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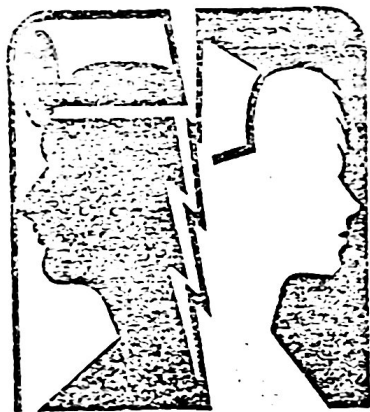
Harassed Nurses . . . War Of Sexes Rages In Hospitals, They Insist

There is surfacing in the world of medicine a sometimes adversary relationship between doctors and nurses — particularly in hospital settings — that often goes to the roles of males and females. What follows is the first of a five-part series on the subject.

By Sigrid Bathen
Bee Staff Writer

Lorrie Morris was 18 years old and a student nurse working in a county hospital when she learned a harsh lesson about how to behave around physicians. The year was 1947.

"I was working a night shift. A doctor walked in and felt I had not stood up quickly enough. He hit me across the head and knocked me out of the



chair."

Lorrie Morris had failed to honor the rigid code of conduct — upheld in many of the nation's nursing schools and hospitals until at least the 1950's

— which dictated that nurses stand when doctors entered.

There are variations on the same theme. Nurses didn't eat with doctors in the hospital dining room. "When I was in training," Ms. Morris recalls, "the doctors ate at one end and we ate at the other. To sit at the doctors' dining table was tantamount to dismissal from nursing school."

Nurses were instructed not to get on elevators with doctors unless they had a specific invitation from a physician.

And they rarely questioned a physician's medical judgement. Even if they knew — to cite extreme but common examples — the physician was drunk or taking drugs or sexually

abusing female patients. They were silent because of their educational conditioning and the reality of work in physician-controlled hospitals — and because they knew they would be ostracized or fired if they complained.

So they wrestled with their professional consciences, or left the profession. But mostly they were silent.

With the advent of the women's rights movement, unionization of nurses and increased recognition of their pivotal role in the health care industry, nurses say the more blatant abuse of nurses by doctors has largely ceased. But it has been replaced, they add, by more subtle forms of harassment and intimidation. And most of their current criticism is directed at hospitals, where the American Nurses Association estimates nearly three out of five nurses work.

Lorrie Morris doesn't work in a hospital anymore. She is a family planning nurse-practitioner, one of a growing number of nurses with ad-

vanced professional training who provide direct patient care, often in a relatively independent setting. She works for Planned Parenthood in Sacramento and says her work with physicians there "is one of my great joys."

She remembers that night 22 years ago when the doctor knocked her off her chair: "It was so different then. My reaction now would be to fight back, but that was 1947 and I was 19 years old and I knew there wasn't any recourse in this world had I wanted to fight it. Nurses were conditioned not to fight back. If I had fought it I would have lost.

"By and large, relations between doctors and nurses are much better today. At least it's not so overt. I doubt many nurses would tolerate

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being hit over the head, but I think a nurse would consider it very gravely before she did anything that might put her job on the line.

"It's still 'just the word of a nurse' against that of a doctor."



Bee Photo

LORRIE MORRIS
knocked off her chair

Sandra Doll Neri was working as a circulating operating room nurse at Sutter Memorial Hospital in Sacramento on Feb. 11, 1977, when she noticed anesthesiologist Dr. William Miofsky acting "strangely."

"I was walking by the anesthesiologist," she testified in Sacramento Superior Court last spring. "and I glanced to my left and noticed he had his penis in the patient's mouth." She reported her startling observation to another nurse, who confirmed what she had seen.

"On that very day," Mrs. Neri testified, "I told Dr. O'Kane." Dr. Calvin O'Kane, who performed the operation on the 52-year-old female patient.

In the two years to follow before Miofsky was banned from the operating room at Sutter Memorial, other nurses reported "strange" behavior by the physician. To other physicians, to the hospital administration, to

nursing supervisors. Their complaints were disbelieved or ignored.

After two years and news media exposure of the case, William Miofsky was charged with sex perversion in one of the most bizarre cases to come before a Sacramento court in years. He pleaded no contest to three of the seven felony counts against him and is expected to be sentenced after psychiatric reports on his mental condition are completed.

State health officials have since moved to revoke or suspend the licenses of O'Kane, Dr. Elijah William Rector, former chairman of the board at Sutter, chief surgery nurse Allyn Waters O'Kane, operating room supervisor Viola Katherine MacClanahan and Nursing Director Carlynn Damm, for failing to "act responsibly on information they received" about Miofsky's conduct. Sutter has lost its national hospital accreditation, and state health officials have uncovered numerous state licensing violations in their probe of the facility.

Many saw it this way: In a sense, it was not only William Miofsky who was under indictment, but the entire system of physician "peer review," the domination of hospitals by physicians — and the role of nurses.

Sexual abuse of female patients by male physicians is not new. But, like so much of the American medical system, it is largely hidden from public view. Nurses interviewed throughout the country for this series expressed surprise at the nature of the allegations against Miofsky — because his alleged behavior occurred during operations, and because an operating room is a busy place — but they were not surprised that a physician was accused of sexual misbehavior involving female patients.

Many were surprised that the complaining nurses were not fired, particularly in a hospital where nine of the 15-member board of directors were physicians. It's hard to say what Sandra Doll Neri and other Sutter nurses experienced those two years, because nurses in the Sutter Community Hospitals haven't been talking to reporters.

"Sexual misconduct by health professionals — including psychologists as well as physicians — is a growing problem," says Michael Krisman, deputy director of the state Department of Consumer Affairs, which oversees licensing boards for health professionals in California. "Maybe it's always been there and has just been overlooked before."

Bob Rowland, executive officer of the state Board of Medical Quality Assurance, said six cases of sexual misconduct involving doctors were the subjects of disciplinary action in a 12-month period in 1977-78, roughly 4 per cent of the total disciplinary actions by BMQA against California doctors.

"Remember," Rowland added, "those are only the cases we know about." Last week, BMQA moved to suspend the license of a Sacramento urologist, G. Kenneth Washington, accused of sexually abusing a female patient on whom he had performed a breast implant operation.



Cartoon by Arno Sternalass

One interpretation of the doctor-nurse relationship, as it appeared in the "American Journal of Nursing," August 1971.

Krisman said a bill dealing specifically with sexual misconduct by health care professionals — making sexual misconduct grounds for charges of unprofessional behavior under the state licensing laws — is pending in the Legislature.

Nurses who are willing to talk about

sexual abuse of patients by physicians say it reaches its worst extremes in facilities where health care is delivered to poor people who are less likely and less able to complain about it than their wealthier counterparts.

"When I was head nurse on the 'charity ward' of an East Coast hospital, I personally witnessed the chief resident in obstetrics-gynecology rape a patient," said a well-known and respected California nurse who

asked that her name not be used. "He specifically chose to rape only female patients with pelvic inflammatory disease. . . .

"These were poor women, uneducated, largely black. A black woman came to me and said the doctor 'diddled' her. I wasn't sure whether she had misinterpreted a pelvic examination, so I started watching this particular physician. He would always do rounds alone, and always when the nurses were busy with something else, during report and shift change.

"I could see the bottom of his legs beneath the curtain at the patient's bedside. Then I didn't see his legs. I looked in, and he was on top of the patient.

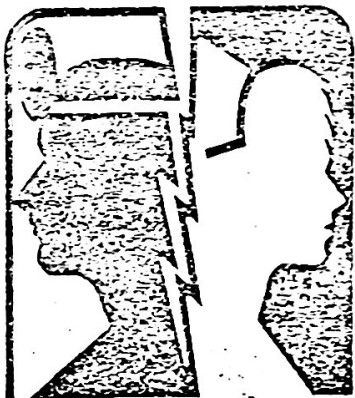
"I went to the director of nursing, who was a man. He pooh-poohed it. So I called the medical director, and I told him if he didn't do something I would call the police. . . The doctor in question was a resident of a foreign country. The medical director told him if he was not out of the country immediately, he would take action. The man left the country, and no action was taken.

"I presume he still practices medicine in his own country."

As nurses do, this nurse has worked in many different hospitals. "Geographic mobility" is what the American Nurses Association calls the tendency of nurses to change jobs and move around a lot. Other, less official, sources say nurses are dissatisfied with their work, and they move on in the hope of finding something better.

"When I was director of nursing at a small hospital in (a southwestern state)," the nurse continued, "there were complaints against a physician responsible for admitting female drug addicts. One woman said the doctor would only prescribe medication if she would orally copulate him, and the allegation was substantiated by a nurse.

"I knew his orders were erratic — days without dosages, then days with



large dosages. I couldn't ignore it. The hospital administrator was an unusual administrator, in that he told me to handle it.

"All of the physicians refused to talk to me about it. They knew this man's behavior was strange, but they needed him because without him their workload would increase tremendously. Finally, one physician agreed to be with me when I met with the man.

"I called him and told him to come to my office. Most physicians would say no when told to come to a nurse's office, or they would at least want to know why, but he didn't even ask why. He came to my office immediately. He was very nervous. He denied it. He discharged the patient. She would not file criminal charges, and the other physicians would do nothing. He is still practicing today.

"These cases are not unusual. They are just extreme."

Derisive remarks by male physicians about female anatomy are common knowledge among nurses. They say the low esteem in which many physicians hold female patients extends to their view of nurses, 98 per cent of whom are women.

"You stand by when a medical student examines a female patient and you get to listen to 'get a load of those knockers,'" says a former hospital staff nurse. "The operating room is the worst place. The tension, the ugliness, the dirty jokes. You have to stay there. You can't break scrub. I would object, but they would avoid the issue and ask me why I was so paranoid."

Until recently, when women began inching their way into medical schools, physician-professors commonly used slides of nude women in provocative poses, interspersed among the pathology slides to "hold the attention" of male medical students.

A recent textbook, "The Anatomical Basis of Medical Practice," contained lascivious pictures of women to brighten the pages, health writer Gena Corea reported in her book, "The Hidden Malpractice." The textbook was withdrawn when women objected to it, but the authors reportedly called one of the major protesters, Dr. Estelle Ramey, physiology professor at Georgetown University Medical School, "a sour old maid who couldn't take a joke."

At UCLA Medical School, a female student recalled for Ms. Corea, the last slide in a presentation would sometimes be a picture of naked female buttocks with "The End" written across them.

Patients were ridiculed, even when dying, that student said. "A dying woman's emaciated body and huge, swollen body were presented. 'Now this is Bubbles, and as you look into her lovely eyes. . . .'"

"That joke has disturbing implications," Ms. Corea observed, "for women who need medical care."

At a low-income women's health clinic in New York City in 1971, a staff gynecologist examined women without gloves and manipulated them

"Sexual misconduct by health professionals is a growing problem"

sexually, Ms. Corea reported. Patients and nurses complained about him, and the director of the center finally fired him. No medical association took any action, and no charges were filed.

About a year later, the director of the health center learned the gynecologist was working in a women's prison.

Despite the importance of their work to patient care, nurses complain they are underpaid based on their level of skills. The average registered nurse, according to the American Nurses Association, made \$1,079 a month in 1977; licensed vocational nurses and nurses' aides make much less. The latter, including a heavy preponderance of minority women, sometimes make wages which qualify them for welfare.

And nurses say they are grossly overworked, expected to perform hospital tasks and paperwork which take them away from their primary responsibility for patient care. The California Hospital Association reported last May that 17 per cent, or almost 8,500 of all full-time R.N. positions in California, went unfilled in the third quarter of 1978. Low pay and dissatisfaction with their work were cited as major reasons nurses left their jobs.

The American Nurses Association says more than 400,000 of the nation's 1.4 million registered nurses (an esti-

mated 155,000 of whom reside in California) do not practice nursing at all. According to the California Hospital Association survey, the state's hospitals annually spend as much as \$182 million on recruitment and orientation of nurses. Patients concerned with spiraling health care costs can only guess where the money comes from.

The relationship between nurses' rights and patient care — particularly the care of women — is one which is receiving increasing public and professional attention. Coalitions of health care consumers and nursing groups are forming throughout the nation.

In Northern California, parents interested in alternatives to traditional hospital childbirth rallied around a nurse, JoAnn Ruiz, who was being investigated by the state Board of Registered Nursing for practicing illegal midwifery. The investigation

was dropped.

That same group, aligned with women's rights groups and an arm of the California Nurses Association, recently pressed the Sacramento

Many physicians' low esteem of women extends to nurses

County Board of Supervisors to appoint a nurse to what has traditionally been regarded as "the doctor's seat" on the eight-county Golden Empire Health Systems Agency. The board appointed a physician, but for a one-year term instead of the usual two. The seat had never been contested in the eight-year history of the agency.

And last week, a nurse-consumer coalition demanded that consumer and nurse representation be included

on the board of directors of Sutter Community Hospitals.

Nurses who have been fired or forced to resign because they questioned hospital policy or physician judgment are beginning to talk publicly about their experiences. They are beginning to organize, forming groups like Nurses NOW (a task force of the National Organization for Women) and Nurses In Transition, a nursing support group based in San Francisco.

"It takes a lot of energy to speak up continually and not get much support," says San Francisco nurse Tisha Kenny, an active member of Nurses In Transition. "You begin to feel there is something wrong with you. We try to tell nurses there isn't anything wrong with them, that it's just part of being a woman and a nurse."

Next: Nurses and Women's Rights —
"The Doctor-Nurse Game"