scared. Lori discussed a patient who, in extreme pain, tightly squeezed her hand to the point that she too felt pain. When she asked him to stop, he coped with his pain by hitting and kicking another nurse who was also caring for him at that time.

One patient had my hand really tight, and I would tell him, "Let go of my hand. You're hurting me. Let go of my hand." And after, you know, kind of negotiating, well not negotiating, but after a few minutes he would let go of my hand, but then he would start hitting and kicking and trying to do something to the other person who was there helping me. So, I don't confront it if I don't have to.

Lori did not confront this patient because she knew that he was coping with his pain through physical reaction. Lori assessed that he could not control himself when the patient tried to stop hurting her hand and then kicked and hit another nurse. In this case, the squeezing and kicking was not personal. Trixie also explained the tension between understanding patients' pain and hunger, while still enduring abuse. "You don't yell at them back. And you have to understand that this person hasn't eaten for hours and hours and hours. He was told his surgery was going to be at this time [and now it is delayed]. So I think, put myself in his shoes; but still it's hard. It's hard not to take it personally." Although nurses empathized with their patients, they too endured pain and abuse as a result of patients coping with their pain but their emotional labor helped to

maintain professional intimacy (Hochschild 1983).

Nurses knew that some patients could not control their actions and acted in response to physical pain or mental disorientation. They believed that these patients reacted violently out of frustration or feelings of entitlement. As Mia explained:

Patients who would try to hurt you, they're mad at you, they could throw a pitcher of water at you. There was a patient that came in and he had a knife there. He started to get the knife and he was going to stab me because he was so mad about the situation.

Mia thought that this patient reacted violently, not because he was feeling physical pain or fear, but because he was "mad." Other nurses described patients who verbally or physically threatened them. For example, Amy described a patient who walked off the unit and locked himself in another room. Amy and another nurse followed the patient and asked him to unlock the door. When he did, he became extremely violent when she and the other nurse approached.

My colleague said to the patient, "Let's go back to your room." She put her hand to, you know, to walk, and he goes like he's going to take her hand, and he just gets his arm and he just gets her around the neck, like in a choke hold. And, so, I was grabbing his arm to pull him off and then he came after me, and he, like, grabbed me by the hair and threw me on the ground.

After Amy told me this story, I asked her how the hospital reacted. She told me that she took leave and the CEO sent her flowers but that she thought there was nothing else that could have been done.

Helen described a patient who threatened to kill another nurse because the nurse had not

retrieved his medication from pharmacy quickly enough. The frustrated patient called down to pharmacy and pharmacy contacted the hospital nurse supervisor to address the problem. When the nurse supervisor arrived on the floor, he rushed past the nurse and went directly to the patient. After seeing the patient, the supervisor reprimanded the nurse for not medicating the patient quickly. Helen explained that she was upset with the nurse supervisor because he did not address the patient's threat.

This was no empty threat as he [the patient] had hit another doctor in the hospital.

The threat was there. I agree, we just have to give him his meds, but the patient had not listened to his nurse. She couldn't get in touch with pharmacy. The nurse supervisor never addressed the issue with the patient; that he can't talk to staff that way. That's a threat. Anywhere else, the supervisor would have called the cops. There is no policy in place, no repercussions for patients if they threaten a nurse.

There was no institutional protection from the potential verbal or physical harm from patients because the hospital did not think that these incidents normally occurred. The hospital did not acknowledge these encounters until after they occurred and when they did, they either blamed individual nurses or acknowledged them for handling the conflict. As a result, floor and charge nurses addressed angry patients with little if any institutional support.

Nurses tolerated angry and abusive patients to maintain professional intimacy, when they felt empathy for the patient, or when they thought the patient had no control over their actions. Although they disliked these situations, nurses tried to not take these situations personally but, instead, to aim for patient satisfaction.

4.2.2 Sexualized interactions

In addition to verbal and physical harassment, nurses experience a wide range of sexual interactions and situations from patients and family members. These range from harmless flirting to physical touch and requests for sexual stimulation. Patients flirt with nurses and make comments about their bodies and appearances. Patients also persistently taunt, leer at, and physically touch nurses. They proposition nurses and request sexual stimulation. They try to kiss nurses and grab their buttocks and breasts. Even nurses who do not personally experience sexual interactions from patients and family members describe incidents that happened to other nurses. Moreover, nurses are forced to deal with patients who are intimate with their visitors during their hospital stay including hugging them, kissing them, sleeping in the same bed, and engaging in sexual intercourse.

4.2.2.1 Sexual Interactions from Patients

Nurses simultaneously describe and deny that they experience sexual and intimate interactions from patients and family members. In the beginning of each interview or informal conversation most nurses told me they “rarely” experienced sexual interactions from patients and family members. However, each nurse described at least one story of sexualized interaction. Most did not describe these interactions as sexual harassment. They remarked that patients were too dependent to sexualize their hospital stay. Nurses justified these sexualized behaviors as from patients who were confused and, thus, unaware of their behaviors. Some older nurses also thought that patients might sexualize younger nurses but would not find interest in them. Using these explanations, nurses were able to negate or justify sexualized interactions from patients and family members while still reported feelings of discomfort.

Although many nurses do not define sexualized interactions from patients and family members as sexual harassment, these interactions disrupt professional intimacy and the potential for optimal care. Josie did not think sexualized interactions were sexual harassment but said they affected how she cared for patients: “But as much as I don’t define it as sexual harassment, does it affect my caring for that patient? Yeah. Because I’ll ignore [the patient], I won’t go into that room as much. Or, I’ll ignore him more than my other patients. I won’t want to deal with it.” Danae also asserted, “Somebody told one of the nurses that she had a nice, nice ass, you know. That he liked to watch, watch her come in the room. You know, and that, right there, now the nurse doesn’t want to go in there anymore.” Nurses knew that how patients interacted with them affected care because professional intimacy is an exchange between patients and nurses. If nurses did not know how to professionally negotiate these kinds of intimacies, patient care suffered.

Young and new nurses express surprise over the frequency of sexualized comments and behaviors from patients and family members. Josie, a nurse in her twenties, told me that she heard a sexualized remark, usually from a younger male patient, at least once a day. Joyce, a new nurse in her thirties described an inappropriate comment from an elderly, paralyzed male patient. She said, “It was this old guy and he was paralyzed. And he just made all these comments like ‘I need a back rub. You have a nice ass, even though you’re a little thick. You’re husband must treat you good because you’re always smiling.’” She grimaced, “He meant, good in bed.”

Nurses also described male patients who simultaneously exposed themselves and proposition their nurses. Josie said that patients did this “a lot. They’ll basically ask to sleep with you. It’s gotten to the point where there are male patients who will literally just lift their clothes up and hang out and talk about their size and stuff.” Josie knew that patients were deliberate in

their exposures because they combined these actions with verbal requests for sex and descriptions of their sexual prowess. Patients also propositioned nurses in front of their spouses. Sonia described a patient whose “wife was sitting in there and he said something totally inappropriate, especially in front of her, like, ‘what are you doing later?’ or ‘You could come home with me.’” Patients simultaneously sexualized nurses and did not consider how these interactions would affect nurses or their spouses. They both did the act and minimized the act. They could minimize the act in part because they did not consider nurses to be legitimate social actors in these exchanges. The purpose of the nurse in their minds was to care for the patient and meet the patient’s needs. The dichotomous view that nurses are either sexy or maternal exacerbates the negation of nurses’ agency. As Bridget Anderson (2000) describes, both care work and the bodies that do this care work are commodified. Patients rightly feel entitled to good care but sometimes this sense of entitlement extends to nurses as well.

Male nurses also described how male and female patients made sexualized remarks about their appearance. For example, Bill explained how gay male patients or visitors commented on his looks. He said, “I’ve taken care of a few gay men patients that have mentioned to their partner, ‘Did you see my nurse today? He’s really cute.’ You know, and things like that. And I usually don’t respond back to that.” In contrast to Bill, Jason discussed his discomfort when male patients propositioned him. He explained one case, “He was kind of making suggestive coming on comments. And I was not comfortable, but I mean, I didn’t shun him. I wouldn’t consider it [sexual harassment] because it was not overt.” Brett also experienced propositions from male patients. Although he was not uncomfortable, he thought these interactions were inappropriate. He said to patients, “That’s inappropriate. I’m your nurse. I’m here to take care of you.” He told me that he simply tells patients that, “Comments like that will not be tolerated.” Bill ignored

these behaviors because he did not want to make them worse. Jason did not think they merited attention. In contrast, Brett described why he confronted sexualized behaviors from patients immediately. He said, “I felt really degraded, personally as well as professionally.”

In the first month of my study, I observed Jackie, a new nurse try to manage the sexual advances of an older male patient during her care for him. When she helped him back to bed, he grabbed her arms, grabbed her shirt, and asked her to come to bed with him. She later told me that he grabbed her breasts. I heard her say “Hey what are you doing?! I am not your wife!” I watched her leave his room and quickly move to her next patient’s room. It seemed that she had no time to reflect on the exchange. When she had a free moment, I asked her about the interaction. She told me her patient was “confused” and disoriented due to his medication.

Two days later, in the staff room, Jackie told me that the same patient was sitting in a regular chair in the nurses’ station “visiting” the nurses. When Jackie walked by him, he abruptly grabbed her from behind and pulled her down on his lap. I asked Jackie if she thought this was part of her job. She exclaimed in shock, “What?! To sit on his lap? Of course not!” When I asked her why she did it, she seemed unsure. Although initially Jackie seemed uncomfortable with my questions, she later told me that the patient “wasn’t too bad” and she knew “he liked me.” I asked her how she knew this and she did not tell me. She just shrugged her shoulders.

When Jackie left the staff room, Mimi, an experienced patient care technician who listened to the conversation said, “They need to be told.” I asked, “By whom?” She said, “By the person who they do that to.” Mimi told me the majority of patients who “cross the line” stop when they are told to do so. She agreed that educators do not teach nurses how to how to stop inappropriate behavior, but that nurses learn how to do this over time. She said, “The girls should be trained because some men are just like that.” I asked Mimi how nurses should stop

inappropriate behavior and she suggested being firm but gentle and respectful, in other words, by professionally negotiating intimacy.

Nurses named patients as “confused” to explain and justify their sexualized interactions. I observed a variety of patient situations that nurses called “confused.” These included when patients were heavily medicated, disoriented, unfamiliar with their surroundings, unable to clearly communicate, or expressing unexpected emotions like anger or love towards nurses. Early in the study when I asked about the label, “confused,” Bill told me,

There are different levels of confusion. It’s not always from mental disorders. A confused patient can still know who they are and recognize family members, but they may not know what day it is. And it may be an orientation thing, where they just need to be told the date. This can happen to you and me also, if you wake up one morning and are not sure of the day. It might just be that they’ve lost some time and space in the hospital, in intensive care. They’ve been medicated with pain medicine. They’ve been out for four hours at a time. So there’s some confusion there. Then you get to the confusion where the patient knows his name but they don’t know anything else. They don’t know who they used to be, what they used to do, who their family members are. They don’t recognize anything.

The identifier, “confused,” referred to multiple situations. Patients could be confused for days or could reorient after minutes. Confused behaviors were inconsistent. Patients could be aware of their interactions, bodies, and emotions while unsure of the date and time. Patients could know names but have no control over their movements.

Indeed, much confused behavior is unintentional but some patients act purposefully confused. Bill describes, “You can tell unintentional confusion over intentional confusion by

experience. Experience will yield the answer to that a lot of times. Usually you can smell intent, you know, to harm.” Even confused patients deliberately behaved sexually. Over time and through experience, nurses learned to distinguish legitimately confused behavior from purposively disruptive behavior. Experienced nurses assessed the intent of their patients and adjusted their caring strategies accordingly.

Older, experienced nurses see how sexualized idealizations of nursing persist alongside actual representations of nursing and how these images affect patients’ perceptions and interactions. When I asked about sexual interactions at work, Mary commented, “You talk about sexuality, think about how nurses have been portrayed in the media for so long. Even in movies, how nurses dress up sexy. That’s the image. The reality is different!” Patsy agreed that although patients interacted with actual nurses who were wearing baggy scrubs, patients imagined sexy nurses. She said, “They look at the nurse, as the nurse with the chest coming out of the uniform, with the tight uniform. I think there is an underlying feeling whenever they look at the nurse. And I don’t know... I want to... Well it’s nice for younger people to think that way.” Patsy expressed discomfort with being sexualized but quickly isolated these interactions as happening to younger nurses. She removed herself from the possibility of having to confront sexual interactions from patients and family members.

Older nurses attributed not experiencing sexual harassment to their age. Jody, a nurse in her fifties, told me she did not experience sexual harassment at work because she is older. She said, “Yeah. I don’t have that problem. Probably because I’m older and don’t have the sweet little innocent looks that these young girls do. I don’t know if they have any problems or not, but I don’t.” Mary agreed and said, “It probably happens with young nurses. It probably happens. See I’m an old nurse now (she laughs).” Although some nurses insisted they were too old, other

older nurses also told me that patients regularly sexually interacted with them. Even Patsy, who claimed she was too old to be sexualized, discussed how patients sexually interacted with her. She said, “Innuendos, innuendos, sexual innuendos. Patients say, ‘Just get into bed with me.’”

Rather than seeing these as inappropriate behavior, many older and experienced nurses described sexualized interactions from patients as harmless flirtation. Mia described a situation with a male patient thirty years her junior. He flirted with her, asked her out and “made a pass” at her. She gently laughed at him, poked fun, and told him that she could easily be his mother. She was not at all threatened. Angie also described many experiences of patients hitting on her. She described times when patients asked if she was married. She says that in those situations she did not know what to say so she always said “yes.” Patients persisted, asking if she was happily married and if they could go out after getting “out of here.” “It is inappropriate”, she told me, but “you just blow it off.” She described another situation,

I had one guy who I knew was crazy. He didn’t want anyone else to take care of him. He came to the hallway and I said, “Where are you going?” He said, “I’m looking for my nurse!” So I come and I say, “You want to see me.” He says “I want to tell you something.” I said, “Ok. What do you want to tell me?” He said, “I really, really love you.” (She laughs). I said, “I know but I want you to get better so you can go home.” Then he said, “Yeah but I want to take you home with me.” I said, “No, you can’t take me home with you. You have your wife at home.” “I don’t want her!” It was funny. I got along with him pretty well.

This patient did not bother Angie because she knew how to expertly negotiate his advances. Moreover, she focused the conversation on his care. Angie was accustomed to patients developing feelings for her and was not surprised when it occurred. She skillfully acknowledged

this patient's needs in a way that did not disrupt her process of caring for him.

In contrast, Anna, a new nurse, expressed significant discomfort when a patient remarked on her appearance. She said,

Just last week, a patient in a car accident told me, "Oh you're very beautiful." I'm like, OK. I don't take that personally. Then he goes, "So are you taken?" I'm like, "Yes, I have a boyfriend." He goes, "Well, let me know when you dump your boyfriend. I would like to get to know you better." That's not appropriate. And then the other nurses told me, "Oh you know that patient said that you're beautiful." I acted like it was no big deal, but I'd just try to stay away from that room. I mean I'd go in there to make sure he was OK, but other than that I wouldn't stay very long.

Anna felt uncomfortable with the attention from her patient. She did not expect his affections and did not know how to address the situation. Moreover, Anna did not know how to talk about these concerns with other nurses who told her that she should learn to remain unaffected. She tried to act unconcerned but she still felt discomfort.

Less experienced nurses had trouble determining the intentions of patients. Alicia did not know if her patient that had "grabbed my breast" knew what he was doing because he "could not follow simple commands." She did notice, however, that "his friend saw him doing it" which made her feel "uncomfortable." Similarly, Nadine described a head trauma patient who explicitly requested her presence while he masturbated in his bed. She explained:

I had a patient who he had a gunshot wound to the head. He wasn't completely present. He was masturbating. And we had this communication thing where one finger was "stay" and two fingers were "go." And he would try to get me to stay so that he could look at me. I told him "I know you want me to stay." I said, "No,

I'm leaving. You can figure this out on your own." It was totally inappropriate.

He wasn't all there but it was hard to deal with.

Patients also made special requests to be washed in their genital areas, not because they needed to be cleaned there, but because they sought sexual attention. Patsy explained how she knew this distinction. She said, "So he kept his gown up, you know. And he wanted you to wash that area, particularly. I knew he knew what he was doing. At first it wasn't blatant, later on it was like his door was open and he was unclothed." Patsy explained how she determined her patient's motives by assessing his actions over time. At first she was unclear that her patient was inappropriate but later, his persistence became overt.

Experienced nurses refused inappropriate requests for washing. Mia told me, "Sometimes they ask you to wash them down there and stuff and I just say no, I am not going to do that." Mia has learned over time that there is a difference between caring for the patient and feeling taken advantage of by the patient. In contrast, Carey, a new nurse, described a patient who specifically requested that *she* give him a shower. When she tried to defer to the patient care technician, he insisted that he wanted *her*. She acquiesced and afterwards, he sexually propositioned her. She explained,

This one guy wanted a shower, and his nurse told him he had to have a shower.

But then he wanted me to come wash his back and the tech was there so I said the tech can do it and he said, "No, I want you do it." And I was standing right there and I quickly turned around and did it quick and said, "Now I'm done." I said, "I have to go." And then afterwards he said, "I want a wife, I need a wife, I just need someone to take care of me." How gross.

Carey complied because she wanted to meet her patient's needs but she was disgusted

when he reacted to her in a personal, sexualized manner.

Sexualized interactions from patients and family members affect professional intimacy in other ways. Josie described her discomfort with patients who sexually propositioned her, but did not want to hurt her patients' feelings. She said, "It's more uncomfortable with young men that they will just say inappropriate things, or ask you out, or give you your phone number. What do you say to that? You don't want to be mean to them. You know it's so hard." Josie's discomfort resulted from not knowing how to confront sexual interactions from patients without harming them. Her unwillingness to embarrass or "be mean" to patients overshadowed her uneasiness.

Sexualized interactions from patients affected nurses and their ability to conduct professional intimacy. Although some individual nurses told me that sexualized interactions from patients and family members were infrequent, my study demonstrates how sexual interactions from both confused and aware patients pervade hospital nursing.

4.2.2.2 Sexual Interactions between Patients and Visitors

In addition to experiencing sexual interactions from patients, nurses witness patients who sexually interact with guests. Depending on the acuity level of their illness, their age, and how permissive their nurses were, patients slept with visitors and engaged in sexual behaviors such as kissing and oral sex. For example, Tammy told me that she "walked in on somebody having a blowjob once. It was a family member who had stayed the night." Melinda had "patients and visitors in the shower together." Jill described how she entered a patient's room in response to a medical signal and interrupted an intimate moment.

I was taking care of a guy with a bowel obstruction and he had a NG tube and his girlfriend came in and I left them alone. And beeper goes off, I walk right in and the curtain is wide open and she is sitting there, giving him a blowjob! I didn't say

anything. I didn't do anything. I just walked out. I let them be together for a bit and forgot about it.

Although intimate interactions occur at all hours, they are infrequent during the day because doctors, physical therapists, lab technicians, social workers, and other hospital staff are constantly moving in and out of patient rooms. Sexual and other physical intimacy happen more often during the night shift between 7:00 p.m. and 7:00 a.m. Sometimes, patients planned their intimacy with spouses. For example, I overheard one patient tell a day nurse that her husband would be coming to visit her that evening. Excited, she said, "He wants to sleep in the bed with me." The nurse responded that this was the night nurse's decision and that it might be a "weight issue." I was surprised to learn that the "weight issue" referred to how much weight the bed could hold. The day nurse evaded the issue of intimacy because she knew that would not have to confront it. When I asked her if it was appropriate for the patient's husband to sleep in the same bed, she told me the night nurse would make that decision.

Not all night nurses agree that it is the responsibility of night nurses to determine whether visitors stay the night. One evening Mia expressed annoyance to me because the day nurse "allowed" a male patient's girlfriend to sleep with him. I had just observed a woman in a slinky, shiny outfit arrive on the floor at approximately 9:00 p.m. when I followed Mia to her patient's room and saw that the visitor climbed into bed and snuggled up to the patient. Mia pulled me aside and said, "Here's the deal." Mia explained that she still needed to go into the patient's room with or without the visitor in bed. Mia told me that this behavior was "unacceptable" but she felt powerless to confront her patient because he had already received approval. As Mia and I both overheard the patient and his girlfriend giggling, I asked her if she felt like she was entering their bedroom. Mia nodded and shrugged at the same time. She said, "Yes, but what can you do?"

They know this is a hospital. You don't do that. I just have to close my eyes.”

Confronting actual or the potential for intimacy between patients and their guests is an additional responsibility for night nurses. Although hospital visiting hours officially ended at 8:00 p.m., nurses did not enforce these hours the duration of my study. Nurses were lenient with patients and family because they understood that family members provided comfort to patients during their hospital stay. When I asked Eva if she strictly enforced visiting hours, she said,

Oh no, I slide. Sometimes family members don't get off work [in time] so I'll say, “The patient is going to need to sleep at 10 pm.” Would you mind waiting in the waiting room so she can get some sleep?” Or I'll say, “Are you aware of the visiting hours?” Sometimes we might say things that are inappropriate but we have to remember to do customer service.

Eva risked patient satisfaction to ensure quality care. Nurses did “customer service” by negotiating the emotional and medical needs for patients. They understood that the schedules of visitors did not necessarily coincide with hospital rules. Nurses bargained with patients and visitors because nurses knew that contact from family members and friends contributed to quality care and, also, increased patient satisfaction. Patient satisfaction did not always transfer to quality medical care; that is, the interests of patients were not necessarily in their best medical interest.

Visits from friends and family members are good for the well-being of individual patients but disrupt sleep, medical care, and could potentially bother other patients in the unit. Night nurses said that ensuring that patients sleep was their first priority. As much as possible, they facilitated sleep on the unit. They lowered their voices and dimmed the hall lights after 9:00 or 10:00 pm. They knocked on doors softly before entering rooms. They were careful to ensure the

comfort of other patients in semi-private rooms and patients in the unit. Danae said, “You do what is beneficial to the patient. We allow people to stay until 10:00 or 11:00 pm. If they can be quiet without making noise or getting in conversation that’s fine because the next person has just as much right to their privacy and their rest.” Josie agreed, “But most hospitals are semi-private rooms, and for the sake of the other patient, you know, you just can’t let a person of the opposite sex stay.” Melinda explained that visitors come to the hospital at, “eleven thirty, twelve o’clock at night and we have other patients in the room sleeping, and we’ve had six, seven, you know, eight people in a room at a time.” Eva generally told visitors to leave because patients had roommates. I asked her how often this happens. She replied,

All the time, I have to explain to them the policy that they can’t stay because this patient has a roommate. “It’s like your bedroom,” I tell them. “Would you like a strange person to be in your bedroom? It is nothing against you but my job is to make everyone safe and to keep these patients safe.”

Eva framed how she balanced the needs of patients in terms of safety. She did not simply keep patients safe. In addition to balancing all patients’ comfort with the requests of individual patients and visitors, nurses consider how visitors might threaten medical care.

Depending on the illness, the injury, or the potential emergency, nurses negotiate the physical closeness between patients and family members. Nurses were not concerned that patients were having sex in their rooms but whether or not this activity was safe for their patients. They used discretion and thought mostly of their patients’ well-being. Tom explains,

We let them stay. We kind of, you know, turn the other way when visiting hours end. Because, that patient has been there, you know, for three weeks, or whatever,

you know. Yes that's also part of health care. And if I can find a room where its, where it's not going to, you know, um, offend anybody, you know, a roommate next door, or they have their own room of their own. You know, that's ok. You know, we usually allow it. But, like I said, it all depends on the patient's health risks. If that's a fractured femur I cannot risk, you know, having that, you know... It's life versus having a sexual encounter. I mean what do you choose, you know? I mean, do you want your patient to be alive?

Other nurses said that visitors sleeping with patients was completely "inappropriate" and insisted that family leave. Some nurses avoided negotiation altogether and simply enforced hospital policy. Danae did not allow family or friends to get in bed with patients. She said it was against hospital policy. She told couples that sharing a bed could interfere with emergency care. She told friends and family, "Your loved one is my priority." Similarly, Anna described a patient with a crushed leg. Infections and high temperatures complicated the injury. One night, Anna found her patient's wife in bed with him. She said, "I remember seeing her in the bed. I said, 'I can't really have you in the bed. I know he's your husband, but he's running high temp and your body heat and his body heat make his temp stay up.' And I didn't have a problem." Eva told me that

It is usually the younger kids and the women who like to be in bed with the male patients. They don't want to be sexual. I [say to patients], "I understand that she wants you next to her, but [I say to visitors] do you mind sitting in the chair because if something happens to him, I'm responsible." I ask these women, "Would you consider that for me?"

Eva asks patients to "help her out" Danae and Anna justified their decisions by educating

patients and visitors on medical risks. That nurses needed to justify their decisions demonstrate the pervasiveness of a culture of patient satisfaction.

Most nurses agree that a visitor could sleep with their patient if the patient has a private room and there is no medical threat, but it can be awkward for the nurse. Josie described that she hates “feeling mean” when she finds visitors in patients’ beds. She did not want to tell them no mostly because it was awkward to discuss the subject.

And, as much as I don’t want them in the same bed, because I need to come in and do my checks, and it’s just awkward, it’s awkward for me. Like have to push an IV while one person’s arm is around them. [Laughs]. But, I don’t ever tell them to get out, because [laughs], again, it’s awkward on my hand. I don’t want to deal with one extra thing of somebody being upset because they’re not sleeping in the same bed. And really, when it comes down to it, is it really hurting me? But it’s a little uncomfortable and I don’t feel like I can say anything.

Even when nurses confront patients and family members, they do not necessarily listen. Eva explained how patients continued to be sexual after she left the room. She told me that she became frustrated knowing that there was little she could do to change the situation.

I can’t do anything, whatever the patient says is right for the patient. You just have to – you can’t be anyone’s mother. You try to give them an example, but it doesn’t work. And it’s hard, it’s hard, and then you have to bring in the forces, the supervisor, your team leader, can you go talk to this patient. You are trying to take care of the patient. Nurses don’t have time to negotiate things like that.

Like other nurses, Eva acknowledged that she did not have time to negotiate professional intimacy. Nonetheless, and even when they felt discomfort, nurse found time to facilitate an

environment that was safe and comfortable for patients.

4.3 CONCLUSIONS

To provide quality care, nurses both encourage professional intimacy and professionally respond to patients' intimate needs as defined by patients and family members but intimate care is not always inherently good, safe, or emotional for nurses. Professional intimacy requires that patients express themselves. In addition to ordinary medical, care, and service needs, patients express entitlement, anger, and sexual desire, which are produced in part by familiarity gained from professional intimacy and the hospital's focus on patient satisfaction. Although nurses are at best uncomfortable and at worst harmed by these interactions, nurses manage physical and emotional discomfort in their professional care of patients and family members.

Nurses simultaneously deny and describe verbal, physical, and sexual harm from patients in part because they receive little or no educational training on these interactions or how to handle them. In addition hospital policy and administration responses to these incidences encourage patients to feel entitled, which lead to work arrangements that overburden nurses and limit how nurses conduct professional intimacy. Nonetheless, individual nurses learn how to manage interactions over time. Teams of nurses also collaborate on informal strategies. How nurses manage and negotiate boundaries with patients and family members during intimate conflict is the focus of chapter five.

5.0 BOUNDARY-MAKING IN PROFESSIONAL INTIMACY

In this chapter, I explore how nurses define and enforce boundaries that address conflicts that results from professional intimacy, while maintaining professional intimacy with patients and family members. Patients and family members express harmful and harassing behaviors and nurses manage these interactions, what I call *intimate conflict*, as a part of professionally intimate labor.

Although the administrators in my study supported and appreciated nurses and care work, nurses handled generally intimate conflict on their own. They employed individual strategies, such as ignoring, confronting, and negotiating interactions with patients and family members, but sometimes also worked together, collectively strategizing through the support of charge nurses, the practice of switching patients, and sharing knowledge with each other.

5.1 INSTITUTIONAL RESPONSE

Nurses have little institutional support for dealing with intimate conflict. Although institutional policies prohibited patients from sexually and physically harassing nurses, nurses did not access the support from these policies and procedures because they perceived them as unclear and irrelevant to their work with patients and family members. For example, the hospital in my study maintained a zero tolerance against sexual harassment policy, which prohibited verbal, physical,

and sexual harassment by patients. However, in the history of this policy, no complaints against patients had been made. Moreover, nurses did not mention the sexual harassment policy as a viable strategy when dealing with harassing patients. Even when I specifically asked about the policy, nurses dismissed it and talked about something else.

Prioritizing individual patient satisfaction over general policy is one reason nurses do not use policy to protect themselves from intimate conflict. For example, nurses referred to visitor hours to establish boundaries with patients and guests; however, nurses did not always follow these guidelines because each unit enforced policies to meet patients' individual circumstances. Tammy, an experienced night nurse, explained that she observed how other nurses enforced visitors' hours when she started working at the hospital to determine how and when to enforce this policy. She previously worked in a psychiatric unit in the VA hospital and was accustomed to strict enforcement of policy.

I came in at a really funny spot. You see, a lot of those old nurses are just so passive, and they don't do anything about anything; and so I really didn't know where administration stood with all that. And I wasn't going to be the new person creating trouble. But now that I've been there a while, and now that I've talked to the unit director, I just tell them to go home.

New to the unit, Tammy did not automatically follow policy because her colleagues were lenient, and she did not want to disrupt the unit culture, even though it contradicted her practice. She talked to her supervisor, not because she did not know how to handle visitors or because she wanted to follow the rules, but because the unit's practice seemed to contradict her own.

Nurses also do not have time to formally address conflict. Josie said that she incorporated intimate conflict as part of her work because she could not take time out of her busy schedule to

file a report. “Would I ever report it? No. I just deal with it as part of my day. And I don’t have time to report it. You know. [Laughs] I’m just like, ignore it and go on with my day.” Like Josie, most nurses did not think that institutional policies applied to their interactions. Because they felt that policies and procedures took too much time, they paid little attention to policies and found ways to cope with what they considered individualized situations.

Although some nurses prefer to assess the needs of individual patients, their own workload, and the culture of their unit to determine their response to patients, other nurses think that institutional negligence increases intimate conflict. Brett explained,

But what’s really worse is when the organization or the unit does not take any type of action. And they perpetuate that behavior from patients because they always coddle the patient, tending to whatever’s upsetting them. And I believe the more we do that the more that we allow this type of behavior from individuals, the more we need to correct that type of behavior. Not necessarily discipline, but correct it.

Helen agreed that nurses have “no recourse” when they encounter intimate conflict and family members as part of their work and failing to correct conflict reinforces negative behavior from patients. She described how her director’s focus on the patient encouraged him to continue treating nurses poorly, “[My director] went in and held his hand, day after day after day, which, to me, promoted that he treat us like shit all the time. So it comes back to that customer service.” Both experienced nurses, Helen and Brett argued that if left alone, intimate conflict would worsen and that, rather than handling intimate conflict individually, nurses should be able to access institutional support.

Nurses think that their leaders do not handle intimate conflict. For example, Helen

attributed her director's and other administrator's inability to address conflict to traditional feminine norms.

I don't even feel like my own director can go in and handle it appropriately or satisfactorily because of her personality. I think there's a generation difference. I mean [sighs] some of them are as old as my grandma. They weren't brought up to be confrontational or strong women. And I think they don't have it in them to do it.

Helen thought that nurse supervisors viewed themselves as passive and so they did not confront harassing and harming patients. She is not alone. Although providing care often includes managing intimate conflict, acts of caring are generally defined through traditional feminine characteristics such as soft, compliant, and deferential. It could also be that nurse supervisors do not feel they can confront harassing patients without appearing disrespectful to them.

Administrators may feel pressured to respond to intimate conflict in traditionally feminine ways or nurses may not be trained to handle these interactions. In any case, how nurses focus on ensuring patient satisfaction and the amount of work they do in a limited time significantly influences how they manage intimate conflict individually, rather than systematically.

5.2 INDIVIDUAL STRATEGIES

Nurses see "boundaries" as important in their practices, but are vague in their definitions of what exactly they mean by "boundaries." They characterize boundaries as personal traits, which confuses new nurses, mystifies this labor, and does not use institutional resources most

effectively.

When I asked nurses if they experienced intimate conflict, nurses with more than one year of experience, like Jill, quickly said, “Oh! Of course! And you just have to ignore it or tell them that their behavior is inappropriate.” Bill, a senior nurse with over ten years of experience, advised, “But you want to use your intuition and smell those things to sniff out the problem.” Although she had only two years of experience, Melinda agreed with Bill. She explained how she identified and managed conflict with her patients by using her own judgment.

I think I’m a pretty good judge of character. I feel that I can sense when someone is joking or someone wishes to pursue it further, or someone might be hateful. Then, depending on where it’s coming from, is how I feel if it’s appropriate. I could have an old man say, [imitating old man’s voice] “I’d like to take you home, you know. You could be my wife.” Whatever. And then I could have someone else tell me the same thing, and it could be completely inappropriate.

Although nurses disclosed that they set boundaries with patients and family members, they characterized this as a personal attribute, not a skill that was honed over time. Even when nurses described their skills in this arena, they attributed to it working with patient populations known for conflict, such as prison inmates or psychiatric patients. For example, Tammy, an experienced nurse, explained why she does not encounter inappropriate behavior. “Probably not so much with me because of all of my psych experience. I have pretty good boundaries.” Although it’s likely that Tammy’s experience with psychiatric patients helped her develop boundary skills, she does not address how she developed these skills and how her experience with all patients informed this process.

Mia explained how she developed boundaries over time and through her experience on

her unit.

What I do is, I still get close to them in a way, but there is a line, and I don't know how I draw that line, not to get so involved. I don't know how to tell you exactly how to separate yourself. I don't try and cry anymore when they're hurting. I used to hold their hands, and when I knew that they were Christian, I would pray with them. I still do. I still do but not to the point that (pause) I would go to their house and visit them (she laughs, a little embarrassed). I used to do that. You have to protect yourself.

Other nurses emphasized the importance of boundaries to protect them from harm. For example, Jody said, "Because I really try to have more of a professional relationship with people. Once they know that you're not professional, they will take advantage of you." Melinda described how she begins each shift by presenting herself formally to patients and then over time she is more comfortable exhibiting compassion and sensitivity.

I think I make it clear that this is my job. I talk about what we call a plan of care. I'm pretty formal when I first introduce myself. As the night goes on, and I get to know my patients, I soften up a little bit; you might see the caring side of me. It's not that I don't care at first; this is still my job, what I do. I like what I do. I love what I do. I'm here to give you the best care possible. But (pause) that's a boundary you place there. It's how you present yourself and take care of yourself.

Melinda is a caring nurse, although how she makes boundaries may challenge traditional meanings of care.

Although she doesn't call it "making boundaries," Sandra also acknowledged that she shows two sides of herself to her patients: personal and professional.

I usually try to talk to them, ease their feelings, talk about my kids or my husband, but let them know as their nurse I'm professional with medical knowledge and I'm not here to, you know, shake my behind and throw them some happy pills.

Adopting professional distance helps nurses maintain boundaries during conflict and avert potential conflict, but it can seem cold to patients and family members. Nurses know this; thus, they balance formality with a personal, intimate disposition.

New nurses who had not yet encountered intimate conflict from patients or family members know that they need to learn boundaries because other nurses tell them that intimate conflict was inevitable. Carey, a nurse with two months of experience, told me she would "handle" a patient if he continued to make lewd remarks to her. She explained, "I would have definitely set boundaries and said, "This can't happen again," and then if it had persisted, I would have reported it again." Younger and less experienced nurses knew they should maintain boundaries with patients but did not know exactly how to do this. Celia, a new nurse with less than a year experience, asked other nurses in her unit how to do boundary work.

I'm learning to draw the line. And I remember they were like, "You need to stand up for yourself." I told them, "I can't." They said, "Oh you'll learn. [Laughs] It's something that takes time, but you'll learn once you draw boundaries."

Experienced nurses talked about boundaries, but had difficulty describing how they learned to do this work. New nurses knew that boundaries were important but, like Celia, could not imagine setting them with patients. Like meanings of care, nurses took meanings of boundaries for granted, assuming that each nurse would determine how to set them through their own experience. Although individualized, nurses assumed common strategies to manage conflict.

Nurses set boundaries with patients and family members as a way to prevent intimacy from becoming uncomfortable or harmful, balancing their own emotional responses against the needs of their patients. Although I observed nurses consistently set boundaries in multiple ways, nurses struggled to describe how they strategically avoid, confront, and negotiate with patients to stop and prevent intimate conflict.

5.2.1 Avoiding Intimate Conflict

Nurses avoid intimate conflict because they want to help patients heal and to avoid theirs and patients' embarrassment. Although avoiding intimate conflict by ignoring it is a useful strategy for nurses, it also results in nurses feeling distance from their patients, which hinders professional intimacy.

Some nurses avoid intimate conflict with patients by accepting responsibility for patients' negative emotions. Jane described how she chose to account for the emotions of her patients to help give them a sense of control in their care. After a patient complained about her, Jane told her charge nurse that she would apologize to the patient rather than switch patients with another nurse. "Well, you know, I'll just go back there, and maybe if I apologize and if I tell them that, you know, I was wrong and they were right, maybe they will feel a little bit better. They won't mind that I'm taking care of them. You know it might make things better." Jane apologized to her patient, not because she felt she provided bad care, but to ease her patient's discomfort. Melinda agreed with Jane that apologizing helps avert conflict, "You have start by apologizing for whatever has happened before. 'I wasn't here. I don't know what happened. This is what I can do for you now.' Never tell them 'no'. [Laughs] Reword it." Apologizing could avoid immediate conflict, but if consistently heard from different nurses over time, could also seem

disingenuous to patients and family members.

Nurses also avoid potential conflict by allowing patients and guests to sleep together. Nadine was more lenient with patients if they were having surgery the next day.

I might close the door and kind of walk away. I don't mind it – if someone is going to surgery. Perhaps they think it is the last time they spend with that person. Like a bypass surgery is a life and death surgery. If they are in the bed cuddling, that person is in the bed saying, "I love you." That's ok but not if they are doing more, you know, something inappropriate.

If Jill saw that a patient and a visitor were being intimate, she quickly left, hoping they had not noticed her. If they were not intimate, she worked around the guest, "If there is somebody in bed with the patient, I'll still take care of the patient, come in and out and talk to them. All the time knowing that the other person is not really sleeping in the bed with them, I don't care." Tammy also worked around guests who slept with patients. "I just made a bunch of noise, so they knew that I was in that room. So I just didn't acknowledge it, and anytime I went back in that room, I just made a whole bunch of noise. That happens a lot actually." Josie also avoided conflict by allowing guests to sleep with patients, but unlike Jill and Tammy, encountering intimacy and the potential conflict that could result, made her nervous.

I guess it would come down to them saying, "Well, why not?" And I don't have a good answer for that. You know? I really don't. Why not? Oh, well because it makes me feel awkward. "So can you not [sleep together]?" That's my only answer really. I can still give them good care with a patient with someone in the bed with them."

Avoiding the issue altogether helped Josie provide care, avoid embarrassment, and avert

conflict.

In addition to patient-visitor intimacy, nurses strategically ignore comments from patients to avoid conflict. Chrissy, an experienced nurse, explained why she ignored inappropriate comments from patients, “I think it is better to pretend. You can tell them I don’t like the way you act or what you said. But then they can deny it and then complain about you.” Knowing that her patients could complain about her if she responded to intimate conflict, Chrissy disregarded her patients’ actions altogether. Similarly, Bill avoided direct confrontation because he did not want to aggravate his patients’ discontent. “If I just overheard them, I would never bring that up and say, ‘I heard you say I was cute when I walked out of the room.’ No, now that’s just getting stuff stirred up, and I would not want to stir it up.” These nurses ignored disruptive patients as a way to prevent potential intimate conflict, but they consequently interact less with their patients.

Ray, a nurse with five years of experience described how his attention to patients changed over time, which avoided intimate conflict, but ultimately affected how patients trusted him and the care they received. At first, Ray spent extra time with patients, relating to them on a personal level, to encourage them to work through their pain and fear about illness or a necessary medical procedure. Over time, his attention waned.

I’ll tell you this much. My first two years out of school, I would try to talk to them, get down on their level, really talk to them. “If you were my dad this is what I would want you to do.” Somewhere between the third year and now, I don’t really argue with them. I’ll go to a point, not as much as I used to. I’ll just tell the doctor.

Eventually, Ray’s initial compassion changed to avoidance. He could not justify “arguing” because he felt it made no impact in their care and only increased conflict, but to avoid this

conflict, he spent less time with patients. In addition to spending less time with patients, Ray discussed how his demeanor with patients changed.

In the beginning, I was real calm, I would try to talk them out of [leaving against medical advice], even if the patient wanted to leave, and I would go through why you need to stay. Now I would say I got somewhere 90 percent of the time. But if it happened now, I'll get you the paper. I get tired of arguing with them. It just got to the point where my attitude was, "you are a grown man or woman; it is up to you. Think about it." And then I'll go do something else. I don't try to sit there and coax them into it.

Although Ray acknowledged that his efforts were successful, i.e. he "got somewhere [with them] 90 percent of the time," he stopped trying because arguing with patients on a daily basis felt unproductive. At first Ray took responsibility for encouraging patients through fear and pain, but then he shifted this responsibility to patients. He respected his patients' right to make choices about their care but cared less about how they made these decisions. He distanced himself from patients to avoid conflict with them, but failing to encourage patients through decision-making processes, could negatively impact their trust in him.

5.2.2 Confronting Intimate Conflict

Nurses individually confront intimate conflict, but new nurses, not accustomed to intimate conflict, expressed discomfort when they responded spontaneously out of anger or frustration. They feel pressure to handle difficult patients on their own, but do not always know how and sometimes minimize their harm in hopes that patients will focus on their skill. Other nurses called security, but also found this approach ineffective. Finally, although confrontation often

worked in the short-term, some patient's behaviors persisted so that nurses had to repeat and adjust their confrontational strategies.

Nurses respond to conflict individually because, although they rely on other staff, they think of nursing as an individualized profession. Celia explained how new nurses feel this pressure to "handle" conflict.

Because I know I'm new, I'm being judged. That's just any time you're new. I don't think they're intentionally judging me, but everybody always judges a new person to see what she can handle. Am I going to be known as a good nurse or as the one who always need to be checked because I'm screwing things up? Can I not handle it? I don't want to be the whiney nurse always complaining.

Anna, another new nurse, minimized the harm she felt from patients' inappropriate attention to demonstrate her skill. Although she told me she thought that patients who commented on her appearance were sexually harassing her, she chose to address it herself. "Definitely. Definitely I do. I mean, if they kept going on, then I would ask to be changed. You know, I would take care of it. I mean, I wouldn't make a big deal." What was most important to Anna was to negate her experience of the interaction. Like Celia, she wants attention to her labor to be about how she handles conflict herself.

New nurses do not think they can confront patients and surprise themselves when they lose control and are able to confront. For example, out of sheer frustration from constant questions about her sex life, Anna spontaneously confronted her patient. "At first I ignored it, but as the day progressed, he pulled up his gown and said, 'What do you think about this?' I said 'Knock it off' and just kind of snapped at him. I am not a prostitute, I am a professional; treat me as such." Anna shocked herself when she unexpectedly yelled at her patient. Experienced nurses,

however, were not surprised at this response because they learned that intimate conflict sometimes required confrontation.

Some nurses depend on security guards to handle intimate conflict with their patients. For example, Melinda told me that although she knew allowing family members to stay beyond visitor hours helped her patient trust her and be comfortable, sometimes she faced the delicate balance of keeping her patient happy and keeping him safe. If family members refused to leave because they felt entitled to be with the patient, she called security.

I believe in nipping it in the bud before it gets to something that's out of control and we have to call security. You ask them nicely the first time. You let them know what the rules are. And my personal opinion is I don't even deal with it, I just call security. You know, in that type of situation. That's not our responsibility. Our responsibility is that patient and keeping that patient safe. Eight people in a room are not safe. I mean, at eleven thirty at night, twelve o'clock at night. I'm not going, you know, I'm not going to play games.

Although Melinda used security to confront patients and family members, most nurses tried to reserve security for dire situations. Elizabeth explained,

If it got to be really bad and they just didn't listen to the nurse, we would go get our charge nurse or maybe our director. We'd find somebody. Oh, and I think if it got really, really bad, she'd probably call security. And have them come in and try to just give them a little kind of scare or something, but we never had to take it that far.

Calling security is a last resort because staff members on each unit reserve calling security for the worst, most threatening cases and it rarely occurs. Even when nurses call

security, they do not necessarily solve the problem. Helen found security to be reluctant to confront intimate conflict. When they arrived in the unit, they deferred to nurses, asking for instructions on the appropriate response.

We had a bunch of security issues on our floor. And they said call security. And security says, “Well, yeah, but what do you want us to do? You nurses need to tell us when we get to the floor exactly what you want us to say and do with this patient.” Well most nurses aren’t equipped for that.

Nurses are not trained to address intimate conflict as part of their care, but it occurs as part of professional intimacy so they incorporate strategies that vary according to their level of experience. When I asked Mia, a nurse with over 15 years of experience, if it was fair to assume that nurses addressed patient and family conflict without hospital support, she said, “Yes. Because we just take care of it and that is the end of it, it doesn’t get big, out of hand.” She added that, “If that person is really bad and harassing and stuff, we get security.” I asked her if that ever happens, if they ever had to call security. She admitted, “Not really, I have not seen it happen because we take care of the situation.”

Most experienced nurses often deliberately confront inappropriate behavior quickly and abruptly. Helen said that she tells patients who exposed themselves to “throw a sheet on and cover up.” Brett described a time a male patient tried to solicit sexual activity from him. He told the patient, “That’s inappropriate. I’m your nurse. I’m here to take care of you. Comments like that will not be tolerated.” Nadine also told me that she tells patients when they are inappropriate, “You just tell them to get out of bed. ‘I’m sorry that is not appropriate.’ you say.” Angie explained her approach when patients were inappropriate.

I had a patient that absolutely refused to tell his girlfriend to go home, and she

was sleeping in the bed with him. But since the curtain was pulled and the other patient was sleeping, it's easier not to rock the boat. But if you are inappropriate, then I am happy to get you a cot, you know, or a fold out bed, you know, chair that you can sleep in next to, but, you know, you just explain to them that that's not appropriate.

Although direct confrontation seems like a useful strategy, one that is also suggested by administrators, it does not work over time because patients refuse or persist with inappropriate behavior. Josie explained, "Even though they do go over that like, 'If a patient asks you out, then you just say, I'm your nurse and that's crossing the boundaries,' it just doesn't work though in the real world. They'll still be persistent." Melinda agreed. She repeatedly told patients, "I'm not talking to you with this disrespect. I will not tolerate you talking to me" and patients may never respond." Nadine insisted one family leave after visiting hours because they were making too much noise. Although the family wanted this closeness with the patient, they disrupted the rest of the unit. She confronted the situation in multiple ways; none of which worked.

You know if you have a family with a ton of kids and if you kind of make them feel unwelcome, then they'll leave. So if they are making a ton of noise, I'll go in and say I'm going to shut the door here because other people are trying to sleep. I'm going to close the door if you can be quiet, kind of wrap it up. Visiting hours are technically over. Then you have the ones who won't leave. So you get them a cot. And close the door (her tone is resigned and ironic). Some family members are there 24 and 7. Those drive me nuts.

Nadine repeatedly indicated when family's behavior was inappropriate in a hospital setting but still some families – even well intentioned families – insisted on staying, especially when they

felt entitled and did not understand how their behavior could disrupt quality care.

Although nurses sometimes describe confrontation in hindsight, as if these interactions occur in isolation, confrontation usually includes a series of interventions that occur over an entire shift or for days. Elizabeth described repeated interactions with her patient who first harassed a patient care technician and then proceeded to harass her.

I told him it was inappropriate behavior and that we're doing a job. I said, "We're here to take care of you, but we're not here as any kind of girlfriend relationship, or a sexual relationship. My tech is totally uncomfortable coming in here because you've made a few comments." And he said he didn't do anything, and I told him, "Well, she took it like you did. So you have to remember that we're doing a job here. This is our job to take care of you, but you have to be kind of appropriate with us too because it makes all of us feel uncomfortable.

Despite her efforts, he continued his behavior throughout the three days that Elizabeth had him. In addition to comments, he purposefully and repeatedly exposed himself. At first she tried to instruct him on how to comfortably keep a blanket over himself.

He had a permanent erection, and it was painful for him to have the covers over him, and so he'd throw his covers off and just be lying there naked with his big erection, [laughs]. It was like, "Oh my god." [Laughs]. So, I told him, "You know what; I know it's painful for you, but maybe you could put your knees up and put your sheet over your knees when we walk in the room." And he was ok with me for a while after that, but I heard, trickling down from shift to shift that he was still doing it. And I think he got a kick out of it, really. He was just showing off his manhood.

When Elizabeth realized that he had not stopped the behavior, she increased her interventions. She warned other nurses about him, knocked on his door, and announced that she was entering the room. Elizabeth told me that he managed to stay covered most of the time, and when he did not, she would remind him of their agreement.

I'd pick the sheet up and put it over him. And I'd say, "I'm covering you up because it's uncomfortable for me to have everything displayed." You know [laughs] just tried a real nice way. So, I mean, what are you going to do? I'd go in each day and I'd go in and tell him, "Good morning Mr. So and So, remember our little rule with the sheet." [Laughs]

Although this patient's behavior affected the entire unit, no one advised her to intervene. Elizabeth told me that she knew what to do because she had sixteen years of experience.

I just knew. No. I don't think anybody ever coaches us on that. I really wasn't willing to deal with him doing that and have everything displayed every time I walked in his room. Because it is an uncomfortable feeling, you know. This isn't a porn house. This is a hospital, [Laughs]

There is a difference between how nurses talk about how they address intimate conflict and what they actually do. Although nurses may talk about confrontation as if each incident occurs in isolation, they consistently incorporate strategies to deal with intimate conflict throughout their work routines. Although Elizabeth did not explicitly say that she negotiated intimate conflict with her patient, she repeatedly confronted her patient, explained the conflict, acknowledged his pain, and attempted compromise. As he persisted, she also warned other nurses and adjusted her approach.

5.2.3 Negotiating Intimate Conflict

Although it takes time, nurses who negotiate with patients and family members can simultaneously maintain professional intimacy and control over care. Nadine explained how she sets boundaries with families at night by telling the patient “their” plan for the night. She knew from experience that family members who witnessed these instructions tended to leave, telling her when they would be back to visit. By negotiating with the patients, she incorporated families into her plan, which both maintained their trust, and gave her control over the care process.

If patients are here for a major surgery, I usually let the family stay so we can talk about what happens. Usually by that time they’ll realize that I have business to do. I’ll say we have to get you a shower tonight and a shower tomorrow morning. And usually they’ll realize oh this is pretty hectic. And they’ll say, “You know what, we’ll come back tomorrow morning.” And I’ll say, “Oh that would be great. So at 5:30 I’ll give him a second shower and then by this time I’ll be done, so you can come visit before he goes up to surgery.” And usually I try to make them see that I want you here to visit. But let me know when you are done, then I’ll get started and then that is usually when visit time is over.

Nadine negotiated visiting hours with this family in part by not talking to them directly. She hoped they heard her interactions with the patient so she could avoid saying she had work to do and needed them to leave. Moreover, she hoped that the family left knowing that she understood how important they were to the patient. Without explicitly saying so, she conducted her work in a way that would preserve professional intimacy.

Just as Nadine counted on her families to listen to her, Mia listened to the concerns of her patients and then tried to strategize with them to solve problems.

Listen. Just listen. I'll just sit down and just be quiet in that moment and just let them get it all out. A lot of times when you do that, you have to find out where they're coming from. And second of all, what's the solution? What can we do? I mean, what do you expect? And then when I find out what they expect and then what can we do, ok, and if they're difficult and don't want to do things, "Ok, let's do a contract. Do you agree with this?"

Mia took time to listen to her patients, but also involved them in their own care. She engaged with their concerns and solved problems cooperatively. Jason agreed on the importance of giving patients choices about their care as a way to avert potential or additional conflict.

I think a lot of it is about making choices, giving him the power. I think a big problem is when they feel powerless. All this stuff is being done to them. They don't know what's going on; they don't know what to expect. Options and freedom have been taken away. Acknowledge their feelings are valid. I mean that's pretty much the first step, not talking down to them. That's just about letting them know that what they're feeling is OK. And letting them express those feelings. And working with them on their options.

Jason saw that although they may express anger or other inappropriate behavior, patients typically create conflict when they feel powerless. As a way to avert potential conflict, Jason simultaneously facilitates patients' expressions of their feelings and gives them power through choice.

Although nurses describe boundaries as a personal attribute, i.e. nurses either "have" boundaries or they do not, boundary making is a series of strategic decisions that include avoiding behaviors, confrontation, and negotiating with patients and families. Nurses set

boundaries to aid healing, out of respect for the patient, and to avoid conflict. While individual strategies can work, they do not address the larger picture of intimate conflict, take too much time, and minimize conflict labor. Handling conflict individually locates the problem of intimate conflict in individual patients, such as patient attitudes, background, and illness. Defining intimate conflict as an individual problem masks the systemic nature of intimate conflict and how it inevitably occurs with professional intimacy.

5.3 COLLABORATIVE STRATEGIES

Just as nurses have strategies to address intimate conflict, so do nurse teams. I define nurse teams, as opposed to nursing staff, as nurses work together on the same shift in the same unit, regardless of permanent position. Float nurses who were not assigned to any one unit, traveling nurses, nursing interns and students, and other transient staff frequently staffed units. Nurse teams used informal, collaborative strategies such as getting support from charge nurses, switching nurses, and learning from experienced nurses to deal with intimate conflict.

5.3.1 Charge Nurses

When nurses cannot handle conflict themselves, they approach the charge nurse. Charge nurses are the first line managers in each unit. They manage staff, including shift assignment, supervision, and general oversight. Charge nurses help problem solve and ensure patient satisfaction. Some charge nurses visit each patient and others and – depending on staff availability – provide direct care. Not all charge nurses avail themselves to staff nurses during

intimate conflict, but those that do, do so because they feel strongly that nurses should not be abused. Lydia, a charge nurse on nights, explained why she made managing intimate conflict her responsibility.

“Because,” and that’s the way I said it to this patient, “Because my nurses do not have to put up with it.” They should be able to work in an environment where they can be truly free to render care to that patient. And not feel like they’re on guard, which can actually undermine the kind of care they’re going to give to this patient.

Lydia recognized that intimate conflict, and the distance that nurses create with patients as a result, undermined care. Thus, she informally created a culture that did not tolerate abuse from patients. “I don’t mince my words. I just tell them, anytime it happens, ‘guess what, this hospital does not have to put up with it.’ So, we have a right to a work environment that’s free of any kind of harassment like that. So that’s the end of that. I don’t give them options.”

In addition to addressing intimate conflict with individual patients, Lydia handled intimate conflict that resulted when guests wanted to stay in patients’ rooms. She mentioned the visitors’ policy but was more successful when she told families that she was concerned about her patients’ safety.

I tell the couple that if they share a bed, then it could interfere with emergency care later. If you find that your patient is slightly short of breath, then, boom, you need to do everything in your power, right then and now, get him to the ICU, correct diagnostic tests, whatever it is. I just explain it to them, “Your loved one is my priority.” After I say that, it usually changes things. If you bring it back to the patient, they change their attitude.

As a charge nurse, especially on nights when no other staff members were present, Lydia possessed authority that helped create a culture that supported nurses and did not tolerate inappropriate behavior from patients.

Formally expanding the charge nurse role so that all charge nurses are trained, supported, and granted authority to manage disruptive patients and family members may help distribute the burden of intimate conflict. However, increasing charge nurse responsibilities would require increased compensation and a reorganization of administrative labor. In my study, unit directors shared administrative responsibilities with their charge nurses, especially if they did not have full time administrative support staff. In order for the hospital to provide the charge nurse as a resource for managing and averting conflict on each shift, each director would need full time administrative support, freeing the charge nurse to handle administrative duties only relevant to that shift, such as scheduling and assessment. Moreover, charge nurses would need institutional support for their efforts. Recognizing that intimate conflict occurs in concert with quality care would help charge nurses and the hospital justify interventions, interventions that would ultimately increase overall patient satisfaction because they would facilitate professional intimacy.

5.3.2 Switching Patients

If nurses are uncomfortable with or felt harmed by their patient's behavior, nurses – especially new nurses – ask to be reassigned immediately or the next day. Charge nurses are not surprised by these requests. They happen often and are usually discussed collaboratively on a shift. Although this is a useful strategy for nurses, if over-used, nurses risk appearing ineffective over time. Joyce told me, as a patient care technician studying nursing, she went to the charge nurse

after a patient made a sexualized comment to her, but now that she is an RN, she would handle the situation differently.

But as an RN I would just tell him, “You’re not allowed to talk to me like that way at all. And if you keep it up, I’m not going to be able to take care of you. Your choice.” And you just have to cut it off right there. And you have to stand up for yourself in such a way that it’s not real confrontational. But that, those boundaries are pretty clearly set, and you can do that.

Like most nurses, Joyce thought that the more experienced she became, the better she would be able to handle difficult situations on her own.

Although Joyce and other nurses thought they would not need to switch patients as they gained more experience, the act of switching patients did not necessarily lessen over time. Although she has been an RN for five years, Josie explained that in the worst cases of inappropriate behavior, she asked for another patient. She felt pressure from other nurses to manage the conflict, but identified her discomfort as uneasiness with being “tough.”

There’ve been times, to the point where I’ve asked not to have the patient back because I felt so uncomfortable. It’s just to that point where no matter what you’ve said, or you know, and maybe I’m not as tough with them. Because some nurses are like, “Oh, I just put them in their place and I tell them... and they don’t bother me anymore. Or I just give it right back to them. Or something like that.” But I don’t, I can’t do that. And maybe it’s the shyness in me or something, I don’t know. [Laughs]. I just get uncomfortable, and I don’t want to deal with it.

Despite her experience, Josie expressed doubt about switching patients because she was concerned that she looked like she could not do her job. In a work culture that equates

professionalism with individual problem solving, she did not want to seem weak. In contrast, Jackie, a new nurse, appreciated this strategy. “If I feel like this patient is not treating me like a nurse, it’s very easy. Just tell the charge nurse which patient, and they will switch you.”

Even though some nurses felt that it could appear as a weakness, asking for another patient could be a useful collaborative strategy. Instead, nurses internalized conflict as a measure of their individual abilities and saw handling patients by themselves as an indicator of good, qualified nursing. Acknowledging that working with intimate conflict is a part of providing quality care, rather than keeping conflict labor covert, would identify its systemic nature that, although is intrinsic to professional intimacy, prevents professional intimacy that is necessary for quality care. The persistent practice of switching patients does not indicate less skill or professionalism of individual nurses, but rather points to the persistent of problem of intimate conflict. Making the practice of switching patients a viable option could lead to a fair distribution of labor, which may ease individual nurse burnout and increase nurse retention.

5.3.3 Experienced Nurses

In spite of an individualized, “handle it on your own” work culture, many new nurses learn how to provide intimate care, handle intimate conflict, and set boundaries from experienced nurses. For example, Jackie learned how to deal with patients who exposed themselves to her, from Grace, a more experienced nurse.

So once I told Grace about that, and she said, “Jackie, tell me which patient! I’m going to let him know.” So she goes [sic] up to the room. The thing is he’s not covered. So Grace tell [sic] him, [laughs] she gave him a speech. And then she said, “Jackie, you’re not going to let them control you. You’re going to go in

there and tell him that how they do is not appropriate.” And, after that I tell patients.

Jackie did not know that she would encounter patients who sexually interacted with her before she worked at the hospital. Not knowing how to handle these situations, she sought the advice from a good friend with more experience. Grace empowered Jackie and taught her how to confront inappropriate behavior, which was all the encouragement Jackie needed to act on her own behalf.

Melinda also attributed much of her practice to more experienced colleagues. In addition to practical tips and medical practices, she learned how to manage intimate interactions from patients and family. She explained how she shares this knowledge with new nurses.

I have excellent charge nurses and nurses with 20 years of experience, and I’m just like, “OK, what do I do?” You know, and sometimes you have to take a step back and either ask for advice or just say, “You know what, can you please go in there and deal with him? Or go in and give him medication? Because he’s a jerk, and I just don’t like him.” And it goes back to having a team that you can count on. I mean there are other nurses, and I’ve done the same for them, that they’re just like, “This patient and I” or “I’m at my wits end.” I respond, “OK. I’ll go give them medication.” You know, just work together that way.

Although she did not describe it this way, I characterize how Melinda explained sharing knowledge with her colleagues, as collaborative mentorship. Collaborative mentorship requires that nurses feel comfortable and supported when asking questions and sharing advice.

Although extremely useful, the informal practice of collaborative mentorship depends on the condition that new nurses feel safe asking questions and experienced nurses feel comfortable

giving advice. Jody, a nurse with twenty-five years of experience, did not feel that she could assist other nurses with their practice because she did not want to seem disrespectful. Nurses generally feel great pride about their individual nursing practice because it is in part how they define their professionalism. Nonetheless, Jody reacted harshly to a nurse who seemed too gregarious with a patient, but felt that she could not express her views to the nurse. “Put it on a leash,” she said. “But you can’t do that. It wasn’t my place. If that’s the reflection you want on you, fine. But it’s not going to be cast on me.” Although she disagreed with the nurses’ actions, Jody kept quiet.

In contrast, Patsy, a nurse with thirty years of experience, explained how she warns new nurses how to handle inappropriate behavior from patients. “I tell the younger nurses not to go in there by themselves. Always have somebody with them, to take care, care of the patient. You know, things like that.” Collaborative mentorship needs willing participants. At this hospital there was no systematic way to connect nurses who were willing to ask questions and share knowledge. Nurses found each other by working on the same unit, over time, and by coincidence. Also, like any new professional, new nurses valued the knowledge of experienced nurses, but did not always know the questions to ask. A hospital-facilitated volunteer mentorship program would capitalize on experiential knowledge without over-burdening individual nurses.

5.4 CONCLUSION

Boundaries are personal and professional; individually and collaboratively produced. It is work that requires skill, knowledge, and experience. Setting boundaries indicated professionalism, experience, and skill, which limited its scope to individual nurses rather than a collaborative

strategy used by nursing teams.

Because they find institutional measures irrelevant, nurses address patient and family conflict on their own. Nurses respond to intimate conflict individually in part because nursing is defined as an individual practice, which satisfies individual patients. Although ignoring patients can be strategic, nurses' *non*-response to conflict perpetuates the invisibility of professional intimacy, conflict labor, and boundary making. It also stifles professional intimacy because nurses spend less time with patients and the relationships they develop seem artificial. Although immediately useful, the benefits of confrontation do not last. Confrontation quickly morphs into negotiation because nurses have to repeat and alter their confrontation strategies. Nurses who negotiate with patients and family members have the most lasting success, but these measures also take the most time. Formalizing collaborative strategies like working with charge nurses, switching nurses, and sharing knowledge acknowledges the systemic nature of intimate conflict – especially as it relates to maintaining professional intimacy – and takes the responsibility off of individual nurses.

6.0 RECOGNIZING PROFESSIONAL INTIMACY AND A CALL FOR COLLECTIVE PRACTICES

By recognizing professional intimacy, I demonstrate the significance of both professionalism and intimate labor in nursing practices. Professional intimacy rejects dichotomous framings of care as either altruism or professional skill to show how hospital nurses use both to provide quality care to patients and families. My research reframes the discussion of what it means to be a good nurse by rejecting naturalized definitions of care, femininity, and whiteness. Instead, my analysis reveals the labor that is required to conduct care in a hospital setting. Rather than focus on whether nurses are motivated to care for either altruistic or economic reasons, my research shows that nurses and patients construct what it means to provide care and also that ideas of care are constructed along lines of gender, race, and nationality.

This dissertation has both theoretical and practical uses. Recognizing professional intimacy has significant theoretical implications for understanding the relationship between intimacy and the economy and for elaborating how intersectionality theory can be used to study everyday life. In addition, collectively recognizing professional intimacy has practical value, helping nurses better understand the shared conditions of their labor. Attention to issues of professional intimacy in nurse training and in hospitals also may increase patient satisfaction and nurse retention, which might help alleviate the nursing shortage.

6.1 CONTRIBUTIONS TO THEORY

This dissertation contributes to the sociological literature on emotional labor and care work by recognizing the intrinsic relationship between intimacy and the economy in hospital nursing (Zelizer 2005). It also contributes to feminist theory by using intersectionality theory to study the everyday relations in hospital nursing (Collins 2000; Smith 2005).

6.1.1 The Relationship between Intimate and Economic Practices

A key theme in the literature on care work is the study of emotional labor, body labor, and organized emotional care (Anderson 2000; Hochschild 1983; Kang 2003; Lopez 2006). Hospitals encourage nurses to conduct emotional and body labor to maintain patient satisfaction, but some nurses are uncomfortable saying that care work is intimate because they fear that doing so will negate altruistic definitions of care, which recognize the genuine feelings of kindness and generosity they have towards patients and their families. Moreover, nurses hesitate to acknowledge intimacy because it contradicts mainstream definitions of professional labor. By minimizing intimacy and emphasizing professionalism, nurses want to show the value of nursing in hospital medicine. Recognizing professional intimacy in nursing will solve this problem because it demonstrates that acknowledging the economic relationship of intimacy in professional nursing values care through the skill and specialized knowledge that are required to provide intimate labor. Encouraging collective strategies or what Lopez (2006) calls “organized emotional care” will increase the value of both the intimate and professional nature of nursing care.

The current health care crisis, including the global shortage of nurses, demonstrates how

the global commodification of care affects local relationships between nurses and patients (Folbre 2001; Hochschild, 1983, 2003; Misra 2003). Recognizing professional intimacy in nursing demonstrates how intimate labor matters to global economies by revealing the precise dynamics of intimate labor that are exchanged in global care chains (Hochschild 2000). Currently, professional intimacy contributes to profit because it is not counted as part of nurses' work; rather, it is expected by patients and assumed by administrators. Not only is professional intimacy invisible labor but its production is also invisible. Revealing how nurses learn and do professionally intimate labor could inspire collective training and mobilization efforts that cross national boundaries and result in better working conditions for nurses (Moody 1997).

6.1.2 The Relationship between Intersectionality and the Study of Everyday Life

The concept of professional intimacy recognizes invisible labor experienced by nurses who vary by gender, race, and nationality. By conducting an ethnography and using feminist standpoint theories, I interrogated normative meanings of care, intimacy, and professional labor. Until they started talking about it, nurses did not necessarily think that their work was intimate. Studying the operation of professionally intimate care labor from the “ground up” and prioritizing the perspectives of nurses helped demonstrate how experiences of intimate care are both socially constructed and also, normalized as natural personality traits.

Intersectionality is a socially responsible method of studying everyday life because it reveals how multiple subjectivities contribute to all social relations, including inequality. Nurses and patients negotiate trust and familiarity through intersections of race, gender, and nationality. In my study, the intersections of masculinity and sexuality and the intersections of femininity and race were found to be particularly salient. For example, all nurses experienced intimate

conflict, but similar to Kimberle Crenshaw's (1991) point that women of color specifically experience violence shaped by race and gender, nurses of color experienced intimate labor through the intersections of race, gender, and nationality.

Using intersectionality to study professional intimacy challenges hegemonic meanings of nursing and care labor. Meanings of "professional worker" and "care" change when considering intersections of race, gender, and nationality. Because professional intimacy relies on interactions with patients, it is shaped by how patients perceive their nurses' experience; however, how patients understand such experience depends on their assessment of nurses' race, gender, and nationality. These perceptions have less to do with the actual work of nurses than with cultural norms and racist, sexist and nationalist stereotyping.

6.2 CONTRIBUTIONS TO NURSING PRACTICES

This research distinguishes the desire to care from the capacity to do nursing labor. Whether or not it is taught, institutionally supported, or assessed, nurses are expected to ensure quality care through professional intimacy. Not all nurses are prepared to handle intimacy in their profession, but all nurses can learn how to do this work. Naming professional intimacy reveals the skills and specialized knowledge required for care labor. Understanding care labor in these terms encourages institutional and educational supports for such invisible aspects of nursing.

I present this research with hope that nurses might use it to advocate for a reorganization of their workspace, labor, accountability, and education in ways that will better accommodate professional intimacy; however, I also realize that this research could be used to the detriment of nurses. As health care costs increase and the nurse shortage persists, administrators could

conceivably use this data to argue for maintaining the status quo by celebrating how nurses balance professional intimacy with medical, administrative, and other care tasks without implementing institutional supports. As the hospital CEO said to me in reference to the caring abilities of nurses, “I do not know how they do it, I am just so glad they do.” Even managers interested in supporting professionally intimate labor may inadvertently harm nurses. They could add to nurses’ already-overburdened labor by expecting nurses to formally train each other without compensation or institutional support. They could require additional charts and other documentation to standardize policies and procedures without reorganizing labor to accommodate these efforts. While taking nurses for granted and keeping professional intimacy invisible could occur in the short run, it will not help patients or solve nurse burn-out or other problems associated with nurse retention. Recognizing professional intimacy could help formalize individual strategies into collective strategies that could be taught in nursing programs and instituted in the workplace.

Instituting a volunteer mentorship program and teaching nurses – at both the associate and baccalaureate level – about professional intimacy *before* they reach the bedside would encourage the use of these practices. Other institutional supports could be reorganizing workspace, coordinating responsibilities, and dictating, rather than writing, charts. With barely enough time to chart, dispense medications, assess and provide medical care, and give service, nurses have little time to spend with their patients; however, experienced nurses fit professional intimacy in their work schedules. Nonetheless, these efforts could be better supported if professional intimacy were recognized as labor and, also, if a majority of their time was not spent being interrupted, charting, and following up on the work of other staff. Documentation and phone calls take significant time and take nurses away from their patients. Moreover, both nurses

and patients want patients to access nurses when they need them, as characterized by a nurses' station that is in the center of the unit, open, where people freely walk and talk. The problem is that this is not the only purpose of the nurses' station as other staff members – including physicians, respiratory and physical therapists, and social workers – also use this space to conduct their business.

Hospitals could better use nurses' time by reorganizing space and responsibilities to accommodate professional intimacy. Reserving the nurses' station for interactions between patients and family members and giving other staff a separate place to work may encourage professional intimacy. Increasing the responsibilities of administrative support staff to include follow up with staff may also free nurses to conduct professional intimacy. Finally, dictation of charting would save nurses time – that could be spent with patients.

As it stands, nurses are the point people for patients and family members. They are the clinical staff members most likely to catch illness or injury when it turns for the worse. Allowing nurses to conduct professionally intimate work will ensure better medical care to patients, care that could ultimately save lives.

6.3 SUGGESTIONS FOR FUTURE RESEARCH

Future research in the area of professional intimacy should continue to use intersectionality theory to further develop the concept of intimacy as it works in other professional work such as social service, pastoral care, and education. The theoretical development of professional intimacy could also occur by studying the professional nature of intimate labor such as massage therapy, the sex industry, and the beauty/spa industry.

Finally, the concept of professional intimacy should be studied in the international professional care labor market. These studies should focus on the relationships between race, ethnicity, and migration status in nursing and how nurses negotiate cultural stereotyping and economic discrimination in their host and home countries. Studying how these factors condition the experiences and understandings of professional intimacy will bring us closer to increased social and economic values of professional care work as it occurs around the globe. This dissertation lays the groundwork for such future endeavors.

APPENDIX A: INTERVIEW SCHEDULE

How and why did you decide to become a nurse?

What do you like/dislike about your job?

Does your charting capture your care work?

What is the most important part of your job?

Changes between first started and now?

How much does being caring comprise your work?

How much does service comprise your work (i.e. your call lights)?

What is the difference between service and care?

What do you delegate to your techs?

What and how did you learn at school about caring?

What and how did you learn on the job about caring?

Do your ethics or politics affect your care work? How?

Describe your relationships with your patients and family members.

Discuss any conflicts you may have.

Walk me through your interactions with patients, your routine.

What do you do to make patients comfortable? Emotionally? Physically?

Do you nurture patients and family members? How?

How much of a nurse's job is to provide care?

How is your unit different from other units re care work?

Do patients ever ask you how long you've been a nurse? Do they ever question your skill or experience as

a nurse?

Do you think patients expectations of what a nurse is factor in the ways that patients interact with you, gender, race, age, etc.

Is care at the bedside intimate, i.e. close, personal, and private? How?

Do you think patients expect intimate interactions or closeness from you?

How do you determine when your intimate interactions with patients are productive and helpful for healing?

What are reasons that you request not having a patient or reasons that nurses request this from you?

Are your intimate interactions with patients ever uncomfortable? Inappropriate? Harmful?

Experience any incidents of sexual harassment?

Did you expect _____ when you were in school?

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