

**Sexual harassment of nurses by patients:
Competing tensions of identity and
control**

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Abstract

While research has typically explored femininity and masculinity as separate constructions, scholars have begun to argue for a dialectical approach to gender in which masculinities and femininities are viewed as coconstructions. Issues of power lie at the center of this dialectical construction of gender. Using Giddens's Dialectic of Control, the present study explored the competing constructions of power when male patients sexually harass nurses. It is argued that some male patients sexually harass to shore up their hegemonic masculine identities. Nurses respond to this sexual harassment by shoring up their professional identities as caregivers. For both patients and nurses the sexual harassment and responses to it tend to center on issues of identity and control.

Sexual harassment of nurses by patients: Competing tensions of identity and control

Historically, femininity and masculinity have been studied as concrete arenas with discrete interactions. While important to building an understanding of gender in society and organizations, the separation of gender studies into “masculinities” and “femininities” fails to recognize the dialectical nature of gender (Ashcraft & Mumby, 2004) in which gender is a co-construction, meaningful only when masculinity and femininity are considered in relationship to each other. Power is at the center of this co-construction, weaving together and stabilizing the discourses of masculinity and femininity (Ashcraft & Mumby). To explore this conconstructed process, Ashcraft and Mumby argue for the study of the “dialectical interplay of certain masculinities and femininities” (xvi). It is therefore important to explore dialectical processes of power in order to better understand the dialectical nature of gender. We turn to the intersection of sexual harassment and the highly feminized field of nursing in order to capture this co-construction of gender between men and women.

Sexual harassment is an important context from which power and gender can be explored. Sexual harassment is not about sex, it is about power (Conrad & Taylor, 1994; Dougherty, 1999; Jansma, 2001; Payne, 1993), both in organizations at large and in health care organizations more specifically (Dougherty, 2006). Traditionally, power related to sexual harassment has been conceptualized as a formalized product of the organization’s hierarchical structure (Firestone & Harris, 1999). Consequently, it was assumed that sexual harassment was always hierarchically downward, such as a physician sexually harassing a nurse and a teacher sexually harassing a student. However, there is a growing recognition that when it comes to sexual harassment, power is far more complex than it initially appears (Dougherty, 2006). For example, researchers now recognize that coworker sexual harassment is prevalent in the

workplace and that sexual harassment can also occur from subordinate to superior (Firestone & Harris, 1999). More closely related to the present study, Libbus and Bowman (1994) found in a study of Missouri nurses that most sexual harassment of nurses comes from male patients. This type of sexual harassment comes from outside of the traditional organizational hierarchy and is particularly difficult to manage because the standard mechanisms for resolving this type of behavior simply do not apply to patients. It is extremely unlikely that patients will be “fired,” demoted, or even moved to another hospital location because of their behavior. Consequently, despite the well documented evidence of the existence of sexual harassment from patients to nurses, nurses are provided with little training in how to manage this form of harassment and sexual harassment policies provide little, if any, protection (Hanrahan, 1997). It is clearly important to understand how power is negotiated when sexual harassment comes from outside of the organizational hierarchy.

Power in the health care setting is distinctive and structured around gendered dynamics of masculinity and femininity. Built on rigid patriarchal norms of hierarchy and status, at the most basic level, the health care system has been granted an inordinate amount of social power such that physicians are considered to be more powerful than patients (Lupton, 1994). In the healthcare encounter, patients are in a less powerful position, characterized by health care providers as childlike and dependent (Lupton, 1994) and unintelligent and unmotivated (Geist & Dreyer, 1993). Interestingly, however, the relationship of nurses to power in the health care interaction is less clear. Although nurses provide care when patients are most vulnerable, the social position of nurses in relation to patients is highly complex (Lupton, 1994). The complexity comes from the different sources of power claimed by men and by nurses. Specifically, men tend to have more social power than women. Given the patriarchal structures of society, men tend to

have greater access to political power, wealth, and physical power than women. However, the health care context tends to feminize patients, handing control to “professional” health care providers (Geist & Dreyer, 1993). Consequently, nurses may have more contextual power in the healthcare setting than their male patients. Thus a dialectic is established between the male patient’s social power and the nurse’s contextual power in the health care setting.

The dialectic of control (Giddens, 1982) provides a useful lens from which to view the complexity of power in the coconstruction of gender. Specifically, by using the dialectic of control it is possible to capture the ways in which masculinities and femininities are intertwined in a complex web of interactions. Results of a qualitative study suggest that gender relations play an important role in the sexual harassment of nurses by patients. Specifically, we argue that some male patients sexually harass to shore up their hegemonic masculine identities. Nurses respond to this sexual harassment by shoring up their professional identities as caregivers. For both patients and nurses the sexual harassment and responses to it tend to center on issues of identity and control.

Dialectic of Control

The dialectic of control (Giddens, 1982) conceptualizes power as being shared by actors in any social system, what Giddens calls “an intrinsic relation between agency and power” (p. 6). Central to the concept of the dialectic of control is the notion that “however wide the asymmetrical distribution of resources involved, all power relations express autonomy and dependence ‘in both directions’” (Giddens, 1982, p. 36). Thus, power relations are not simply exercises of control by powerful forces on the powerless who may or may not engage in some form of resistance. Rather, the dialectic of control opens the possibility for *simultaneous* exercises

in power from actors in social contexts (see Giddens, 1979; Jermier, et al., 1994; Knights & Vurdubakis, 1994).

Within the dialectic of control, the concepts of resistance and control are seen as being inextricably intertwined. This vision of power is shared by feminist and critical communication scholars. For example, Clair (1998) calls control and resistance “self-contained opposites” (p. 123). Mumby (1997) utilizes dialectics to articulate a more nuanced reconceptualization of hegemony in which resistance and control are dialectally related. Ashcraft and Mumby () specifically argue for power and resistance as a dialectic, ending the tendency to bifurcate these concepts at the micro level. The dialectical view of control and resistance illustrates how the dialectic of control changes the way that issues of power, control, and hegemony can be studied and conceptualized. Instead of the binary opposites of the powerful and the powerless, or of one dominating hegemonic frame, such an approach allows for “power that co-inhabits a particular space” (Fleming & Spicer, 2002, p. 76).

Such a site presents itself in the healthcare setting where hegemonic masculinity of patients may collide with the professional identity of nurses. The dialectic of control promises to allow the nuanced treatment necessary for understanding the complexity inherent in such intersecting and competing sites of power and control.

Male patients in control: hegemonic masculinity

Traditionally, men in western societies have greater power and control than women. This power has been socially granted and socially enforced. Hegemonic masculinity is loosely defined as the way in which men are judged based on their ability to embody and enact an idealized form of social control. While some argue that hegemonic masculinity is exclusively enacted by ruling-class men with the effect of controlling women and most men (Donaldson, 1993), others argue

that all men are trapped to varying degrees by the pressures to conform to hegemonic masculinity (Cheng, 1999). Hegemonic masculinity can be enacted in multiple ways, such as the need to bring home a paycheck or through physical manifestations of strength—a young, healthy, competent body. Both of these performances are threatened when men become patients in the health care setting.

At the core of hegemonic masculinity is the muscular male body that symbolizes such characteristics as dominance, sexual potency, and independence (Wienke, 1998). This form of hegemonic masculinity may be most readily apparent on children's cartoons designed for a primarily young male audience. The first author's son received a copy of the movie "Rescue Heroes" for his third birthday. The male characters are decidedly compelling. Their muscles are large and exaggerated, never to be found in real life men. The characters are utterly competent, rescuing numerous people with casual acts of courage and heroics. While these characters are intended to be positive role models, the adult variants strewn across mediated forms are far more sinister. For example, music videos, pornography, magazines, comic books, movies, and television shows frequently show the idealized male dominating both women and other men—often through acts of violence. In these portrayals, the ideal man is utterly heterosexual and utterly in control. Research suggests that men evaluate themselves based on their proximity to the ideal male body type, both accepting and rejecting hegemonic masculinity (Wienke, 1998)

Simply because there is an idealized male body does not mean that all men enact maleness in the same way. Most men are not violent toward women. Many men do not conform to the hegemonic masculine ideal (Cheng, 1999). However, all men are judged by their proximity to this ideal, suggesting that hegemonic masculinity is an important signifier of social position for all men and women (Boon, 2005). The results of the present study suggest that

because the hegemonic ideal is the standard by which all men are judged, and because it is never fully attainable, some men strive toward the ideal in increasingly exaggerated ways. This is particularly likely when a man's performance of hegemonic masculinity is threatened, creating a greater distance to the ideal.

The health care system feminizes patients, creating a threat to men's performance of hegemonic masculinity. Illness itself produces a threat to hegemonic masculinity, particularly to ideals such as male competence, strength, and independence (Gray et al., 2002). This threat becomes pronounced as men age and lose the youthfulness required of the hegemonic performance of masculinity (Drummond, 2003). According to Drummond's study, older men tend to be more concerned with what their bodies can do than how they look. However, when their bodies begin to fail, older men experience inadequacy in their performances of masculinities. The health care system heightens the threat to masculinity. Men are dressed in "gowns," control over their body is given over to care providers, and the illness itself is emphasized in terms of what patients cannot do—or as a physical weakness that is antithetical to the masculine ideal. We call this process the feminization of patients, the antithesis of the ideal male. It is at the intersection of men's needs to conform to hegemonic masculinity and the healthcare system's tendency to threaten the performance of hegemonic masculinity by feminizing patients that we situate this study of the sexual harassment of nurses by patients.

Nurses in control: Professional identity

Not only are patients feminized in the healthcare setting, but their care is provided by a nursing profession that has also been highly feminized. Because this deeply embedded notion of the feminization of nursing interacts with hegemonic masculinity of patients, and because it

interplays with the professional identities of nurses who provide care, it is important to examine the nature of this feminization in nursing's history and in the media portrayals of nurses.

That nursing has been seen as highly feminized is clearly illustrated in the history of the profession. Traditionally the ethic of care (or the "obligation to care") was part of a woman's duty to family and community (see Reverby, 1987), and in the nascent years of nursing the role of nurses was considered to be an extension of this duty. As a result, nursing was associated with "women's work" and in the early 19th century carried the same status as the laundress, cook, or other domestic servants (see Roberts & Group, 1995). According to none other than Florence Nightingale, the ideal nurse was forged "out of the natural qualities of the good woman" (p. 50, Reverby, 1987). As Kalisch & Kalisch (2004) summarize in their review of nursing's history, "The strength of the link between women and nursing was perhaps one of the strongest in any occupation" (pgs. 376-377).

Certainly the feminization of nursing has made its status as a legitimate profession more difficult to obtain (see Gordon & Nelson, 2005). However, the expansion of its role in the healthcare system in the 1970's thrust nursing more firmly into the bounds of professionalism in the more traditional sense (see Schwirian, 1998). Now nurses no longer see themselves as domestic servants (see Roberts & Group, 1995). They do not see a dichotomy between caregiving (a traditionally feminine domain) and professionalism (a traditionally masculine domain), and consider themselves important, functioning, and critical elements of the healthcare system. Thus, the professional identity of nurses involves the timeless ethic of care within a framework of nursing as a professional endeavor (see Loewenstein, 2003; Manthey, 2000; Fagermoen, 1997). Though nurses must constantly renegotiate their roles within the changing landscape of health care (see Apker, 2001; Miller, Joseph, & Apker, 2000; Pearson, 2003;

Fullbrook, 2004), their identity and empowerment as nurses remains centered on their role as professionals (see Styles, 1982; Chitty, 1997).

The notion of nurses professional identity and the notion of control are intertwined in important ways. While patients often feel a loss of control in the health-care setting (Oberle, 1992; Bufe & Abdul-Hammon, 1995), nurses often equate their professional identities with the ability to maintain control of the caregiving environment. Fagerber's (2004) longitudinal study of RN's illustrated that as younger nurses become more experienced, their ability to feel in control of the various situations they face with their patients becomes an important element in the construction of their professional identities (see also Öhlén & Segesten, 1998). The nurses in Henderson's (2003) study reported that they perceived the exercise of power and control (i.e., regulating medications, visitations, patient movement, etc.) on the part of nurses to be a necessary and positive component of providing care, though they also report making efforts to equalize the power imbalance. This sense of control is not absolute. It is contested by physicians and the rigid hierarchical order in the healthcare system (Eisenberg et al., 2005). More significant for the present study, it is also threatened by mediated images of nurses and the nursing profession.

The professional identity of nurses is highly contested by social norms and images. Nurses' professional identities often clash with the strong feminization of nursing as stereotypically represented by media characterizations of nurses as either ministering angels, battleaxe matrons, or sex symbols (see Gordon & Nelson, 2005; Bridges, 1990). Such media portrayals reify the feminine nature of nursing within power structures that also embrace a hegemonic masculinity (see Karpf, 1988). For example, some argue that the media portrayal of the "battleaxe nurse" serves to target the power imbalance between the female nurse and the

male patient whose illness necessitates care and loss of control (see Karpf, 1988). By ridiculing the nurse and portraying her professional role through unflattering images characterized by inappropriate power plays (i.e., Nurse Ratchet), the professional nature of the nursing profession is devalued. Similarly, portrayals of nurses as sexual objects challenges nurses professional identities (Salvage, 1983). A feminist view of this image is offered by Karpf (1988) who posits that, like the battleaxe image, this portrayal of nurses as sexual objects re-establishes male virility and reverses the power that nurses hold in caregiving situations. Within such portrayals of nurses, the professional identity of nursing is subsumed within stereotypical and subservient frameworks of femininity that better correspond to the place of women in a masculine hegemony. Because of the feminization of nursing, many nurses have trouble distinguishing between sexual harassment and the nursing role (Hanrahan, 1997). Consequently, nurses are highly unlikely to utilize sexual harassment policies to combat inappropriate behavior they encounter in the workplace. Thus, nurses professional identities, the stereotypical feminization of nurses abetted by the media, and the notion of control and power inherent in the nurse-patient context are all intertwined.

Embedded in this complexity is the dialectic of control between nurses and male patients. The literature suggests that both groups have a “legitimate” claim to social control. By legitimate we mean a socially accepted norm that grants a sanctioned right to rule. Male patients tend to have more social power derived from patriarchal structures and adhered to through hegemonic masculinities. Nurses tend to have more contextual or situational power granted by the prestige of their profession and the control granted to the health care industry at large (Lupton, 1994). Despite their legitimate claims to power, both groups are subordinated to physician power in the health care setting. Consequently, for both patients and nurses, power is relative and complex.

Each needs the other to reestablish power and control stripped away by the power granted to physicians in the health care setting. It is when these two forces collide in competing ways that the dialectic of control becomes most apparent, creating the potential for an ongoing cycle of control and resistance in the health care setting. The purpose of this study is to explore that collision as a communication phenomenon.

Methods

Participants

In this study we used an interpretive approach to interview 29 nurses from across the country (California, Colorado, Missouri, Florida). Twenty five women and four men were interviewed. We selected participants using a snowball sampling technique (Lindlof, 1995).

Participants were from a variety of organizations and backgrounds ranging from nursing homes, to emergency room nurses, to those currently working in doctor's offices. Participants' ages ranged from 22 to 88 with job experience ranging from a few months to 45 years. Twenty-one of the participants were European American, three participants were African American, one participant was Filipino, and three participants were Hispanic. Interviewees included a nursing student, part time nurses, full time nurses, and retired nurses. The interviews lasted from approximately 45 minutes to an hour and a half.

We conducted open ended interviews. We started with an interview guide which asked participants to describe inappropriate sexual behavior from patients. Both planned and spontaneous probes were used to generate richly textured stories about these incidents. Because discussing sexual harassment can be somewhat intimidating, we chose to broach the topic after a warm-up period during which related topics were addressed. For example, we asked participants

to tell us about their jobs and about the ideal patient. After the warm-up period we asked participants to describe “inappropriate sexual behavior” by patients with a follow up question asking if the nurses believed the behavior was sexual harassment. This strategy was used because nurses do not always label their experiences as sexual harassment since the frequency of sexual harassment in the health care setting has made it normative and therefore invisible (e.g., Hanrahan, 1997).

Data Analysis

Prior to analysis the audio tapes were transcribed and checked for accuracy. Transcriptions totaled over 290 single spaced pages. A thematic analysis of nurses’ discursive description of their roles and their strategies for dealing with patients who sexually harass them or exhibit sexually inappropriate behavior was conducted. Themes were developed and analyzed using the selective or highlighting approach (Van Manen, 1990) with the reduction, explanation, and theory steps suggested by Lindlof (1995). These steps represent cyclical processes with large areas of overlap. First the data were sorted according to potential emerging themes, with tentative labels given to each theme. The data collection process had cued us into possible emerging themes based on gender and control. Therefore we focused on these issues in the data. Comments and other notes were made in the corresponding margin. Then the transcripts were examined again; each time a theme was noted in the margin of a transcript, its location (page number and manuscript number) was noted in a separate data file until all themes in all transcripts had been noted. As these themes were collected, corresponding memos and exemplars were also included under each theme heading in the database file. Within this database, the strongest themes were identified based on their persistence across participants. Once these themes emerged, the transcripts were examined once more to identify any contradictions and/or

inconsistencies in the original analyses.

Of particular concern in the analysis process were the behaviors of male patients. Because male patients who sexually harass medical staff are not accessible for research, it was necessary to use the accounts of the nurses to ascertain behavior and motives. We took great care to focus on behavior described frequently by the nurses. While we took into account motives for the men's behaviors attributed by the nurses, we remained aware that the problematic behaviors by these patients may not be limited to the health care setting. Given the rather odd nature of the behaviors reported by the nurses, however, we strongly believe that at the very least the health care context intensifies the inappropriate behavior by the patients described in this study.

The Dialectic of Control

Preliminary results suggest that gender relations play an important role in the sexual harassment of nurses by patients. Specifically, male patients sexually harass to shore up their hegemonic masculine identities. Nurses, respond to this sexual harassment by shoring up their professional identities as caregivers. The stories told by these participants suggest that for both patients and nurses the sexual harassment and responses to it tend to center on issues of identity and control. Two primary themes emerged. The first theme involved power identity and control. The second theme explored sexual harassment by male patients and the nurses' responses to the behavior.

Power, identity, and control

The stories told by the participants indicate that male patients who sexually harass and the nurses who participated in this study, operated from competing constructions of power and resistance. The following subthemes address these differences.

Hegemonic masculinity and the feminization of patients.

The healthcare process strips men of their carefully formed and nurtured hegemonic masculinity by feminizing patients and removing their ability to control and dominate. The nurses in this study were highly cognizant of this process. For example, one nurse explained:

It's a whole other culture inside the hospital. Because we, um, you know, we strip patients of their, um identity. I mean we don't even mean to, and we try not to, but we do it. It's like, "Oh, bed five is a cabbage (CABG- Coronary Artery Bypass Graph)"... And then we take all their clothes off, put them in a gown, you know. We do everything for them. I bathe my patient top to bottom. "Here you go. Just put on a gown."

Often, patients are placed in "gowns," their space of action is limited to a small bed or room, their ability to earn a living is at least temporarily compromised. The very process of caregiving places patients in the subordinate position in the healthcare setting. While this is true for all patients, especially hospital patients, it is particularly problematic for men who value their hegemonic masculinity as a central feature of their identities (Drummond, 2003). Based on the scholarly findings that sexual harassment is always an act of power (and not about sex), as well as the notion that hegemonic masculinity is a masculine ideal centered around a certain type of control, the nurses in this study seemed to believe that many male patients enact the hegemonic masculinity of control and virility by sexually harassing nurses. For example, a male nurse participant described a male patient who asked him for a "blow job." Based on previous comments from both this participant and comments from other participants, the interviewer asked the nurse a perception checking probe about masculinity and motivation:

Interviewer: Do you think there's a masculinity issue there when a patient does something like that?

Joe: You know, it probably is. It's maybe controlling. Yeah. Maybe it's trying to control the situation. Because a patient is very vulnerable laying there in the bed. Nine times out of ten they're there for a reason that put them in bed. So... Personally, I've had to lay in the hospital bed for quite [a while] and, uh, you *do* feel vulnerable in that bed. So maybe that's part of it, too.

Interviewer: Trying to take back control?

Joe: Trying to control the situation, period, versus being controlled the whole time you're in there.

Interviewer: And that's a masculinity issue?

Joe: Oh, yes. Men are very much so that way. You want to be in control.

This man was clearly able to articulate the loss of control and resultant vulnerability from the healthcare process. This man himself had been in a life-altering automobile accident that kept him in a hospital for many months and was speaking both from his experience as a nurse and from his experience as a male patient.

Many of these participants experiences support what the literature suggests: the healthcare process threatens male patients' sense of identity and control. Male patients can respond to this threat in many different ways. For example, they may become depressed, may become violent, they may redefine their masculinity, or they could retake control of their health and care. In this study we were interested in one particular form of response, the sexual harassment of nurses by patients. This particular response becomes most interesting once the role of power and professionalism in the nursing profession are considered.

Nurses and professional identities.

Nurses do not view nursing as a sexualized profession. Instead they view themselves as caregiving professionals who are placed in charge of patients in order to provide care and educational support. They tend to view themselves as hierarchically superior to patients, viewing the patient as their "charge" and therefore in their control (Geist & Dreyer, 1993).

Not surprisingly then, the nurses in this study believed they had a legitimate right to control. While the men's legitimate claim to control came in the form of institutionalized patriarchy and associated hegemonic masculinity, the nurses' legitimate claim to control was acquired through their status as healthcare professionals. While this right to control is contested by physicians, by patients, and by images perpetuated by the mass media, it was viewed as an

absolute by the nurses in this study. In other words, they did not see their right to control as complex. It was simple, direct, and linear. This legitimate claim to control was most apparent when the nurses were describing sexual harassment by patients. For example, one nurse told a story about a man who kept ripping his sheet off to show his full erection, even though she kept telling him that he did not need to take the sheet off. Later in the interview came this exchange:

Interviewer: So what did that guy do when you told him “you don’t need to take the sheet off?”

Ann: He just kept smiling at me.

Interviewer: Was it kind of a freaky smile?

Ann: It’s one of those, like if you were in any other situation—like if you were in a back alley or something, you’d be petrified. But since he was in my area, my domain, I felt fine.

Interviewer: You weren’t nervous at all?

Ann: No. Just more embarrassed. Because he was in my surroundings.

Territory was a common theme expressed by these nurses. While these nurses acknowledged that men may have more societal power in general, everything changes when they enter the health care setting. One nurse articulates this situational control very clearly when describing how she responded to a patient who was behaving inappropriately:

And I went to my supervisor that was on, and she just basically told me, “Look, you can... you, you go in there and you just tell him, ‘I’m here to take care of you, but I DO not have to put up with your kind of behavior, and if it continues, I’ll go in and talk to [name of supervisor].’” And he did, I mean, he actually seemed like he respected me after I said that. But, there again, *I’m in a place of control and power now, because I’m taking care of him*. So he backed off. Had it been the other way around, I don’t know if that would have worked that way or not. No, I actually believe that’s three-fourths of the reason [for sexual harassment], is the power. The man always feels like they’re, they’re so much more powerful than the woman, and the control that they have in the position. And, uh, little man’s syndrome. The need to feed their ego.

Of interest here is the overt articulation of situational power and control. While the man may have more power elsewhere, this nurse was granted greater power and control in the health care setting because of her status as a professional nurse. Note the role of the supervisor. Instead of

referring the nurse to a policy and assisting with the technical aspects of filing a complaint, the supervisor told this participant what type of response was required from a good nurse.

Another nurse ties the vulnerability of patients to nurses' abilities to control.

I really think the patients feel that they're at a disadvantage in the hospital... I really feel that they're at a disadvantage because they're sick, and we're there to take care of them, and they know that they have to behave themselves if they want to be taken care of. And also, I feel like in that situation, *it's my territory and I'm in control of the situation*. I mean, they're at a disadvantage. They're in bed; they have an IV maybe; they have a heart monitor, all of those things kind of tying them down and making them realize that they're weakened at this point. So I really can't think of specifics with patients. Now co-workers is another issue. They were a different story, but we had a different kind of relationship. It was more of an equals relationship as opposed to "I am the nurse. I have the needle."

This nurse is very aware of her power and equally aware of the powerlessness of her patients.

She goes on to say "I can be very authoritative when I'm in that position [as a nurse], because I actually know what I'm talking about and what I'm doing. You know, that's my territory." The position she is talking about is a professional position. Not only are her patients in a weakened and compromised position, but they just are not privy to the professional knowledge that she has "I know what I'm talking about..." This privileged position as a knowledgeable and capable professional, gives her claims to legitimate situational power in relation to her patients.

Sexual harassment and the dialectic of control.

The preceding theme suggests that, at least from these participants' perspectives, nurses and male patients who sexually harass operate under competing definitions of power and control. Ironically, both are in feminized roles in the healthcare setting. Both are in subordinate positions. Both require control over the other to support their identities as powerful entities. The present theme details these processes of control and resistance during the sexual harassment of nurses and during the nurses' responses to that harassment.

Sexual harassment of nurses as hegemonic masculinity.

The stories told by the participants in the present study suggest that sexual harassment of nurses by patients is unusually aggressive. While in the past this type of harassment in the United States was quite common across professions, it is now limited primarily to sex professionals (e.g., strippers) and nurses. For example, the nurses in this study tended to describe groping, such as a patient touching or grabbing a breast or bottom, as “mild,” common, and mundane. The authors and many of the readers of this manuscript are academics. An analogous experience would be if students grabbing breasts, bottoms, or other private areas, was considered mild, common, and mundane. This scenario in the academic world is currently unthinkable. Given that sexual harassment is a communication phenomenon (Bingham, 1994), it is important to understand what is being communicated when it occurs. The stories told by these participants suggest that male patients who sexually harass do so, in large part, in an attempt to communicate their proximity to the hegemonic ideal.

The commonalities among the stories told by the study participants support this argument. Specifically, the nurses frequently told stories in which the patient’s penis was displayed either physically or discursively. Other nurses told stories of patients’ discursive role-making through labeling.

Penis stories. The penis is a central feature of hegemonic masculinity. It is revered for its size, endurance, and virility. The frequency of penis stories told by these nurses support the argument that sexual harassment by patients was an attempt to shore up these men’s hegemonic masculinity. In these incidents, the nurses told of male patients either exposing themselves or threatening to expose themselves to the nurses. For example, one female nurse described the behavior of a male patient who had a tonsillectomy:

Ellen: And I was going around to each of them helping them to do their [rinsing], and this one particular college age man was calling me frequently to help me do it. Even more often than what was ordered. It is usually ordered like every two hours or something like that. He was asking me to come help him do that more often. And then one time when I went in the room, he was underneath the sheet, laying in the bed underneath the sheet, um, and he was making all kinds of movements underneath the sheet, like scratching himself underneath the sheet. Like scratching himself. And he said he was itching. And I said “where?” He rips down the sheet. He was totally naked, he’d taken off his gown, and he had a big erection and said “right here” [point to crotch].

This was a fairly typical “penis” story in which the male patient revealed himself to the female nurse. This type of story repeatedly emerged during the interviews as the kind of incident the nurses found most disturbing. The fear of male violence is a common reaction for targets of sexual harassment (Dougherty, 1999). In each story told, violence and domination was either implicit or explicit in the message. For example, as previously mentioned, a male nurse also told a “penis” story in which the patient revealed himself and propositioned the nurse:

Joe: Big guy. Big guy. And he pushed his call light, and I went down the hall to take care of him and opened up his door and he was laying on top of his covers on top of his bed with his gown covering him. And, I stepped up to the foot of his bed to take his chart up, and asked him what I could do for him. And he proceeded to pull his gown back and told me exactly what I could do for him.

Interviewer: Ok. This is the graphic part, but tell me what exactly did he say.

Joe: Exactly?

Interviewer: Yeah.

Joe: He looked at me and he says, “Do you give a good blow job?”

Penis stories were very disturbing to the participants in this study because they suggest an implicit threat of violence. This participant emphasized the patient’s size, stating two times that this man was a “big guy.” This patient’s size became frightening when he showed his penis and propositioned this nurse. On occasion, the violence implicit in the description was actualized in the patient’s behavior. For example, one female nurse described the behavior of a male alcoholic patient going through detoxification:

June: We um for the age he was [elderly] he could raise his legs up and kick you if you were standing at the head of the bed, he’d knock you, he’d grab a hold of you.

Interviewer: Now was this sexual or just violent?

June: No that was [violent]. Then he might just say things “I’m going to knock you upside of the head with my penis.”

This man not only threatened violence with his penis as a weapon, but he would kick and hurt the nurses who cared for him. A number of things are interesting in this excerpt. First, this male patient made explicit what was implied by many other patients who exposed themselves. The penis was a weapon to be used to control and hurt others. Given the number of women who are raped by men, this threat of violence is not to be taken lightly. It is a serious reminder that these men could hurt the nurse if they chose. In this way the centrality of domination and control in hegemonic masculinity is enacted in the health care setting. Specifically, the threat of violence is a sharp reminder that many men derive social power, in part, from their physical size and willingness to use it to harm others.

Discursive Role Making. Discursive role making occurs when patients use language to realign roles in the healthcare setting. Specifically, the male patients described by these participants attempt to realign caregiver/patient relationship into a sexualized man/woman relationship. This behavior was disturbing to the nurses in this study because it questioned the very identity of the nurses’ professional roles. Discursive role making often involved the use of labels, either for the male patient or for the nurse. For example, one male patient asked a female nurse to call him “Studdly.” This term springs from horse breeding in which “studs” are used to breed with mares. While this label emphasized the male patient’s sexual prowess, another patient compared a female nurse to a prostitute, discursively relegating her to a sexualized profession. This Vietnamese woman nurse believed that her race invited this type of behavior from some male patients:

Kim: And a lot of men had experiences with those kind of women [prostitutes]. And when they come here... most of them like in Vietnam or some other war, they have some

kind of emotional problems [from the war]. Being Asian, I think that that kind of reminds them a bit [of the war], and so they try to... They kind of think you are like that. . . . So they try to suggest something. Or try to touch you in a way that is sexual.

Interviewer: Well, that's really interesting. It sounds like you've had an experience or two in that way. Can you describe for me a specific experience you've had?

Kim: Ok. Just recently – I would say a few months ago – we had a patient who was, an in-patient, who was middle-aged. Let's say he was 50, 65. And, um, I was, um, asking him about. When he was being admitted, part of the care that we do is to find out if they already have high blood pressure, diabetes, and all of that. And, um, he had started to kind of flirting. And then he would say, "You know, you remind me of someone I saw before." And I said, "Oh yeah? What?" "I think you look [like] somebody who is around the Orange Blossom Trail." Now, if you're familiar with [name of town in Vietnam], Orange Blossom Trail is the trail where most prostitutes...that's where most prostitutes stand there to get their customers there.

Interviewer: Oh really?!

Kim: And he suggested, "You look like someone I've seen on Orange Blossom trail." So, um, I just glanced up and said, "Huh? That's not me. And I don't like your comment about saying that. That isn't nice." You know, I [said it] just kind of jokingly.

This nurse recalls the male patient comparing her to a prostitute. Anyone who had lived in Vietnam would recognize the implications of the man's comments. Women who sold themselves for sex lined Orange Blossom Trail. The man was implying that this nurse looked like someone who was a prostitute.

Discursive role making was particularly problematic for these nurses because they provided a direct threat to their valued professional identities as "nurses." While the popular culture has historically portrayed nurses as sex objects, the nurses in this study viewed themselves as health care professionals. They distinctly defined their roles in non-sexualized ways. They were valuable, not because of their sexuality, but because of their skill at providing health care. When the patients' attempts to regain control of their hegemonic masculinity collided with nurses attempt to retain control over their professional identities, a dialectic of control occurred.

Emasculation: Responding to sexual harassment.

What happens when two groups' legitimate claims to power and control intersect? In this study, we argue that some men's hegemonic masculinity is threatened by the health care setting, so they sexually harass their nurses to regain a sense of their masculinity. By sexually harassing nurses, these patients are threatening the nurses' identities as professionals. The nurses then respond in a way that reasserts their legitimate control as professionals, which ironically heightens the threat to the men's hegemonic masculinity. This cycle of control is very much a dialectic between two competing forces: hegemonic masculinity versus professional identity. Each group simultaneously asserts control and resistance to control. While the nurses responded to sexual harassment by patients in a variety of ways, in this section we will focus on the various ways in which these nurses reassert their professional control by emasculating the male patients who sexually harass them. Emasculation was a discursive process in which the nurses verbally limited the virility and control of male patients. This behavior verbally distanced the patients from the hegemonic ideal. This could be done to the patient directly, or at a social level. For example, the nurse may speak directly to the patient or they could engage in sense making with other nurses. Direct confrontation provided a direct threat to the male patient's hegemonic masculinity. Sense making with others, on the other hand, tended to reinforce the patient role by highlighting the men as ill and in need of control. Consequently, these nurses did not feel a need to respond to the harasser in order to respond to the hegemonic masculinity and threat to their professional identities.

Ageism. One of the most common forms of emasculation was accomplished by referencing these patients' ages. Ageism is a growing and understudied problem in the Western world (Allen, 2004). It is so subtle that "some people may not even realize that they are enacting

age ideology” (Allen, 2004, p. 169). It is the construction of age as a medical problem that is the greatest interest in the present analysis. According to Allen, “the construction of age echoes patterns evident in other aspects of social identity in that medical or scientific ‘knowledge’ has often been used to justify a hierarchy based on human physiology and the decline of bodily functions due to aging” (p. 170). In fact, the deficit model of aging was created by physicians who viewed old age as signifying a period of physical and mental decline (Allen). Aging is clearly an undesirable condition in contemporary Western society but has particular implications for hegemonic masculinities. Specifically, the ideal male has an archetypal body that is closely associated with youth. “Significantly, those bodies that do not exhibit such physical attributes are often ranked lower on a continuum of masculinities” (Drummond, 2003). Aging men who rely on the archetypal male body image may find their masculine identity threatened (Drummond). The nurses in the present study tended to use labels and stereotypes that emphasized the aging process for the male patients who sexually harass. These male patients, regardless of age, were variously called “little old men,” and “dirty old men.”

Joann: Yes. Yes. I’ve heard other nurses talk about it.

Interviewer: What kinds of things

Joann: Dirty old man.

[laughter]

Interviewer: That sounds like it is a standard line.

Joann: Yes. Yes.

[laughter]

Interviewer: What do these dirty old men do to get that label?

Joann: Oh, they’ll pat the nurses, talk sexual or dirty to them. Or, um, try to hit on them, you know. “Let’s go out. Can you come back after your shift?” You know, that kind of stuff.

A second nurse echoed this sentiment:

We just go “oh it’s just a dirty old man.” [both laughing]. You know? “Poor old man. He’s just a dirty old man.” You know, that kind of stuff.

This reliance on age stereotypes to manage sexual harassment by patients represents a form of ageism. Youth is the ideal. Age is generally viewed as the enemy (Drummond, 2003). What was truly intriguing about this tendency to label patients as “dirty old men,” is that older patients who were sexually aggressive were also described as “childlike.” Similarly, older men who were caught having sexual relations with women in a nursing home were called “cute,” and childlike: “You see little children playing with themselves. And old people will do it like children will do it” (Nurse 20). The assumption here, of course, is that only elderly men and children “play with themselves,” despite the fact that masturbation is considered to be a common act by men of all ages. Even more interestingly, people labeled as “old” by these nurses ranged from 16 to 90 years of age. In other words, labeling a person as old appeared to be more of a discursive strategy designed to emasculate a patient than it had to do with more objective measures of age.

Objectification. A second form of emasculation was accomplished by objectifying patients. Patients were turned into objects in multiple ways. However, the most intriguing in light of the present discussion was the objectifying of the penis. Hegemonic masculinity is judged to a great extent on a man’s sexual prowess, epitomized by the extraordinary size and staying power of his penis. There is nothing normal about the hegemonic male penis. It is always extraordinary. By normalizing and objectifying male patients’ penises, these nurses bring into question these men’s proximity to the hegemonic ideal man. As one nurse told a male patient who exposed himself to her, “If I had something that looked like that, I wouldn’t be showing it to nobody.”

Others expressed similar sentiments:

It’s like parts is parts. I’ve seen hundreds and hundreds of these [penises]. So it’s [healthcare] a whole different lifestyle. A whole different culture. And so I think that’s why people [nurses] tend to say, “Oh, you know, no big deal.” You know, if he rubs against me, rubs against my boob, I’m not really going to worry about it too much. I mean, how many times a day do I have to hold on to a man’s penis in my job.

And if you put them down, then right away, you know they know you don't care. You know [to male patient] –“if you've seen one [penis], you've seen them all. They all look alike. In fact nothing you can do can shock me, so let's not even go there.”

In these quotes, the male penis becomes not only ordinary, but an asexual object. It is routine, normal, or in the first quote, comparatively small. These evaluations are professionally derived: “You've seen one, you've seen them all” indicates long experience on the professional level. One could hardly imagine such a response if a female in any other non sex-related profession was harassed by a man who exposed himself. She would hardly say, “If you've seen one, you've seen them all.” By calling these men ordinary, or even inadequate, these nurses use their professional experience to negatively evaluate the men's genitals. This negative evaluation acts to counter the hegemonic behavior of the male patients who harassed them.

Medicalizing sexual harassment. A third form of emasculation occurred by medicalizing the sexual harassment by patients. In essence, these behaviors were viewed as merely an extension of the illness faced by the patient. In some cases, such as in head traumas, the behaviors were indeed a part of the medical condition. However, many of these nurses viewed all such behavior as part of the medical condition. In essence, because they were patients, the nurses should expect irrational behavior:

But you gotta understand [why patients make inappropriate comments]. You gotta move on. He's not independent anymore. He's not, you know?

* * * *

Interviewer: That's fascinating. So in your experience, then, uh, that's happened to you personally or that you've witnessed with other nurses, then would you say that all patients' inappropriate behaviors or sexual harassment is tied to the fact that they are ill?

Natalie: Yes.

Interviewer: So that would always be an underlying excuse?

Natalie: Yes. Yes.

For these nurses and others like them, the fact that a patient behaves in an inappropriate way simply reinforces the fact that they are sick. They seem to believe that physically healthy people

would never behave in such a manner. What is interesting about medicalizing sexual harassment is the way in which the patient role is reemphasized. From the patient perspective, the sexual harassment resists the medical role of the patient. Conversely, from the nurse perspective, the sexual harassment reinforces the individual's role as a patient. Note the odd cyclic quality of the dialectic of control. Both the patients and the nurses resist their feminized roles by asserting control in the healthcare setting. The health care system threatens the male patient's hegemonic masculinity, who responds by sexually harassing the nurse, who responds by assuming that his illness made him sexually harass, who responds by

Conclusion

This study explored the dialectic of control between nurses and male patients, illustrating the dialectical nature between masculinities and femininities. This study also highlights the close relationship between gender and power. This is a particularly interesting phenomenon because both groups in this study have socially sanctioned claims to control. The men's claim to social control springs from normalized notions of hegemonic masculinity. The nurses claim to contextual control springs from the prestige of their profession and the control granted to the health care industry. Both groups also face threats to their control in the health care setting. The patient role as subordinate threatens men's hegemonic masculinity. The feminization and the sexual stereotypes of nurses tend to threaten the nurses' professional identity. When these two forces collide in the health care setting, the dialectic of control becomes apparent.

Most male patients do not sexually harass nurses, despite the threat to their masculinity associated with illness and the health care industry, possibly because there are many ways of managing threats to hegemonic masculinity (Weinke, 1998), only one of which is the display of hyper sexuality. When male patients did sexually harass their nurses, the behavior tended to be

physically and verbally aggressive. Often the behavior was accompanied by a threat of violence. Always the behavior seemed designed to establish the man as dominant, aggressive, and sexually potent. These findings are consistent with scholarly findings that sexual harassment is not about sex, it is about power (Conrad & Taylor, 1994; Dougherty, 1999; Jansma, 2001; Payne, 1993). This type of dominance, then, treated the nurse as a sex object, there for the sexual pleasure of the man. The behavior also demanded that the nurse bear witness to the fact that the patient was still very, very male.

The right of nurses to control patients in the healthcare setting has been historically contested by physicians and threatened by media images of nurses. Despite the tenuous nature of their professional status, the nurses in the present study tended to view themselves as in control of patients in the healthcare setting. While they acknowledged that men are more powerful socially, the nurses argued that they were more powerful situationally. While nurses responded in many different ways to male patients' inappropriate sexual behavior, the responses designed to emasculate the patients are emphasized in this study. These responses could be directed toward the patient or they could be sense making with others. Regardless, the responses reified the traditional patient role and minimized hegemonic masculinity. The female nurses aggressively rejected the men's sexual behaviors, responding in such a way that the men's sexual prowess was questioned. Men were called physically inadequate, typical, average, sick, and old. Responses were carefully designed to threaten hegemonic masculinity. This threat then heightens the general threat to hegemonic masculinity men experience in the health care setting, which then creates a need to re-establish their proximity to the ideal. A dialectic of control is established between two competing and legitimate claims to control.

So why is this study important from a health care perspective? First, male patients who sexually harass may receive less quality care than other patients. While the nurses in the present study continued to provide technical care, they also indicated a discomfort to work with the patient again. These patients tended to receive a brief, emotively cool, technical care from their nurses. Ironically, this creates the potential for the patient to be sick for a longer period of time—heightening the threat to their performance of hegemonic masculinity.

Second, nurse fatigue and burn out are well established problems. While sexual harassment by patients is not the most serious issue faced by nurses, it is one more environmental force that could ultimately influence attrition in the profession. It is not any one thing that creates a crisis in nursing. It is the cumulative effect of numerous environmental issues that creates problems for nurses. The sexual harassment of nurses by patients is simply one more unpleasant thing nurses must face on the job.

We wish that there was an easy answer to how to manage this issue. Unfortunately, there is no readily apparent way to eliminate this problem—short of eliminating current masculine ideals that are culturally dominant while simultaneously creating a more constructive conception of the relationship between provider and patient. Instead, a more practical and ongoing response is called for. Geist and Dreyer (1993) call for a dialogic relationship between healthcare providers and patients. This would require a radical shift in communication and the traditional notions of healthcare roles. In some instances this type of shift in communication may prove productive in managing sexual harassment from patients. Specifically, a dialogic approach would recognize male patients' knowledge of their own body and medical condition. This would create a more positive role for patients and less loss of control. A second suggestion would to prepare nurses for the possibility that they could face inappropriate sexual behavior from their patients.

Most nurses we interviewed were completely unprepared for the aggressive sexual behavior from their patients. Preparing them for the possibility will allow them to create multiple scripts they can use to manage the problem.

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