Nursing care requires access to every part of the body which is potentially touchable. However, in Western cultural traditions, certain parts of the body are more (socially) accessible and more readily touched than other parts. We are culturally ‘non-touching’ and this is especially so for the British. As nurses learn how to perform their work, therefore, they must overcome their own sociocultural backgrounds and adjust to a particular professional subculture and its established methods that permits handling other people’s bodies. They must also confront the symbolism of certain parts of the body, in particular parts which have sexual significance, and they must find ways to manage social interaction during those times when they break taken-for-granted rules about the body.

The people whose experiences are discussed in this study [...] found some of their first experiences of working with other people’s bodies to be socially awkward. Coming as they did from a non-touching cultural background, many of the nurses I talked with found that they were, among other things, acutely embarrassed in having to perform body care for others.

Those who had the least difficulty touching and handling the bodies of patients came from backgrounds with a relatively relaxed attitude to the body and exposure (but they were few in number) or had friends or family who were nurses. Most of the interviewees described a style of family life and upbringing where body functions were dealt with in a ‘civilized’ manner (see Elias, 1978). The sensitive bodily functions were carried out in private and they were not discussed. The body was almost always kept covered, consistent with the established cultural patterns of their families, and this socialization was acknowledged as a difficulty for a beginning nurse, as one nurse explained.

I: I can remember the first man I had to wash. That was traumatic... I was timid. I was embarrassed, I guess. The women weren’t quite so bad, I mean that was a shock but a different sort of shock to the men.

R: Why are the men worse?

I: ‘I had never seen men naked and – even though I had brothers – three brothers. I mean you were just very modest, I guess, when you were at home.
R: So you came from a family who kept things covered up?
I: Oh yes.
R: Did they talk about bodily functions?
I: No, see they were very English in that respect. They were something that you didn’t talk about. Nothing like that was.
R: So when people went to the loo?
I: It was behind a closed door and that was it.
R: Did that make it very difficult for you as a nurse to then have to do for others what was [taboo], in your family life?
I: Taboo. Yes, I guess so, yes.

[...] There are other factors, however, that influence these experiences, and they have their origins in the way the body is constructed in our culture. In particular the relationship of maleness and male power to genitalia and sexuality had a powerful effect on some of the female interviewees. The power invested in the male body is a theme which recurs throughout this study. [...]  

First experience of body care for others

While much has been written to educate nurses, [...] nurses are poorly prepared, educationally, for the breaking of social norms which many nursing acts necessarily involve. What they learn of these things they learn through experience.

We are taught the proper way to carry out a bed bath, but not how to deal with the breaking of the social taboos when we wash a patient’s body. Most nurses remember the fear they felt when doing their first bed bath. As a young female you work with a patient (who might well be male), behind drawn curtains and are expected to strip and wash his whole body. I remember feeling shamed and confused; my hands felt stiff, cold, awkward and useless. A bed bath can be embarrassing for the patient at the best of times – but far worse when the nurse herself [sic] is embarrassed. (Berry, 1986: 56)

Berry’s experience is mirrored by that of the people interviewed for this study. They talked of feeling terror, embarrassment and timidity when they first had to confront other people’s nakedness, and at having to undress people, particularly men.

Normal male–female relationships in society are disrupted in nursing, especially when a beginning female nurse encounters her first male patient. She has not yet learned the interpersonal skills that will later make her work manageable. While male nurses experience some feelings of embarrassment when they encounter female patients for the first time, the data reported here suggest their discomfort is not as acute. It is possible, however, that my data reflect what men were
willing to tell a woman about their sense of discomfort and also what women are prepared to discuss with another woman (see Warren, 1988).

For many, sponging a patient for the first time was highly significant, and they have retained vivid memories of that occasion. They acknowledge it as a major milestone – a time when the reality of nursing confronts them. After the first sponge, however, doing body care for others seems to become much easier. […] I asked each of the interviewees if they could remember the first time they had to ‘do for someone else what that person would normally do for themselves’. Almost without exception they related stories of the first time they had to sponge a patient. […]

The naked male body

In many of the accounts I heard from female nurses there was an early sense of profound embarrassment, lack of social competence and sometimes fear associated with men and having to deal with male bodies, particularly when the genitalia are exposed. It is an aspect of nursing practice which is often surrounded by social awkwardness and uncertainty. The following accounts indicate the early discomfort and fear of having to deal with the naked male:

Yes. I can [remember my first experience with body care]. We went to … this long pavilion ward, a men’s ward. [I] begged not to go to a men’s ward first. […] Anyway, went there, and was terrified through the whole procedure. … Just was terrified. … I remember it really clearly. … Women did not worry me. Men worried me a lot.

I copped Male Ward. And I had to go to the corner [bed] – a boy about 18 he was. And he had a plaster on his leg, and so I gave him the dish and told him to wash himself, and he wasn’t going to take his underpants off, and I wasn’t about to take them off either! [Laughter] I can remember that as plain as day! […] And I think that he was embarrassed and so was I. … I had seen men before, but we’d been reared, you know, you don’t look at men. And that to me was just a problem. I was too embarrassed. … I still remember it as clear as day.

I can remember the very first day on the ward … begging that they let me do a female one [sponge] first because I couldn’t bear the thought of pulling down a pair of man’s trousers. At that stage I don’t think it ever occurred to me that my father had genitals. I was that protected from the male anatomy.

The first sponge is often the very first clinical act which beginning nurses perform where the body is completely exposed, and where they touch socially proscribed parts of the body. As the accounts illustrate, the male genitalia are especially problematic and many were very reluctant to touch those areas, as one would expect in a society where the male sex organs are invested with such meaning and kept covered, and where body contact in the genital areas is almost exclusively reserved for sexual contexts. In the absence of learned skills to
manage these situations, the beginning nurse feels socially awkward and embarrassed.

Some interviewees remember their first experiences as occasions where they first saw suffering, disfigurement and death. And like the naked body, one does not normally encounter these things extensively in one’s daily life, nor are they necessarily discussed in detail, and even within hospitals there is a limit to what the public sees, or is allowed to see or know. [...] 

In the very early stages... they took us over to the hospital – it was one of those old Nightingale wards.... It was a male medical ward and there was a guy in a bed near the office and he was obviously on his last legs. Now I had had nothing to do with death except seeing my grandmother who was... very unwell but she wasn’t unconscious, she was a bit delirious. This guy in the bed was, you know, vomiting blood, and the whole ward was like a zoo, and I walked in with one of my mates and I thought ‘my God, what have I got myself in for?’... and we had this guy who was in a single room, you know, he was Cheyne-Stoking and he died [Cheyne-Stokes Breathing is a type of breathing seen in some serious nervous conditions]. When he died we looked at each other and said ‘God what are we gonna do now? He’s dead’... We thought he was dead. We weren’t real sure. We weren’t real sure. We kept saying to each other ‘Is he [dead]? Is he?’ Well, we were sort of hysterical with laughter for a while because we thought ‘yeah, well he is dead ’cause that dreadful noise had stopped’, but then we got sort of sad because we hadn’t witnessed anything like this before. ...

Other nurses remembered their first experiences because, as beginners, they were disorganized, they lacked skill and they encountered scenes for which they were completely unprepared. As a consequence they felt inadequate. It is important for nursing students to feel a sense of competence in their actions (Davis, 1968) and without it they feel unable to adequately convey a sense of being in control – a sense that is needed in order to promote a particular context in which to perform highly intimate care for patients. The following two accounts, given by nurses who are now very experienced and skilled at their practice, illustrate their felt lack of competence – a lack which meant they had not yet developed the occupationally specific methods that they could later use to manage such situations. Speed is often used by nurses as a method by which difficult things are managed, particularly those things which are potentially embarrassing. The first account was given by a male registered nurse, now in his thirties and skilled at care for acutely ill and intensive care patients.

I can remember we went to the ward, and... I can remember lining up with all the bits and pieces, the bowl and stuff and thinking to myself ‘I haven’t got a bloody clue what I’m doing here’. We’d done it on models and dummies and that in the school but never actually done it on a person and I looked at the man I was about to sponge. I can remember him, he was a big man, fat man, and he’d had a cholecystectomy. He had an I.G. tube and he had a drain in and a drip and I thought ‘Where will I start with all this – how will I get the pyjamas off?’ – that sort of stuff. I was slow. I know it took me 55
minutes...and even then I forgot to do things like clean his teeth and do all that sort of thing. I was so intent on getting him washed. It was awful...I knew to wash him, and I knew what I had to do as far as washing and drying and all that sort of thing, but not having any idea of the organization—and being slow. And it was hard because he knew that we were new.

I have often had that woman's situation in my mind since. You know, it's something I have not lost through the years, was going into a bathroom and seeing this elderly lady in a bath and seeing her arm and leg floating on top and she was weeping and couldn't express anything, and I later discovered she'd had a stroke and she was aphasic. She had been a doctor, and you know how stroke people cry, and she just cried and cried, and couldn't express herself and it was sort of a trauma to me that I have never really lost. I can remember her, and I think that's a terrible thing—for a woman like that to come to that state and—I mean she couldn't move anything, her leg and arm were floating on top and the nurses were trying to bat her in a bath, and she was just crying and drooling and couldn't speak...It was "Whatever do I do, whatever do I say?"

**Learning 'basic' nursing**

When these nurses were taught how to do body care for others, it was in a particular manner—a manner that incorporated an emphasis on routine and procedure which involved no unnecessary exposure of the patient's body and which followed the recipe book approach characteristic of the texts. Additionally, the patient's embarrassment was to be considered, and nurses were also taught to maintain 'privacy'—a term which has a particular meaning where body care in nursing is concerned. Privacy has to do not only with avoiding unnecessary exposure, but it is also a notion about the vulnerability of patients. Instructions on clinical procedures emphasize privacy as a central consideration, along with the adherence to routine. [. . .]

**The emphasis on procedure**

The accounts I heard in this study confirmed that nursing procedures, as they are described in texts, as step-wise and relatively stereotyped affairs, are indeed what nurses are taught as students. I asked those I interviewed how they had been taught to perform body care, especially sponging, which is the most central and comprehensive act of body care.

*I*: They [the teachers] were very strict, very 'thorough'—the word is.
*R*: But what did they teach you about how you might socially manage things like other people's nakedness, and embarrassment, and modesty?
*I*: I don't think they ever prepared you for that.
*R*: So they taught you how to do the procedure... . . .
*I*: Physically do it, yeah. By the book! It was a procedure.

Yes, I can remember exactly what they [the nurse teachers] told us. Things they were more worried about were putting the sheets and the blankets in
the right place and the towel in the right place and they never mentioned anything about how you should cope with the person, or the person coped with you. That was never, ever mentioned.

Others remembered being taught about a procedure which incorporated the notion of privacy, and how one might achieve this during the procedure. Privacy in this sense means not overexposing the patient, and it also means ensuring a visual privacy such that others cannot see the patient’s nakedness. In effect, it is dealing with the body in a privatized and ‘civilized’ way, but it is also somological — the nurse must ‘do for’ the body while simultaneously recognizing personhood. The procedure, though, was dominant in their early formal education.

We were always taught to screen the patient and we were always taught about privacy — privacy as in ‘from the rest of the ward’ — to screen the patient and make sure we were in this little closed-off area. We were taught nothing about embarrassment as far as the patient was concerned with the nurse. We were always taught to keep the patient warm which presumably meant you kept them covered, but then in the middle of summer you didn’t need to be covered to be warm. We were always taught to keep them covered and taught to sponge by moving the sheet up and down various parts of the body — that sort of thing . . . . Exposing one bit at a time, but then at the same time we had to expose other bits, but nothing was ever talked about as far as patients’ embarrassment or nurses’ embarrassment. We were taught about privacy but it was privacy as in screening the patient from everyone else in the ward . . . . There was nothing about privacy between the nurse and the patient. It was always just there . . . .

[. . . ]

**Learning to control emotions**

Much of what nurses’ (women’s) work entails, represents what Hochschild (1983) has termed ‘emotional labour’ — a commodification of feelings to suit the public (paid) arena. [. . . ] Nurses are heavily involved in emotional labour because, as well as learning physically and procedurally how to wash another person in bed, there is an expectation that students will learn to control their emotions. Such emotional control is part of the nurse’s ‘professional’ approach, that is learning how to do body care and perform other nursing functions in a manner typical of the occupation.

Many aspects of nursing have changed since it embraced the concept of individualized patient care. One such change is the recognition that some emotions are normal, if not desirable, and that it is probably not healthy for nurses (or anyone else for that matter) to suppress them. Historically, however, one characteristic of a ‘good’ nurse, was the ability to hide emotional reactions and to cultivate an air of detachment — a sort of professional distance.
from one's work. Many of the nurses I interviewed remember being expected to learn such emotional control and to learn it as they developed their nursing skills, and as they coped with a daily working life that was often difficult and disturbing.

One British nurse, who is now in her fifties, described what she had been taught as a student nurse.

I don’t think we had very much at all on relating to people as individuals... You have to remember I’m British and the British stiff upper lip... I think it was just that it was not done. It was not done for the nurse to show emotion... it was to do with being professional and it upset the relatives... I think it had to do with being a professional person... [and] we learnt it because I think if you showed any emotion you couldn’t cope as a nurse you weren’t made of the right stuff [laughter]. You weren’t suitable if you showed emotion... We certainly didn’t look sad, I mean, you were not allowed to look sad or grieve, but neither were you allowed to giggle around the place. You had to comport yourself – with dignity... No frivolity, not at all.

With experience and more generalized social change, many nurses re-evaluate those early influences, particularly as they affect the ways in which they help patients come to terms with illness experience and the lived body. The ability to control emotion is often used by experienced and expert nurses as one method to help patients through illness experience. [...]

Other nurses, who are much younger than the British nurse whose experience is related above and who trained in Australia, relate similar experiences to those of their British colleague. The occupational ethos of emotional control remains relatively pervasive.

You were never allowed to [show emotion] – and you were never allowed to cry. You were only allowed to cry if the Charge Sister let you cry [laughter]. You weren’t allowed to cry if someone died or was really sick, you just felt that you had to give a little bit more to the patient – and you weren’t allowed to laugh either if you could see the funny side of things... You had to appear what they termed ‘professional’, which was very cold and caught up.

We weren’t taught about... emotions... and you weren’t taught... that it’s normal to feel disgust or things like that, which it is, isn’t it. You know, you have a job to do and you do it, but no, not enough emotion or feeling was put into it.

[I was] always told not to get involved and become attached to the patient or – it’s hard not to get involved, I mean you do get involved... I think it gets passed down, you know when you’re looking after a really sick patient [other nurses say to you] ‘you shouldn’t get involved, you know’ and so it goes on.

[...]

Emotional control, as an ideal aspect of professional practice, is now being seriously evaluated in the research literature. Benner and Wrubel (1988), for example, claim that it is impossible for nurses to
care about what happens to patients and to help them during illness experience unless some degree of involvement occurs. Many of the nurses in my study would agree because they have recognized that emotional detachment does not work and that in some cases they have had to unlearn what had previously been taught to them. [...]

I think probably we were taught that [emotional control] to start, but I think I've learnt over the years that that isn't always appropriate to the occasion, that there are times when I think ... that as a person I have the right to let that other person know that they are embarrassing me ... or that I feel uncomfortable in a situation ... I think that's improved. I think once upon a time you weren't expected to be emotional about anything. We weren't expected to feel emotion if a patient we cared about or cared for died. ... Now I think it's quite acceptable for the staff to be just as emotional about the situation as the family is. I think that's good. I think it's important that we let the people we're caring about know — that we really do care ... you can't do that if you remain detached. Looking back I think that in our early training — that we were sort of expected to be a bit remote, you know [we were told] 'don't be silly, Nurse. Pull yourself together'.

[...]

*Lack of affect as a clinical strategy*

Nurses were expected to be controlled — to show no emotion. Many of them interpreted this to mean that they were to be emotionless, but lack of affect is in itself a response — a way of dealing with what would otherwise be a social mistake, a deviant act, an affront, an insult, a source of embarrassment. To show no affective change, for example, at another person's naked body is a way of conferring a very different meaning on nakedness from the usual effect of running naked across the field at a sports event. [...]

Lack of effect is a means by which nurses construct context, so in that sense it serves to assist in the management of otherwise potentially embarrassing situations. The problem for nurses, however, is that lack of affect can become *the* standardized and expected emotional response, in which case it excludes the possibility of sharing difficult moments for patients in a way which allows the nurse to 'make contact' with the patient existentially (see Benner and Wrubel, 1988: Chapter 1).

In many ways nurses operate in a social vacuum because they are often naive or ill-informed (at best) about the work they are expected to do and how they can behave, and little, if anything, in their lives prepares them for what they are required to do for others as basic nursing (body) care. Much of what nurses do is not public to protect patients' 'privacy', and it takes time and experience to feel comfortable in the role of nurse, doing things for other people. Talking with patients about some things is also difficult because there is a problem
with language. Not only is it not always socially appropriate, or acceptable, to discuss what nurses do, there is a real difficulty in choosing appropriate words or simply having conversation about various things to do with the body. This [...] is richly indicative of ‘the problem of the body’ and privatized body functions and it highlights the silence of the body in discourse generally.

The problem of language

I asked the interviewees what they found most difficult to do when they first began nursing, and while many found the physical and procedural aspects of caring for other people’s bodies awkward, there was a very real problem with language and conversation. Nurses were taught always to explain what they were going to do to patients, because patients are often unaware of what could happen during a certain procedure. [...]

Explanation, however, is not straightforward because some people are not relaxed about discussing some body functions or body parts; and the choice of words is far from straightforward. The two accounts below illustrate some of the general aspects of this problem. I had asked the interviewees if they found it difficult to know what to say to people when they were doing nursing care.

Embarrassing. Didn’t know what to look at, what to say, because at those times I was quite shy and I can remember it was an old lady . . . with a fracture and . . . we had to . . . sponge and we had to do the whole works not knowing what to say or what to touch when you got to those bits . . . because it’s something you don’t ask . . . We didn’t know if that person would be offended by what we said. If you said ‘your boobs’ would she be offended by that. Being older she would probably be a bit strict.

We were never taught how to deal with that [the language difficulty]. I mean, to ask a patient if they wanted to wash, for example, ‘Would you like to wash between your legs?’ or if you were being jovial you’d hear people say ‘I’ll wash down as far as possible and you wash “possible”’. And all this sort of thing – how do you ask someone if they’d like to wash between their legs. . . . The language is always a problem.

One of the major problems of language in nursing care is that there are no widely accepted standards for the names of body parts and functions. If, for instance, nurses call various body parts by their anatomical names, there is a fair chance the patient will not understand, and if they use language that is in common usage, the choice is by no means simple; furthermore, there are some things which people do not readily discuss. [...]

I think . . . [some] patients, when we ask them if they’ve had their bowels open, they tend to say ‘yes’ routinely because they don’t know what we’re talking about. That happens on a regular basis because they’re not real sure what we’re talking about . . . People tend to call having your bowels open a
lot of stupid things. . . . I think it’s classed as dirty. Whereas it shouldn’t be. It’s only your own body, but I think they’re taught from a young age [that it’s dirty].

With the civilizing process (Elias, 1978), body functions concerned with excretion have become highly privatized, at least by some social groups, particularly those of higher social status. [. . .]

Oh yes. I think it’s definitely class related. Joe Bloggs off the river bank is easy to talk to. They shit, they fart, they piss. You can communicate. It’s the people with a middle-class presentation who don’t have the vocabulary to match.

In summary, learning to be a nurse involves facing the reality of the place of the body in our society. [. . .] Becoming socialized as a nurse, however, means taking on a new way of looking at the body and learning to ‘do for’. It requires unlearning ways of viewing the body. Such unlearning is necessitated by ‘the problem of the body’ and by the extent to which nursing and illness are disruptive of social order and normal rules do not always apply. [. . .] There is also no professional jargon that can be used to describe body functions which would make it possible to sanitize things people regard as dirty. [. . .] In the absence of discourse and socially acceptable language, some nursing functions are located outside socially condoned and accepted practices – they are dealt with by their absence and the silence which surrounds them.

References