
Introduction

Fantasies and Realities in Nursing Care

Anna,¹ a new Latina nurse, prepared for what was next on her shift: she had to go change a catheter for Alan, a young white man. As she gathered her materials, Anna thought about how uncomfortable she had felt the first time she changed a catheter as a nursing student. She marveled about how it did not bother her anymore, but it did sometimes still make her nervous. “When did that change?” she wondered. Anna considered the various ways she could act with her patient during the procedure. When she first asked her mentor, Jason, about this, he suggested she could try not talking as a symbolic way of showing her respect for her patient’s privacy. However, Anna knew that talking could serve to help keep her patient’s mind on something else. From talks with senior nurses, she was beginning to understand that establishing some intimate connection with her patients was necessary for them to feel safe and to feel better, and it seemed to help patients trust her and the hospital. She did not want to seem “uncaring” like her colleague, Joyce, another new nurse, who avoided intimacy with her patients whenever possible. At the same time, she admitted she did not quite understand how to be professional and intimate at the same time. What if Alan does something she is not prepared for? What if he becomes aroused? What if he feels violated? What if he does not like Chicanas? Should she involve Maura, his wife? Would that make him more or less comfortable with the situation?

Inserting Alan's catheter went well. As she performed the procedure, Anna asked Alan personal questions and shared some information about herself. They discovered that they were both army brats as children and could relate to each other on this personal level. Alan seemed fine when she was finished. He breathed a sigh of relief and thanked Anna. She asked if there was anything else she could do. Maura said, "Um, no Anna, we think you are great. We were just wondering when we would see Alan's nurse—you know, the one in charge of his care. We have some questions about his diagnosis, his procedures, and when he might see the doctor." Anna half-smiled and said a little hesitantly, "I am your nurse" and pointed to her badge. Both Alan and Maura appeared embarrassed. Alan looked away, and Maura blushed. At the same time that Maura started apologizing for their mistake, Anna said, "I can get you another nurse if that would make you more comfortable." "Oh no, that isn't necessary," Maura said. "We just didn't realize . . ." she trailed off. Anna was embarrassed and worried, but she put those feelings aside and reasserted professionalism. She offered to sign Maura up for the hospital's patient advocacy program, PAL. She explained Alan's plan for the day. She promised to tell them both when they could expect Alan's physician.

Although Anna knew she had handled herself well, she left the room feeling frazzled. Did she do something to make Alan and Maura think she was not their nurse? Perhaps she should have brought in her clipboard? Maybe she should wear her name tag in a more prominent place? Then again, she knew she had introduced herself to them that morning as their nurse. Her name was on the board in their room, indicating she was the RN. How could they not know?

Anna was assigned Alan the next day, and unfortunately, things took a turn for the worse. Alan's illness had progressed, and he was feeling significant pain. When Anna went to check on him, she found a very worried-looking Maura and a very frustrated Alan. Alan cried out that he needed his medication. Anna gently explained that he was not due for his medication for another two hours. Alan was furious. He told her that she was so nice yesterday; he just thought she would care for him when he needed it. He started yelling at Anna, cursing at her, using racist and sexist slurs, and saying derogatory things like "Why don't you go back to where you came from?" Anna was shocked. Feelings of humiliation and anger poured over her. When she left the room, Alan called out, asking for a "real" nurse. Anna was especially embarrassed because Alan's room was right next to the nurses' station. Anna could not help but notice that several staff members heard Alan, including her charge nurse Lydia. She worried about how Alan's behavior would reflect on how Lydia would perceive her abilities and professionalism.

After she calmed down, Anna thought about what to do. Although she was taught patients would act out and perhaps call her names, in nursing school Anna was not trained on how to handle such situations. She knew that Alan's anger was coming from a place of pain, but she did not think she could tolerate his accusations, especially the racial slurs and the sexist remarks. Yet she worried that if she told her charge nurse, she would seem unprofessional or unable to handle her job. She knew that other nurses watched her to see what she could handle as a new nurse. She thought that rather than go to her charge nurse, she could say something to Alan herself. She could ask him to stop, but she did not want to upset him or Maura. They were already suffering. Besides, she was not sure he would stop just because she asked him to. He was the patient, after all. He was essentially paying for her services. She decided to ignore Alan's behavior and hoped he would stop.

To Anna's relief, Lydia approached her that evening to ask her what had happened. Although the hospital did not have a formal, transparent approach to addressing prejudicial treatment from patients and similar conflicts, Lydia had a reputation for not tolerating poor treatment of her nurses. Anna was thankful that Lydia was the charge nurse working that night. First, Lydia suggested that if Alan used racist or sexist slurs against her again, she confront the behavior. Anna was nervous about doing this, but Lydia coached her through it and promised she would support her. Lydia insisted this kind of interaction would not make Anna look bad. Anna agreed to try. The next time Alan called her names, she told him to stop. She did not yell at Alan. She just looked him directly in the eye and said, "Alan, the way you talk to me is inappropriate. I am your nurse. Don't do it again." Alan looked angry, but he did not behave angrily. Instead, he rolled his eyes and said, "You're too pretty to be mean to anyway. Maybe you can make it up to me in another way." Anna cringed at the sexual innuendo as Alan winked at her. She looked away and avoided the gaze of Maura, who was sitting there the entire time.

The Fantasy of Care: Naturalizing Intimate Care in the Profession of Nursing

When I first began designing this study while living in Pittsburgh, Pennsylvania, I took a picture of a bus advertisement that read, "Born to be a nurse" (see Appendix C). In it, a little girl of color uses a stethoscope to listen to her teddy bear's heart. This advertisement and others like it suggest that nursing is a natural aspiration for a little girl. It is also noteworthy that the little girl in the advertisement is one of color. It could symbolize the legislative and industry efforts to diversify nursing along racial and ethnic lines. In spite of these

efforts and a long-standing nursing shortage in the United States, extremely low numbers of women of color persist in the ranks.²

Historians and sociologists explain race stratification in nursing by showing how racism in nursing education and professional associations reduced structural opportunities for women of color, especially in the twentieth century.³ Over time, white women became and remained the public face of nursing, ideologically and structurally, while women of color occupied primarily low-wage, backroom care work jobs, responsible for the “dirty” work.⁴ Sociologists explain this stratification by focusing on how dominant ideologies about women of color shape their material circumstances in professional care work.⁵ Moreover, the United States has a long history of recruiting immigrant women of color to work in the United States without addressing discrimination, hate rhetoric, or violence.⁶ Rather than address systematic discrimination, recruitment programs emphasize how nursing is a good job for women because women are naturally caring.

There is a long history in nursing that suggests people define good nurses by how much they appear to be naturally good at caring. This lineage in nursing parallels the logic that suggests women are inherently caring.⁷ The belief that women are natural caregivers is partially rooted in how women have traditionally provided the bulk of care work in and outside the home. Nurses, administrators, and educators in my study also participated in this naturalizing rhetoric. I found, and my study participants agreed, that patients defined their nursing experience by focusing on care and using words like *nice* and *compassionate* to describe their nurses.⁸ Similarly, nurses and hospital administrators mostly talked about “being caring” as a value, rather than as professional work. I suggest that a dichotomy of professionalism and care persists in part because intimacy, as a part of bedside care, seems unprofessional.⁹ Indeed, most nurse directors in my study hesitated to use the word *intimacy* to describe their labor. In fact, when I used the word with administrators to ask about work conditions, they grimaced and redirected the conversation to professional care. I was not surprised to learn that the function of intimacy and how it creates and sustains quality health care is virtually invisible in nursing education and in public discussions about practice.¹⁰

Everyone in my study valued good care, but when asked to explain it, each person had trouble. Nurses and administrators reduced the meaning and circumstances of care work to “being caring.” This inability to articulate the process of intimate care work helps maintain what I call the fantasy of care. In the fantasy of care, good care involves almost no conflict between the nurse and patient. When conflict occurs, nurses are naturally adept at handling it in ways that consistently make the patient feel safe. At the same

time, it is hard to imagine conflict because the fantasy suggests that caregivers are naturally adept at caring, and care receivers are eternally grateful for the care they receive. For the patient, the fantasy is that care will always be pleasant, welcoming, and warm. The fantasy of care for the nurse is that the care the nurse provides will be both natural and professional. The fantasy of care locates care in the social imagination as a universal experience that can be recognized only when individuals experience it. It serves as a principal value for nursing care but does not reflect the patterns of professional practice. In my study, this fantasy was shared by patients, family members, nurses, and hospital administrators. It naturalized, glorified, and ultimately erased intimate caring behaviors and care work.

The fantasy of care suggests that care always feels good. The reality of care, however, includes how nurses negotiate trust and conflict so that patients trust them. While care may feel natural to the patient, it is actually a series of intimate acts that nurses purposefully and professionally perform to construct this feeling of naturalness. As exemplified by the experience of Anna described at the beginning of this Introduction, in some cases patients act out in abusive and exploitative ways during the provision of emotionally and physically intimate care. The analysis in this book shows how patients, as they become more familiar with their nurses, sometimes cross professional boundaries in an attempt to get their needs met. The principle that care always feels good is well meaning, but as a practice it proves unrealistic. Ignoring how this principle fails also denies the experiences of nurses and limits the analysis of meanings of professional care.

Conflict is not a new idea in nursing.¹¹ What is new in this book is how I theorize conflict as part of the provision of intimate care. I highlight intimacy in the provision of professional care, which reveals how nurses negotiate conflict with patients. I watched bedside nurses define conflict from patients as inherent to illness or injury and as something that good nurses could overcome. These explanations of conflict were talked about as if common knowledge. I most often heard these explanations when I watched nurses collectively strategize conflict resolution as a team or unit. Much of professional nursing, however, consists of individual practices with patients. When I interviewed nurses, each thought his or her individual experience of intimate conflict with patients was a unique experience that could not be shared with peer nurses and administrators. When I asked why, many shrugged and indicated in some way that it did not occur to them to disclose this information to anyone or that they did not have the time to discuss it. Other nurses told me they worried that talking negatively about patients would make them appear like bad nurses who could not handle the stress of the job. These

responses made sense to me. In the first case, individual nurses considered patient conflict a part of the job and believed there was nothing to be done about it except to endure it during care work. In the second case, individual nurses resisted talking about conflict because each thought handling conflict independently was a sign of professionalism.

Catheters, Slurs, and Pickup Lines: Negotiating Mundane, Insulting, and Sexualized Intimacies

Before Anna entered Alan's room, she strategized on how she would make intimate care *seem* natural to Alan and not like professional work that required training. A catheterization was one of the many mundane, intimate procedures Anna would perform on patients. These procedures did not feel intimate to her; any discomfort she may have felt was in part lessened by her focus on providing medical care. She had learned in school how to consider care from her patient's perspective and the importance of combining compassion with skill while performing catheterizations, IVs, baths, and other nursing acts that involve physical touch. Anna anticipated that Alan might feel nervous about the intimate nature of this procedure because it involved touch that is personally intimate in any other situation. At the same time, she was not sure how to be professional and intimate simultaneously. She was unsure of what outcome to expect because she was not certain how Alan would react to her. She discussed with Jason and other senior nurses how to make patients like Alan feel comfortable during the process of intimate care.¹² For the catheterization to be successful, Alan needed Anna to be at ease with providing intimate care or, in other words, to seem naturally good at it.

In my research, I discovered that "good" nurses were actually experienced nurses who over time had learned to create a sense of familiarity with their patients as a strategy for gaining trust. I refer to such strategies as *intimate trust*. Although she was a new nurse, Anna had modeled her behavior after experienced nurses. She successfully garnered a sense of familiarity with Alan by sharing some personal information about herself and asking questions of him. Partly because of this success, the catheterization went flawlessly. What might have appeared like a natural ability to care was actually a conscious, strategic use of intimate trust in a professional manner. In other words, Anna employed intimate trust so she could effectively execute her professional labor.

I found that nurses helped patients through their fear of hospitals, doctors, illnesses, and health-care systems to accomplish trust. This trust was necessary so patients could receive quality health care. If patients did not trust

their care providers, they would resist procedures, policies, and practices that would help them recover. Once trust was gained, it could be lost at any time. Experienced nurses used intimate trust to work through conflicts that arose from patients' mistrust, feelings of entitlement, and inflated sense of familiarity with nurses. They skillfully negotiated a return to trust so that patients could receive optimal health care.

On the second day Anna was assigned to Alan, after his illness had progressed, Anna experienced her patient angrily yelling racist slurs, making sexist remarks, and using a crude pickup line that could have resulted in a slap to the face in any other context. These acts are forms of *intimate conflict* because they represent a specific kind of intimate labor that nurses encounter as they work to sustain trust with their patients. I learned that an additional form of conflict occurred when patients mistook their nurse's role. For example, when patients misunderstood the position of women of color nurses, new nurses like Anna internalized these misunderstandings and wondered what they could have done to cause them in the first place. Some nurses must first establish and defend their status as nurses for intimate care work to even begin. Alan and Maura thought that Anna was not their nurse. As a result, Anna had to negotiate her feelings about this interaction and simultaneously do more work to professionally gain Alan and Maura's trust. I explain other such instances in this book. I also describe cases where patients outright refused women of color nurses. In each of these cases, nurses were forced to tolerate this treatment, compartmentalize it, and strategize on how to continue care and reestablish intimate trust.

Whether conflict came from patients' fear, anger, entitlement, or increased familiarity with their nurses, I observed a significant pattern in the ways it was a part of intimate labor. Anna did not know how to handle this treatment. She told me she was never taught how to handle these kinds of conflicts with patients. Anna felt threatened, fearful, and frustrated, combined with a concern that Alan would not receive her care. She worried that this disconnect with Alan was her fault and would make her look like a bad nurse who could not care for patients. She did not know how to navigate the racism and sexism that affected her individual practice.

Although much of nursing is valued as an individualized profession, some of the best practices I observed were when the nurses worked together as a team. As Anna considered her next step, Lydia approached her. This simple act relieved Anna from multiple contradictory pressures. Anna did not have to focus on whether her superiors would judge her harshly. Instead, Lydia created a culture that advocated respect for nurses and showed Anna how to care for patients within that context. Lydia offered Anna immediate guidance

on how to handle the conflict at hand and simultaneously demonstrated that negotiating intimate care in nursing can be a collective practice, rather than something that nurses must handle alone. While new nurses felt unprepared to handle intimacy or conflict, I observed, experienced nurses handled such situations with professional ease. Over time, I watched senior nurses take new nurses under their wings and *teach* them how to care. Although these experienced nurses insisted that caring could not be taught, they demonstrated otherwise. Without acknowledgment (from themselves or others), they modeled how to handle intimacy and conflict with patients. They negotiated with the harassing patient, the demanding family member, and the intimate moment. I watched how, in contrast to the idea that nurses eat their young, experienced nurses nurtured new nurses by teaching them how to professionally negotiate intimate care for patients.

The primary goal of this book is to mark the professionally intimate labor of nurses that is invisible, naturalized, and taken for granted yet contributes greatly to quality health care and to hospital profit. Although the administrators in my study used traditional definitions of care to describe intimacy in nursing (in part, to avoid using the word *intimacy*), I learned that senior nurses strategically and skillfully negotiated intimacy as part of care work. In school, nurses learned technical skills, therapeutic communication, and care theory; however, school did not entirely prepare them for how patients would not necessarily recognize these skills. I observed new nurses become rudely awakened to the realities of intimate care work once they got on the floor. They did not fully understand the degree to which care included intimate and uncomfortable situations and the extent to which patients would express and exhibit fear and pain through disrespect, demands, and abuse. I found that new nurses were not prepared to handle intimate conflict with patients in part because learning how to manage conflict that is inherent to care contradicts the fantasy of care.¹³

The Study

Anna's story is one example of many in this book that demonstrate how the provision of professionally intimate care in nursing is both invisible and socially constructed.¹⁴ She was one of forty-five nurses whom I interviewed and observed over an eight-month period to study the relationship between intimacy and professional care.¹⁵ I also interviewed ten administrators and three nursing professors on the meanings of intimacy in nursing and whether they thought "being caring" could be taught in nursing school. I designed this study to consider the influence of intersections of race, gender, nationality,

and sexuality in part to reflect the increasing diversity in nursing but also because work and other everyday life experiences are constructed by these social factors.¹⁶

I conducted eight hundred hours of ethnographic observations in a hospital with a diverse nursing staff in a large, growing city in the southwestern region of the United States, close to the Mexico border. This choice offered me a midsize hospital and a nursing staff diverse in race, age, gender, and nationality. I selected the hospital in part because it was a Magnet hospital. The Magnet designation of the American Nurses Association (ANA) is a prestigious award given to approximately 2 percent of hospitals in the United States. It was established in part because the ANA sought to understand and reward hospitals that excelled at recruiting and retaining nurses. It indicates to patients that they will receive quality nursing care and assures nurses of a work environment that values and respects them and provides resources for giving the best care to patients. That I conducted my research in a hospital ranked in the top 2 percent for nursing in the United States helps position my model of professional intimacy as one that is exemplary of skilled and professional intimate nursing care. I chose the city because it is one of the fastest growing cities in the country and is located in a state that faces one of the worst nursing shortages in the country. As such, the state actively sought to recruit minority and male nurses.

At the time of my study, the city had clear divisions—and tensions—along lines of nationality, race, and class (and these divisions remain). The city is in a border state with a significant proportion of native Spanish speakers. The state's Latino and Latina population grew from 19 percent of the total population in 1990 to more than 33 percent in 2003. At the time of the study, the state 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.

To capture how social dynamics shaped by gender, race, and nationality affect individuals' experiences, I use feminist standpoint theory. Feminist standpoint theory argues that people who are closest to everyday interactions, but possess less structural power than those in dominant groups, should contribute to theory about those interactions. In other words, as researchers, we should seek meaning about social life through a "bottom-up" analytical lens as well as a "top-down" analytical lens.¹⁷ I centrally consider the knowledge of bedside nurses because I believe the perspectives of those closest to the experience of providing intimate care can offer knowledge about meanings of care that other observers cannot see. Therefore, I developed the ideas in this book

with and on behalf of nurses, from their experiences and as they understood their experiences.

Most of the nurses I interviewed, observed, and informally talked with were bedside nurses and as such had a unique perspective on patient care. These nurses represent the “frontline” nurses; they assess patients, coordinate and explain care plans to patients and their families, and are the first people to manage changes in care for patients. This means that when there is a change in the patient’s health, the bedside nurse is the first to know. I believe the experiences of bedside nurses can help all people interested in quality health care understand the nuances of providing intimate care. These nuances include how bedside nurses individually and collectively negotiate conflict with their patients.

Professional Intimacy

The analysis in this book and the model of professional intimacy that results capture how experienced nurses build and sustain trust with their patients. Although it is not recognized, nurses construct intimacy as part of managing care. When managing care, nurses do more than coordinate technical and medical information related to a patient’s condition. Much of this management incorporates physical and emotional intimacy, which nurses must also manage to keep their patients’ trust. Nurses must have sound medical knowledge and skills, but trust also defines what quality health care is and is not. I mark professional intimacy in organizational processes of care work because naming the process of intimate care will help make visible the skill and experience required when one “gives care” in a professional work setting. I hope that naming this labor will help improve nurse recruitment and retention. Identifying professional intimacy will increase the social and economic value of care, which nurses have identified as crucial to quality health care. I suggest that rather than being born to care, people learn how to care over time and in different contexts.

The phrase *professional intimacy* is peppered throughout the published literature in the fields of business and the therapeutic sciences to indicate how professionals mix professionalism with personal engagement and simultaneously make appropriate boundaries. The goal in this literature is to distinguish between professional and personal relationships, but none of it explicitly describes how to do this. For example, a nursing article written more than three decades ago uses the phrase *professional intimacy* to indicate the resolved stage of role confusion for nurses who are transitioning from the bedside to nurse practitioner (post-undergraduate work).¹⁸ Although it suggests that

nurses and doctors mutually depend on each other in a professionally intimate manner, this article does not specifically define professional intimacy; nor does it address the work bedside nurses do with patients.

In this book, I use the phrase *professional intimacy* to name the theoretical model I designed after conducting research with bedside nurses at associate and bachelor levels of nursing education. I define professional intimacy as the set of intimate exchanges among nurses, patients, and family members through which the nurse must balance the patient's emotional and physical needs in a turbulent work environment. I explicitly choose the word *intimacy* rather than the word *care* to mark this labor because doing so makes clear that we are talking about work conditions as exchanges that are socially defined as private.¹⁹ Moreover, I distinguish intimacy from other parts of care and explain that professional intimacy is one part of the science of nursing care. Using the word *professional* along with *intimacy* unabashedly claims that intimacy in the context of hospital nursing is professional labor.

I analyze intimate care in the context of hospital nursing not as a natural attribute but as a routine pattern. When nurses and other people define care as a natural ability, they mask the skill and knowledge needed to make intimate labor *seem* natural. I highlight intimate trust strategies in part to demonstrate *how* some nurses can make care seem natural through the provision of care that is simultaneously professional and intimate.²⁰ Professional intimacy encompasses more than physical, emotional, and intimate connections. Professional intimacy is work that requires skill, experience, and strategy. Professional intimacy articulates the complex set of interactions nurses perform to build and maintain trust with their patients so patients can receive optimal health care. Throughout this research, I found that nurses professionally and intimately negotiated a cycle of trust, conflict, and renewed trust with their patients to ensure quality care (see Appendix C for a diagram of professional intimacy). When patients entered the hospital, they experienced a range of feelings. Some patients felt hope and trusted their nurses immediately. With these patients, I watched nurses make the most of this trust through a series of strategic interactions that helped to further facilitate a sense of intimacy that developed this trust. Other patients felt fear and other negative feelings upon entering the hospital. I watched nurses work through conflicts and establish trust with these patients.

I center my discussion on intimate conditions in health care in part to show how the process of giving and receiving quality health care can *begin* in conflict because many patients enter the hospital already feeling fear and a lack of trust of the medical and health-care industries. Patients' mistrust of doctors and nurses is underemphasized in general discussions about nursing

and, if discussed at all, is not posited as a condition of receiving health care but, rather, as a special circumstance of some patients. As soon as nurses encountered their patients, I watched them provide intimate labor to create trust, negotiate conflict, and renew trust to ensure quality health care.

I found that how nurses established trust sometimes caused conflict because patients felt overentitled to intimacy and acted out in verbally, physically, and emotionally abusive ways. Unlike workers in many other jobs, who can readily report such behaviors to management, nurses alleviated these conflicts so patients could again feel trust and regain comfort and confidence. Nurses turned to their strategies of professional intimacy to alleviate conflict and reestablish trust, and these strategies changed according to intersections of race, gender, and nationality. It is this trust work that fostered the accomplishment of quality health care. Without it, patients and/or their families were less likely to cooperate in their health care. Because nurses must be sure patients trust them to provide quality care, they need education, training, and a specific knowledge set regarding how to negotiate intimacy in a professional setting.

My aim in discussing professional intimacy is to offer a framework that combines the intimate with professional life, which changes according to perceptions and constructions of social identities. As a model, professional intimacy provides a language for patients, nurses, and administrators to explain, teach, conduct, and advocate for knowledgeable and skilled intimate care in a hospital setting. My goal is the inclusion of best-practices training as a result of this analysis in nursing school and places of employment. This would better nurses' labor conditions and increase public understandings of care. My study has significant implications for the health-care crisis because it examines the relationships among commercialized intimacy; the work conditions of nurses; and the effects of gender, race, and nationality. Moreover, it implies that care—as a social and economic act—changes meaning according to social context. In this book, I argue that if care occurs in context, then we must let go of ideas that some nurses are naturally better at caring than others; that some nurses are “born to care”; or that nursing is a gift, a sacrifice, or a calling.

Intersectionality Theory

Anna was one of several Latina nurses in my study. She was born in the United States after her parents had emigrated from Mexico. She spoke both Spanish and English fluently with a slight Spanish accent. She was also brown-skinned. These factors in combination contributed to how Anna experienced her work conditions. They shaped how and when patients trusted her in the

health-care process. Alan and Maura disbelieved Anna's role as Alan's nurse, despite her introduction of herself to them as his nurse and her efforts as a professional caregiver. Many researchers have documented historical and contemporary workplace discrimination against immigrant and nonimmigrant women of color in care and service work.²¹ Some of these researchers have specifically documented discrimination within nursing and detailed how women of color are viewed as unprofessional and white women are viewed as professional.²²

Just as falsely relating care and naturalness hides the skill of intimate trust strategies, it also minimizes how social categories such as race, gender, and nationality contribute to ideas that make intimate labor seem, on the one hand, either unnatural or natural and, on the other hand, either professional or unprofessional. Hospital administrators told me they expected nurses to care equally for each patient, but nurses said, and my observations verified, that patients reacted differently depending on how they perceived their nurse's race, gender, and nationality. Patients treated white women and white men as professionals and treated women of color²³ as ultracaring but also unskilled.²⁴ Patients and administrators tended not to expect white men to be nurturing, and administrators encouraged them to advance away from the bedside and into supervisory positions because they thought men would be better leaders than women.²⁵ It is important to note that this "glass escalator"²⁶ excluded men of color.²⁷

Intersectionality is a conceptual and methodological framework that explains how discrete social categories—for example, race, gender, sexuality, class, and nationality—work together to create unique experiences of privilege and subordination in everyday life. In 1989, renowned legal theorist Kimberlé Crenshaw coined the term *intersectionality* to explain the unique sexual harassments experienced by women of color, which often include simultaneous racist and sexist interactions:

I wish that everyone could have heard the story of an Asian construction worker whose co-workers shoved a hammer between her legs, who was taunted with racial slurs, who was repeatedly grabbed on her breasts while installing overhead fixtures, and who was asked whether it was true that Asian women's vaginas were sideways. She testified that when she was told, "you don't belong here," she couldn't figure out whether it was because she was Asian, Female or both.²⁸

Crenshaw argues that legal and everyday definitions of sexual harassment as gender discrimination do not discuss how the experience of, and consequences

for, sexual harassment are constructed by both racism and sexism.²⁹ If lawyers (and by extension scholars, activists, and employers) prioritize gender when defining what is and what is not sexual harassment, many experiences of women of color get lost. In her analysis of court cases, legal theorist Theresa Beiner makes this very point.³⁰ Beiner demonstrates that judges, when presented in court with harassment cases that contain both sexual and racial elements, toss these cases because they do not fit within existing legal frames.

In this study, I use the intersectional approach to analyze intimate care work from the perspective of nurses who are diverse by race, gender, and nationality and who care for patients who are also diverse by these identities. As a result, this book shows how intersectionality better articulates the experiences and perceptions of the nurses in my study, because nurses perceive that the intimate care they provide to patients changes at the intersections of race, gender, and nationality. My analysis responds to Patricia Hill Collins's call to use intersectionality to study social life and Kimberlé Crenshaw and Bonnie Thornton Dill's mandate to include race and ethnicity in applications of intersectionality.³¹

Throughout the book, I demonstrate how intersectionality is essential to the conceptualization of professional intimacy. Intersectionality informs the process of professional intimacy, and professional intimacy demonstrates how to use the intersectional approach.³² In fact, without intersectionality, I could not have conceptualized professional intimacy as it is explained in this book. Intersectionality theory is integral to the concept of professional intimacy because it helps speak on behalf of all nurses and patients who live at intersections of racial, gendered, and national identities. This analysis also demonstrates how to use intersectionality as an analytic to assess, measure, and articulate professionally intimate care work.

The intersectional approach offers an epistemological change in care by explaining both exploitative and potentially emancipatory caring arrangements at the social and economic site of intimate care in nursing. Rather than define care as a personality trait that some individuals possess, this analysis reveals that "to be caring" is a social act that changes at the structural and ideological intersections of race, gender, and nationality. Because it focuses on structural conditions of life and not on individual personality attributes, the intersectional approach helps take the responsibility from the natural abilities of individuals and places it on the ways that social patterns influence individuals' behaviors and interactions with each other. This method also helps clearly acknowledge the increasing diversity in nursing and shows how the labor of nurses is constructed by these and other intersections. The intersectional approach helps define professional intimacy in terms that incorporate

the intersections of gender, race, and nationality to recognize the diverse work experiences of nurses and the diverse meanings of quality health care.

Commercialized and Commodified Intimacies

When Anna asserted a professional boundary with Alan, he responded with a sexual innuendo. Alan's remark that Anna "could make it up to him" when she said he could not talk to her in a racist-sexist manner could be read as innocent, even playful. Yet, as explained throughout this book, his words represent a consistent pattern in sexualized interactions, which nurses had to negotiate in order to give their patients care. I observed nurses negotiate sexualized intimacy in many forms: as patients' physical and verbal advances and as patients' sexual intimacy with a visitor.

Anna and many others, especially new nurses, told me they sometimes could not respond to sexualized advances and insults from patients, for several reasons. First, they did not feel prepared to handle such interactions from someone they felt was dependent on them for care. They were trained as professionals, and it did not occur to them that patients would ever behave in a sexual manner while in the hospital. Second, some nurses felt there was no institutional recourse or support for their experiences because they did not feel that these behaviors coming from patients counted as sexual harassment. Finally, many nurses shouldered the burden of their experiences alone because they thought that they should be able to handle all patient interactions as part of their individual practice. They feared that if they sought help for these situations, they would appear incompetent.

I analyze these sexualized interactions from patients in the context of literature on commercialized and commodified intimacies as part of the labor process.³³ Although the two are often conflated, *commercialized intimacy* involves the process (i.e., business methods and strategies) of gaining profit from intimacy, and *commodified intimacy* refers to intimacy that is for sale when it was not once before. Intimacy alone is a feeling or an experience. Commodified intimacy is a product that can be bought and sold. Commercialized intimacies describe this market exchange: the marketing, the selling, the buying, and the investing of intimacy as part of labor or as part of industry.

In a recent collection devoted to various types of commercialized intimate labors, Viviana Zelizer, a renowned scholar of the relationship between the economic and the intimate, frames the occurrence of intimacy in labor three ways: as unpaid care in intimate settings, as unpaid care in economic organizations, and as paid care in intimate settings.³⁴ Zelizer focuses on the economic value of unpaid care in homes and other private spaces, the threat and

potential of intimacy in corporations and other economic organizations, and the governmental compensation to individuals who provide care for people in household-based care.³⁵ By her own admission, Zelizer avoids discussion “of paid care in economic organizations on the ground that we already know more about the varieties of care provided by medical professionals and other licensed caregivers than we do about caring elsewhere.”³⁶ She is quick to add, however, “Even there we can gain a clearer understanding through recognition that, in the delivery of care, professionals and their clients are likewise negotiating definitions of their social relations and forms of compensation to represent those definitions.”³⁷ I also assert that the work of hospital nurses in particular is important to the examination of social and economic relations of intimacy, because nurses provide paid care in an economic organization (hospital) and also in a household-like arrangement (the patient’s room).

The study of commercialized intimacy reveals how sex, care, and emotions including love are bought and sold in the market as products. These exchanges include how intimacy is the product, as in the case of sex work, care work, and other jobs that require workers to produce intimacy in direct exchange for compensation.³⁸ These exchanges also include those in a work environment that is sexualized to increase profit or how formerly nonsexual work environments become sexualized as part of employee interactions, as in the cases of feminist magazine production, taxicab drivers, and restaurant work.³⁹ These exchanges can also include sexual harassment from customers that is common, part of the job, and sometimes institutionalized as in the case of waitress work.⁴⁰

Although Anna did not receive direct compensation for providing intimate care to Alan, I observed a pattern over time in which patients and family members gave “tips” to nurses in appreciation for their care. Patients and family members expressed their gratitude to nurses by giving stuffed animals, flowers, and candy. Some nurses told me that patients also offered money to thank them for their service. In addition, although actual hospitals are quite opposite from a sexualized workplace, hospitals and nurses are represented as “sexy” on television and in film. Nursing scholars argue that these representations could affect the work conditions of actual nurses.⁴¹ Finally, most of the nurses did not speak about sexualized interactions as sexual harassment, and senior nurses acknowledged that these interactions felt like “part of the job.”⁴²

None of my observations about commercialized intimate labors throughout my study quite explain the interaction between Anna and Alan, as Anna described it to me. She did not receive a tip from Alan; nor did she feel that her workplace was sexualized or that comments like Alan’s could be a regular part of her job. Nevertheless, this interaction contained commercialized

intimate labor because Anna had performed emotional and body labor as part of her nursing care for Alan. The study of commercialized intimate labor includes emotional and body labor as defined by how corporations make demands on, and profit off of, the emotions and bodies of workers.⁴³ In her landmark study of flight attendants in the United States, Arlie Russell Hochschild coined the phrase *emotional labor* to explain how employers appropriate the emotions of workers and make this a condition of their employees' labor to ensure customer satisfaction and accumulate profit.⁴⁴ Hochschild states that not all jobs that involve care include emotional labor. She explains that the jobs that do include emotional labor have three common characteristics: "First, they require face-to-face or voice-to-voice contact with the public. Second, they require the worker to produce an emotional state in another person—gratitude or fear, for example. Third, they allow the employer, through training and supervision, to exercise a degree of control over the emotional activities of employees."⁴⁵ This last feature could exclude nurses from Hochschild's conception of emotional workers. As professional care workers, nurses have significant autonomy over their work with patients and do not experience the same degree of control by administrators as other workers described by Hochschild. Nurses manage their own interactions with individual patients, and supervisors do not insist on controlling these individualized interactions.⁴⁶ Nurses are, however, managed by an industry that in large part defines care through the feelings it produces in patients. At the same time, nurses strategically negotiate emotions, bodies, and intimate behaviors as part of their labor. I observed, however, that experienced nurses knew that establishing intimacy, negotiating the conflict that sometimes results from that intimacy, and reestablishing intimacy results in quality health care and patient satisfaction.

Hochschild distinguished emotional labor from individual uses of emotion in social interaction by drawing on the work of sociologists Emile Durkheim and Erving Goffman. She explains that the use of emotion in social interaction includes how individuals manage their own emotions to avoid interpersonal conflict. Emotions affect customs, too; they help encourage proper behavior and maintain social order. Emotional labor is different from these uses of feelings because corporations purposefully manipulate and exploit the feelings of workers to make money. Emotional labor alienates workers from their "true selves," which prohibits possibilities for worker resistance to unfair work conditions.

For more than two decades, scholars have confirmed Hochschild's theory of emotional labor and expanded it to include employee negotiation of emotions and resistance to employer dominance.⁴⁷ Institutions obligate

individual nurses to provide “quality” care under any and all circumstances. Patients feel entitled to “quality” care in part because they need it but also because they *pay* for it. In both situations, what quality care means is unclear. British nursing scholar Nicky James uses emotional labor to discuss the “ambivalent status” and exploitative features of care in nursing.⁴⁸ Since James, other scholars have identified how nurses negotiate boundaries with their patients⁴⁹ and increase patient comfort⁵⁰ by actively adjusting their presentations of self through their demeanors and facial expressions.

Professional intimacy differs from emotional and body labor in part because nurses chose to do this work knowing it would lead to better care—not because they or their company would make more money. Hochschild conceptualized emotional labor to articulate how employers require workers to use their own emotions to increase corporate profit. Unlike emotional labor as Hochschild conceptualized it, professional intimacy is not a strategy of the employer to increase hospital profit; rather, it is a strategy nurses employ to perform their jobs effectively. Emotional labor is one aspect of professional intimacy because it explains how nurses’ emotional labor is exploited if left unnoticed by the health-care industry, but it does not fully explain intimate care in nursing because it is not a mandate by the hospital administration.

Commercialized intimacy in labor is part of the increasing commodification of intimacy that permeates and sustains global capitalism.⁵¹ This is to say that as our society advances economically, culturally, and technologically, intimacy and capital become more tightly linked.⁵² The commodification of intimacy reveals the connections between micro-level interactions such as those between nurses and patients and macro-level processes such as the relationship between the nursing shortage and the global economy.⁵³ It shows how experiences of the intimate construct social relations and how social relations such as those that are race-based or gender-oriented construct intimate experiences. To make these connections between micro and macro analyses of intimacy, I again draw on the work of sociologist Viviana Zelizer. Zelizer shows how intimacy is bought and sold not just as products or labor but as part of everyday interactions.

In *The Purchase of Intimacy*, 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 storytellers of public life.⁵⁴ Instead, Zelizer emphasizes 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 the nurses I studied were overrun 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.”⁵⁵ This “resilience of intimacy” in nursing helps patients and family members receive quality health care.

Nurses have fought a long battle to be taken seriously in the medical industry. Framing nursing as professional labor has been an important part of this effort. However, it is this same professionalization that reduces the value of intimate care work. Zelizer demonstrates how “professional organizations, courts, and legislatures collaborate in protecting the boundary of professional practice.”⁵⁶ First, professional organizations worry about the corruption of professional practice, and second, they fear that a focus on intimacy will promote unwanted intimacies. For example, lap dancing laws distinguish prostitution from exotic dancing by setting rules about access between dancers and customers. I found this sort of concern in my research as well. Nurses feared that any discussion of intimacy would take away from the professionalism in nursing work and would also promote an inappropriate sexualization of relationships in professional care.

In this book, I show how professionally intimate care work fits into the larger system of commercialized and commodified intimacies because it seems especially pertinent to several questions about the contemporary state of nursing in the United States and, more generally, about meanings of commercialized and commodified intimacy in professional work. The book addresses how and why new nurses seem unprepared to handle intimacy, in spite of their training, when compared to experienced nurses. Further, it provides one reason why large numbers of experienced nurses leave the bedside and take administrative roles or leave the profession altogether. The book demonstrates how nurses, administrators, and patients idealize care, which only serves to reinforce the misunderstanding of this labor. It reveals the triple bind of professionalism, technical skill, and care expectations that reduces the job of nursing to categories that cannot reflect the complex and intimate strategies nurses use every day to care for their patients. It challenges the idea that there is one standard way to care and that one either does or does not have this “gift.” Most importantly, it reveals that although compassion as a personality trait can seem natural to individual people, care as professional knowledge can be, should be, and *is* consistently taught to nurses. Administrative recognition of professionally intimate labor as

something to be articulated, taught, and formally counted as nurses' work would improve the work conditions of nurses because it would help make space and time for this labor, which is an element critical to patients' health and satisfaction.

Outline of the Book

The rest of this book is organized into Chapters 1 to 5 and the Conclusion. In Chapter 1, I discuss the fact that nurse directors and hospital administrators greatly valued care but could not articulate how care occurred and did not believe it could be taught. I also explore their avoidance of the word *intimacy* when describing nursing. I suggest that the failure to recognize intimacy is at the core of misunderstanding the process of care. Many nurses, patients, and administrators see acts of care through what might best be described as a Florence Nightingale lens: natural to women and indicative of pure and altruistic motives.⁵⁷ Contemporary "Florence Nightingales" glorify care in nursing from what used to be considered a religious calling and is now described as a moral imperative.⁵⁸ This rhetoric could increase the social value of caregiving, but it actually reinforces gender stereotypes of women as natural and preferred caregivers and care as a personal attribute rather than as professional knowledge.⁵⁹ I bring in my data and other studies on male nurses to challenge the natural relationship between femininity and care. I show how administrators seem to contradict themselves when they want a naturally caring nurse for a job that is professional.

In Chapter 2, I draw on sociology of gender and intimacy theories to help conceptualize how being a caring nurse is not a natural personality characteristic but is in fact work that includes managing conflict, is inextricably linked to money, and changes depending on the specific social interaction and according to social and economic forces. I distinguish between personal identity and identities as social constructs to introduce how I use the intersectional approach. I then explain the intersectional approach in more detail and connect it to the salient intersections in my study: those of gender, race, and nationality. In the second part of the chapter, I connect my study to the global enterprise of care by introducing the relationship between professional intimacy and the nursing shortage. I draw on theories of emotional labor, body labor, and intimacy as purchase to show how administrators misunderstand the intentions of nurses and how everyone in the hospital contributes to a consumer culture of patient satisfaction. These explanations serve as an important backdrop to my findings on how nurses develop and sustain intimate trust with patients.

Chapter 3 describes the first stage of professional intimacy: how nurses build, negotiate, and sustain what I call *intimate trust* with their patients. I discuss how bedside nurses described the value of intimacy in nursing care. Nurses did not feel their labor was intimate, but knew that intimacy was important to the patient. This finding helps answer the question about how nurses can both value and reject intimacy in their work. I explain what I call *intimate conflict* in Chapter 4. I found, through my observations and nurses' interpretations of these observations, that relaxed boundaries and a sense of entitlement sometimes encouraged patients to express anger and sexual desire toward nurses. As a result, nurses felt and negotiated discomfort, tension, and threat. Chapter 5 explains how nurses created boundaries that addressed intimate conflict while maintaining intimate trust with patients and family members. I also explain why and how nurses were pressured to handle intimate conflict on their own. As a corrective to this approach, I emphasize the benefits of what I call *collective intimacy* as a strategy for dealing with these conflicts.

In the Conclusion, I turn my attention to theoretical and practical uses of this book. Theoretically speaking, I hope that this model of professional intimacy contributes to understanding of the relationship between commercialized intimacies and the global economy. I also hope that it serves to model how the intersectional approach can be used to study everyday meanings of care. In addition, this model could be tested and developed to help explain intimate labor in other professions. Practically speaking, hospital nursing care and nursing education might be restructured to better accommodate professional intimacy. Hospitals that institutionally and collectively recognize professional intimacy would help nurses better understand the shared conditions of their labor. Attention to issues of professional intimacy in nurse training and in hospitals would also increase nurse retention and patient satisfaction, which could help alleviate the nursing shortage. Professional intimacy demonstrates the significance of both professionalism and intimate labor in nursing practices. As a model and labor practice, it rejects dichotomous framings of care as either altruism or professional skill and demonstrates how hospital nurses use both to provide quality care to patients and families. This book reframes the discussion of what it means to be a good nurse by rejecting traditional definitions of care, femininity, and whiteness. Rather than focus on whether nurses are motivated to care for either altruistic or economic reasons, this book shows that nurses and patients construct what it means to provide care along intersections of race, gender, and nationality.