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Constructing the “other”:
On being a man and a nurse

Thomas S. Harding

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ABSTRACT

This study explores the experiences of men who are nurses in Aotearoa New Zealand. Utilising discourse analysis a social constructionist reading of men, masculinity and nursing is provided to offer an alternative reading to much of the extant literature with respect to men in nursing.

The study draws upon a number of different sources of “text”, including over 600 written works, two films and interviews with eighteen men who currently are, have been or are intending to be, nurses. Drawing primarily upon the “literary” textual sources a number of themes were identified for further exploration in interview with the co-researchers. These themes were the construction of masculinity, the construction of images of the nurse, the reaction to men who are nurses, sexuality issues, career development, and men and caring.

The findings of this thesis reveal that the literature pertaining to men in nursing is replete with paradox and contradiction and fails to adequately account for the male experience. It is argued that the images and arguments provided in the literature with respect to men in nursing are based on out-of-date models and understandings of gender relations, masculinity and nursing. It is suggested that rather than enjoying patriarchal privilege, men who enter nursing must contend with being constructed as both an inferior man and inferior nurse. Their careers are not, as is alleged in the literature, based on developing “islands of masculinity” and male privilege, nor upon the avoidance of the emotional labour of nursing but reflect a belief that career is one way of *doing* care.

It is argued in this work that men in nursing have fewer “taken-as-givens” upon which to base work and that they work to develop trusting relationships with their patients that are based on communication and empathy within a context defined by the patients’ circumstances.

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CHAPTER ONE: Introduction and overview

Preamble

In 1981, I applied to the Christchurch Hospital School of Nursing for entry into the programme leading to registration as a general and obstetric nurse. I was twenty-five years old, a university graduate and working as a professional actor. I enjoyed the creative process of acting, but felt that my professional life was ephemeral and ultimately devoid of engagement with *real* life. Much to my surprise, after the assurances of my friends who were nurses that I would be accepted: nursing did not want me!

Immediately upon receipt of the letter of rejection I made an appointment with the Chief Nurse to discuss the matter with her. Her question upon meeting me took me by surprise, “Are you sure you don’t want to be a doctor?” I was able to convince her that I harboured no desire whatsoever to become a Doctor of Medicine; she overturned the previous decision and I was given a place in the next intake.

April 12, 1982 was not only my first day as a nursing student but it was also “Parent’s Day” at the School of Nursing. I was somewhat bemused that upon entering the nursing profession my parents’ presence was not only welcomed but expected. After being greeted in the Dining Hall in the Nurses’ Home we were asked to go and change into our uniforms. Gathering together again it became apparent that the purpose of the morning was the handing over of daughters into the care of the nursing tutors and the hostel staff. I became acutely aware that both my gender and my age stood out in the class of approximately 90, most of whom were young women.

It was the beginning of a professional journey in which I have had no choice but to stand out-whether or not I have wanted to. It has been a journey in which I have had cause to reflect on what it means to be a nurse and to be a man. It has been a journey in which two questions have been asked of me many times; “Why are you a nurse?” and “Are you a male nurse?” Through the exploration of the relationship between gender and nursing the study that follows attempts to provide a *male* perspective with respect to these two questions

Contextual issues

A gendered profession.

“...this deep-seated and traditional sex-oriented culture” (Suominen, Kovasin, & Ketola, 1997, p. 188)

Numerous authors identify a societal perception that nursing and nursing education have traditionally been women’s work (for example: Evans, 1997; Foreman, 1997; Mathieson, 1991; Meadus, 2000; Okrainec, 1994). It has even been asserted that not only does the work of nursing belong to a “specific gender-defined” occupation, but that nursing knowledge is women’s knowledge (Hagell, 1989, p. 228). The assertion that nursing has traditionally been the provenance of women will be challenged in this study; however, the nursing literature does reveal (Table 1.1) that during the 20th century, throughout the western world, nursing was a gendered profession with a workforce that was predominantly female.

In New Zealand, of the 41, 285 Registered Nurses/Midwives holding practising certificates, 2,454 (6%) are men (Nursing Council of New Zealand, personal communication, 2001).

There are indications that there has been an increase in the numbers of men undertaking nursing education in some countries. In Canada, for example, in the early 1990s men were only 2% of the nursing population (Dassen, Nijhuis and Philipsen, 1990) but by 1998 this percentage had increased to 4.4% (Meadus, 2000). In the United States in 1962 men constituted 1.2% of total graduates from nursing programmes and 0.9% of employed nurses (Vaz, 1968) compared to the 4-5% in the late 1990s (Meadus, 2000; Poliafico, 1998). In the same period in the United States the number of men in nursing programmes had increased to 11.1% by 1992 (Wolfe & Begany, 1994).

Table 1.1

Men as a percentage of the nursing workforce

Country	Men as nurses (%)	Source
Finland	2	Dassen, Nijhuis & Philipsen (1990)
Canada	4.4	Meadus (2000)
United States	4.9	Poliafico (1998); Meadus (2000)
Australia	8	Fisher (1999)
United Kingdom	8.7	Ryan & Porter (1993)
Belgium	14	Halloran & Welton (1994)
Netherlands	18	Dassen et al. (1990)

The increased numbers of men entering nursing, however, have not effectively challenged men's minority position in the profession nor have they been observed in all countries. For example, in 2001 the Australian Nursing Journal noted that there had been little increase in the numbers of men in nursing during the 1990s ("Where are all the male nurses?" 2001). The situation in New South Wales (NSW) was cited where 8.1% of nurses are men, a rise of only 0.3% from the previous decade. The following year the same journal revealed that this was not confined to NSW; nationwide the increase in the percentage of men who were registered nurses was only 0.4% between 1994-1997 (from 7.6% to 8.0%). In the same period the figures for men who were enrolled nurses changed very little from 6.2% to 6.3% (Iliffe, 2002). In New Zealand by 2000 only 5.8% of the nursing workforce was male; a proportion that was largely unchanged since 1990 (Nursing Council of New Zealand, 2000).

Early assumptions.

In March 2002, as I commenced this project I wrote my own "confession" in which I traced the personal and professional development which has led to the point of embarkation for this doctoral work. The writing, which I titled *HIStory*, began as follows:

This year (2002) marks a milestone in my professional and personal life: twenty years involvement in nursing in New Zealand. Reflecting upon this achievement I have to ask myself, "How I have arrived at the position of being a lecturer and a doctoral candidate in nursing?" Nursing: A profession that once I had considered "women's work" and completely unsuitable for anyone with any intellectual ability, either man or woman!

While the statement now produces some embarrassment with respect to previously held beliefs about nursing and masculinity it is necessary at this point to revisit the final section in which I stated my beliefs at the outset of the project:

- There is a paradox, and tension, inherent in men being a minority group in a female-dominated work force that strives for professional legitimacy.

- Nursing considers its male members to be highly visible, but men feel invisible, undervalued and unsupported.
- Men are oppressed, by society and by nursing, when they choose to become nurses.
- Men care differently and the ways in which they demonstrate their care is often not valued.
- Nursing education is preoccupied with the feminist agenda(s) and is unable (or unwilling) to consider the needs of male students as legitimate.
- Within society women have claimed a moral high ground, which has left men alienated and confused.
- Men have difficulty articulating their experience and needs.
- Men, as individuals, are also victims of patriarchy.
- Men are denied the range of professional choices that women enjoy.

As the process of text collection and analysis occurred these beliefs were challenged and reconstructed. The chapters that follow are part of a significant part of that reconstruction.

The aims of the research

At the outset two questions were identified: “Why are you a nurse?” and “Are you a *male* nurse?” By investigating why men become nurses, how they nurse and how they develop their careers this study attempts to answer the first of the above questions. With respect to the second question, through illuminating the place that the man who is a nurse occupies professionally this work attempts to reveal why men in nursing are known as *male* nurses and not as nurses.

This work was originally envisaged as a critical ethnographic study of men who are nurses in New Zealand. It was proposed that description and analysis of the male subculture within nursing in New Zealand would allow:

1. Identification and analysis of the socio-political factors impacting upon the development and maintenance of this subculture.

2. The identification of key elements of a gender-sensitive practice theory of male nursing.

Through the provision of such description and analysis it was to be hoped that there would be exploration of the following questions:

1. Is there any difference between the care provided by men and women who are nurses?
2. What personal characteristics do men identify as significant in keeping them in practice?
3. To what extent does nursing value and support the minority subculture within the dominant discourse?

In researching the literature related to men and nursing for what was intended to be the literature review it became evident that what was emerging was not just context for the study. What emerged was a body of work that was full of paradox and rich with significance in terms of the construction of images and beliefs about masculinity and of men as nurses. This body of work was ripe for critical analysis in its own right with respect to the world(s) that men who are nurses inhabit.

After a year long engagement with the literature, reflection and discussion about this project it was recast as a social constructionist examination of being a man in nursing. As well, the new imperative to analyse the literature as data rather than to use it as descriptive background created a context in which discourse analysis became the appropriate research method.

By stepping outside of discourses that treat both masculinity and nursing as historically static, universally valid categories this study aims to elucidate the range of discursive events (dynamic, contradictory and constantly reproduced) that surround men who are nurses. It will examine the construction of discourses of masculinity and nursing and the manner in which they intersect to create particular images of men in nursing. The power relations that emerge from that construction will be explored to illuminate the production, circulation and authorisation of *truths* with respect to masculinity and nursing. In this way the study will reveal how the discourses of masculinity and nursing operate in a manner that can both potentially empower and disempower men who choose to become nurses. It is to be hoped that this work will have

implications for the freeing of men from restrictive discursive practices that oppress both women and men who are nurses.

Overview of the chapters

This thesis essentially consists of five sections. Chapters 1-4 provide the theoretical and methodological framework for the study. Chapters 5-6 provide a historical context for the development of current stereotypes of Western masculinity and nurses. The next section, chapters 7-10, explores men's motivation to enter into nursing and the response to them. Chapters 11-12 focus on how men develop their careers and how they understand caring and incorporate it into their careers. The final section consists of a single chapter which endeavours to summarise the disparate threads of this work.

Although the structure described above has been imposed upon this work to guide both the writer and the reader, the salient theme from one section is likely to re-emerge in a later section. Thus; for example, while section 3 may largely concern itself with reactions to men in nursing, this theme continues as a thread in the following section as the responses to men's career choices and men's caring are also significant in the context of career development.

Chapter Two contributes to the overall study through the provision of a discussion of the various philosophies that have influenced this work and by describing why a social constructionist methodology has been employed for this study of nursing and masculinity. It also develops an argument that positions me as an *ironic* researcher.

Chapter Three provides the theoretical background to the data collection and analysis. The chapter begins by illuminating why discourse analysis is an attractive tool for the social constructionist. It then moves to a discussion of discourse and the emergence of contemporary understandings of discourse analysis. The chapter outlines the influence of Michel Foucault, Jacques Derrida, Ian Parker and feminist approaches to research upon this study.

Chapter Four completes the first section of this thesis. It lays open the audit trail with respect to gaining approval for the research and arriving at the criteria used for one part of the text collection, that of participant interview. The actual processes of data gathering, primarily the collection of relevant written work and participant interview, and data analysis are described.

Chapter Five, *Being a man*, begins the second section of the thesis. Within the context of the Western gender order this chapter describes how a particular type of masculinity has come to be perceived as the exemplar of true masculinity in New Zealand. The exploration of the image of normative masculinity will provide the basis, in later chapters, for deconstruction of the contradictions and paradoxes that impact upon men's involvement in nursing.

Chapter Six, *The image of a nurse*, continues the discussion on the power of stereotypical images in constructing nursing as "not male". This chapter asserts that the image of the nurse as female is a relatively modern construct that emerged in the nineteenth century. Historical evidence will be provided to support this contention and a critical analysis will ensue of three powerfully gendered symbols: the angel, the mother, and the handmaiden, which have been used to construct nursing as women's work.

Chapter Seven, which begins section three, opens the discussion on why men become nurses. It focuses on factors involved in the decision to turn away from mainstream male occupations. Five thematic groupings with respect to the decision-making process that emerged from analysis of the transcripts are discussed: Formative experiences, the *Call*, expediency, fulfilment and personal acquaintance with a nurse.

Chapter Eight, *Reacting to the man in a nurse's uniform*, is the first of three chapters that specifically explore the societal and professional reaction to the man who is a nurse. In this chapter, two paradoxes within nursing are explored. The first of these is a discourse that constructs the man who is a nurse as androgynous, while simultaneously exploiting male strength. The second is a discourse which is critical of the man who is a nurse because he is perceived to adhere to the male stereotype.

Chapter Nine analyses the paradox of care and historical violence. Generational "snapshots" are provided which historically trace the experience of men with horizontal violence in nursing. A major theme that surfaces in this chapter is the male belief that, in their professional role, they are constantly being watched and judged and that they need to prove themselves as competent nurses through constant hard work. There is also a discussion with respect to the positive feedback that many men in nursing receive and whether this is an artefact of their enhanced visibility or is, in fact, deserved. This chapter also argues that nursing education makes inadequate provision to address the needs of both male patients and men in the nursing workforce.

Chapter Ten, *The problem of men's sexuality and nursing*, moves this discussion of the reaction to men's presence in nursing to issues pertaining to sexuality which were introduced at the end of the previous chapter. It argues that in order to rationalise a man's choice of nursing he is attributed with dubious motivation. In particular, this rationalisation takes the form of assumptions about the man's sexuality; he is constructed either as homosexual or, whether homosexual or heterosexual, as sexual predator. The chapter concludes with a description of the co-researchers' experience of being victims of sexual harassment.

Chapter Eleven turns to the consideration of men's career progression in nursing. It discusses men's overrepresentation in mental health nursing, areas such as intensive care and emergency departments and in administration. The putative tendency of men to congregate in these areas is explored and alternative readings to those commonly found in the literature will be proposed.

Chapter Twelve, *Men, nursing and care*, is the final chapter of analysis and concludes section four. It commences with an argument that *caring* has been constructed as a female attribute and that this poses problems for men in the caring professions, such as nursing. It contends that *touch* has been *feminised* and men's touch has been *sexualised*. The chapter then explores how the group of men who have participated in this study understand and actualize care. Five significant themes are identified: Career as a way of providing care, caring as relationship, caring as "working with", caring as contextual and caring as empathy. The chapter concludes with consideration of differences between the care provided by men and women and proposes that the *masculine* model of care is valued by the recipients of such care.

Chapter Thirteen, *Conclusions and recommendations*, brings together the themes that have emerged in the course of this study. It addresses questions of rigour, limitations and the significance of the study. It is argued that the key findings provide an alternative lens through which men's involvement in nursing may be viewed.

Conclusion

This chapter has introduced the work that is to follow by outlining personal and professional contextual issues pertaining to the study of the experience of men in nursing. It has provided a framework for the work that is to come by identifying the thematic links that have lead to chapters being grouped together. As well, it has briefly summarised the major foci and findings of the individual chapters.

CHAPTER TWO: Philosophical context

The theoretical underpinnings of the present research are eclectic, drawing from a range of theories that inform the study design and interpretation of data. This chapter contributes to the overall study by discussing the various philosophies that have influenced the work and by describing why a social constructionist methodology has been employed for this study of nursing and masculinity.

The chapter begins by describing the key assumptions underpinning a social constructionist approach to understanding human behaviour. It then moves to a discussion of the influence of postmodernism, critical theory and poststructuralism upon the social constructionist critique of ideology, language and social processes. Finally, an argument will be developed for my positioning as an “ironic researcher.”

The emergence of social constructionism

The impact of feminist scholarship following the emergence of the second wave of feminism from the mid-1960s has had a profound impact on previously held notions about gender. Previously accepted scientific “truths” about women and men were challenged, in particular, by research that focused on women, gender and power. More recently this has been accompanied by a burgeoning of scholarly investigations into masculinity which, until the 1980s, were dominated by two approaches; psychoanalysis and sex role theory (Connell, 2000a). The purpose of these sociobehavioural approaches has traditionally been to provide *objective* descriptions of human behaviour and to tender predictions about human development and reactions. Such *scientific* accounts of human beings are challenged by a number of alternative postmodern approaches, which provide ideological, literary-rhetorical and social critique of truth, rationality and objectivity (Gergen, 1994a, 1994b, 1999). Humans as social beings have been studied by researchers from many disciplines, including feminism, philosophy, sociology, social psychology, media studies, anthropology, and history. While the disciplines may be disparate, what many of these approaches have in common is a theoretical orientation that is now referred to as social constructionism (Burr, 1995).

Given such a multiplicity of orientations to the understanding of human activity the usefulness of a single definition of social constructionism is debatable. It is probably

more useful to loosely group as social constructionist any approach that has as its foundation one or more of the four key assumptions identified by Gergen (1985). Thus, a social constructionist adopts a critical stance toward taken-for-granted knowledge, acknowledges that ways of understanding are historically and culturally relative, proposes that social processes sustain knowledge, and that knowledge and social action go together. Therefore, a social constructionist approach challenges the notion that knowledge is based upon an objective and unbiased observation of the world. Understandings of the world are seen not as universal but as products of culture and history that are dependent upon the social and economic environment prevailing in that culture at that time. One's currently accepted view of the world is, therefore, a result of constant interaction, negotiation and construction between oneself and others.

Each of the ensuing constructions then opens up the possibility for a different kind of action; for example, consider changing attitudes with respect to homosexuality. What are now termed homosexual sexual behaviours have a long history (Burr, 1995; Sedgwick, 1990), whereas the word *homosexual* did not enter Euro-American discourse until the last third of the nineteenth century (Sedgwick, 1990). As well, Foucault (1978, 1990) proposed that the homosexual being considered deviant is a relatively recent construction in Western society and it is one that has led to considerable debate. Hoffman (1984) argued that attitudes are mediated by the prevalent cosmology with polytheism being able to accept a wider variety of human sexual expression than monotheism, therefore, depending on the protagonist's *truth* the homosexual can be *known* to be either deviant or someone whose sexuality is merely variant. Each standpoint allows a different response.

Knowledge as socially determined.

Gergen (1994a) traced the genesis of social constructionism to the work of writers such as Weber, Mannheim and Scheler who were interested in the epistemology of science and the ability of language to provide an accurate representation of the world. Within philosophy, however, debate about epistemology has a much longer history stretching back to Kant and beyond to Plato and Aristotle (Demeritt, 2002; Gergen, 1985). More recently the work of Berger and Luckmann (1966) has been particularly influential within the social sciences and can be considered a seminal work in social

constructionism. They proposed that what we understand as *reality* is socially constructed and that the sociology of knowledge must analyze the process by which this occurs.¹ They contended that:

The sociology of knowledge must concern itself with whatever passes for knowledge in a society; regardless of the ultimate validity or invalidity (by whatever criteria) of such “knowledge.” And in so far as all human “knowledge” is developed, transmitted and maintained in social situations, the sociology of knowledge must seek to understand the processes by which this is done in such a way that a taken-for-granted “reality” congeals for the man in the street. In other words, we contend that the *sociology of knowledge is concerned with the analysis of the social construction of reality.* (p. 15)

Social constructionists contend that not only is knowledge constructed socially but also that objective knowledge is not possible (for example: Burr, 1995; Davis & Gergen, 1997; Gavey, 1997; Gergen, 1994a, 1994b, 1999). According to Shotter (1993a), “We can no longer claim to be presenting neutral ‘pictures’ of fixed, already existing states of affairs, awaiting our judgement as to their truth or falsity” (p.34). There is denial of representationalist epistemologies that maintain that there can be a clear and direct grasp of the empirical world and that knowledge simply reflects what is out there.

At this point it is necessary to distinguish between the assertions that the *world is out there* and *the truth is out there*. Common sense would hold that there is a real world out there. The world is, indeed, out there but we have no way of apprehending that world outside language (Edley, 2001a). Knowledge or truth is, therefore, conveyed by linguistic constructions, i.e., sentences. Rorty (1989) asserted that we must drop the notion that language can represent the world as it is “ since truth is a property of sentences, since sentences are dependent for their existence upon vocabularies, and since vocabularies are made by human beings, so are truths” (p.21). Therefore, to say that the truth cannot be out there is to acknowledge that it cannot exist outside of the human mind. The world is out there, but it is only our descriptions of it that can be true or false.

¹ Berger and Luckmann (1966) define “reality” and “knowledge” respectively as “a quality appertaining to phenomena that we recognize as having a being independent of our own volition”, and “the certainty that phenomena are real and that they possess certain characteristics” (p. 13).

The construction of self.

In recent years social constructionism has also emerged as an important orientation in social psychology. Traditional psychological theory has tended to distinguish between the person and/or self and society, ignoring the degree of interrelatedness people have with their environment (Lewis, 2003). Berger and Luckmann (1966) not only emphasised the social construction of reality but they also enlarged upon what was one of the most important points of earlier writers: the social construction of subjectivity. One's private experience of the world, which is apprehended through the senses, is related to the social sphere. Given the earlier assertion that social constructionism focuses on relational activities between people, questions are then raised about how this methodology accounts for people's inner, subjective lives.²

Berger and Luckmann (1966) suggested that individuals develop a natural sense of taken-for-granted reality through the adoption of *plausibility structures*, that is, the rational support for their understandings:

I apprehend the reality of everyday life as ordered reality. Its phenomena are prearranged in patterns that seem to be independent of my apprehension of them ... The language used in everyday life continuously provides me the necessary objectification and posits the order within which these [phenomena] make sense and within which everyday life has meaning for me ... In this manner language marks the co-ordinates of my life in society and fills that life with meaningful objects. (p. 21)

To illustrate this they provided the analogy of the clock and how it now regulates our existence:

All my existence in the world is continuously ordered by [clock time] ... I have only a certain amount of time available for the realization of my projects, and the knowledge of this affects my attitude to these projects. Also, since I do not want to die; this knowledge injects an underlying anxiety into my projects. Thus I cannot endlessly repeat my participating in sports events. I know that I am getting older. It

² See Shotter (Shotter, 1993a, 1997) for a more comprehensive account.

may be that perhaps this is the last occasion on which I have the chance to participate. (p.26)

In such a way, as Shotter (1997) explains, the inner *things* are not so much inside us but are to be found in the “momentary relational spaces occurring between ourselves and an other or otherness in our surroundings” (p. 11). In other words our sense of self is seen as something we accomplish with social interactions; “reconstructed from moment to moment within specific discursive and rhetorical contexts, and *distributed* across social contexts” (Edley & Wetherell, 1997, p. 205). This has led to a conceptualisation of the self as de-centralized, fluid or multiple, with the person or self changing within the context (Gergen, 1991, 1994b; Hall, 1992).

In order to understand how the transformation in Western epistemology outlined above has come about, it is necessary to consider the influence of the postmodern movement in raising questions about the truth of taken-for-granted objects and events and the way language is constitutive rather than descriptive of reality.

Postmodernism and the mirage of objectivity

Postmodernism first emerged as a movement amongst artists and critics in the 1950s and expanded its influence into other disciplines in the 1960s (Bertens, 1995). As a philosophical orientation, it defies simple definition. There is no single *postmodernism*; its influence is found in many disciplines including art, architecture, literature, design, and science (Agger, 1992; Rolfe, 2000; Tiefer, 1997). Of singular importance was the 1970s association of the postmodern agenda with a European intellectual movement that attacked the grand narratives or “legitimizing myths of the modern age” (Sarup, 1993, p. 132). Postmodernism is arguably the most important of the challenges to *modernism*, which Mannheim (1936, 1994) described as “the intellectual orientation of the Western world to the rational and calculating mode of thought characteristic of the period of the Enlightenment” (p.50). The dominant theoretical perspective of the human sciences during the *modern* period was that of empiricism³. The following discussion presents a number of challenges which have emerged to the empiricist philosophy of science. Social

³ Empiricism is an epistemology that asserts that knowledge is derived from experience and aims to test hypotheses to distinguish probable facts about the world from fiction.

constructionism is one such challenge and, according to Durrheim (1996), is best defined in terms of “its resistance to the institutionalised dominance of empiricism” (p. 176).

The emergence of empirical science.

Modernism (or the Enlightenment) represented a break with the Age of Faith, a period when individuals inhabited “a realm of illusion in which the causes ordering their lives were invisible” (Fitzhugh & Leckie, 2001, p.1). The Enlightenment posits a world in which there is a stable, knowable self: a self which knows itself through rationality. The knowing produced by the objective, rational self is *science* which is deemed to provide universal truth (Flax, 1990). From an epistemological standpoint modern refers to “any science that legitimates itself with reference to a metadiscourse...making an explicit appeal to some grand narrative” (Lyotard, 1979, 1984). Although postmodernism as an epistemological movement is generally held to be a late twentieth century phenomenon, scepticism to the notion of metadiscourses⁴ was evident earlier (Fitzhugh & Leckie, 2001; Reed, 1995).

Modernity is about *order*; the project of rationality and rationalization to transmute disorder from chaos. The underlying assumption is that the more ordered (or rational) a society is, the better it will function (Klages, 2003). Societies are antipathetic to disorder, i.e., that which disrupts order:

[T]hus modern societies rely on continually establishing a binary opposition between “order” and disorder”, so that they can assert the superiority of “order.” But to do this they have to have things that represent “disorder”—modern societies thus continually have to create/construct disorder. In western culture, this disorder becomes the “other”—defined in relation to binary oppositions. Thus anything non-white, non-male, non-heterosexual, non-hygienic, non-rational, (etc.) becomes part of “disorder”, and has to be eliminated from the ordered, rational modern society. (ibid, 2003, para. 28)

⁴ A discourse is a set of rules or assumptions for organising and interpreting an academic discipline or field of study. A metadiscourse, then, goes beyond or stands outside individual discourses, to provide a global rather than a local interpretation of what a discipline should be and how it should organise itself. A narrative is a story that explains the world from a particular perspective, and a grand narrative attempts to fit the individual narratives into a coherent whole (Rolfe, 2000).

This pursuit of stability and order is equated by Lyotard (1979, 1984) with the idea of totality, which is maintained through metanarratives: the stories a culture tells itself about its practices and beliefs. Every belief system or ideology has such grand narratives; for example in Marxism the grand narrative is the belief that capitalism will collapse and a utopian world will develop (Klages, 2003).

The disappearance of science?

According to Tyler (1986), “For the world that made science, and that science made, has disappeared” (p. 123). These words summarise the fear that is aroused for many in a world where there are multiple ways of revealing the truth. As Denzin and Lincoln (1994) stated postmodernism “privileges no single authority, method or paradigm” (p.15); therefore, truth is not only embedded in scientific knowledge that purports to represent the totality of knowledge. There can be many constructions of the truth. Social constructionists also assert that we should not assume that *our* ways of knowing are any better than *other* ways of knowing in being nearer the truth (Burr, 1995). Berger and Luckmann (1966) suggested that what might be real (i.e., true) to a Tibetan monk might not be real to an American businessman. Most of us with a Western worldview would probably feel more in sympathy with the perspective of the latter; yet, if we hold uncritically to the belief that our truths, reasons and morals are universal we risk becoming cultural imperialists (Gergen, 1999). Feminist writers (for example: Belenky, Clinchy, Goldberger, & Tarule, 1986, 1997; Gilligan, 1977, 1982; Noddings, 1984) in their critiques of the dominance of a masculinist view of the world challenge a bias to valuing male over female, and here in New Zealand Maori researchers challenge the assumptions of the European colonizer that their understanding of the world is more real than that of the colonised.

The end of ideology.

Postmodernism has disrupted confidence in the universality of truth, faith in human rationality and objective science (Agger, 1992; Eagleton, 1996; Gergen, 1991). Social constructionism also eschews the claim to extant metanarratives that contain universal truths about a world *out there* which are only obtained through rational science. The ideology of modernism has constructed a belief in science as the only way to

establishing truth. For example, science once held the belief that the universe was geocentric and the Sun revolved around the Earth. This *fact* ring-fenced those, such as Galileo Galilei, who wanted to consider the Copernican proposition that the Earth revolved around the Sun.⁵ Science became the gatekeeper to truth and has concomitantly been ascribed considerable power. According to Rolfe (2000):

Truth, by this account, is whatever those in power say it is, and it therefore shifts along with that power. This, of course, leads to the conclusion that truth cannot be the absolute monolith that the modernists would have us believe, and that it does not exist “out there” in the world, but is created by social institutions. (p.3)

Latour and Woolgar (1986) challenged the claim of science to objective truth. They observed scientists at work in order to determine how they arrived at what constituted truth or falsity in their work. They found that what was held to be objective truth was not the result of subjecting hypotheses to empirical test but was a result of social processes: “That is to say the epistemological qualities of validity or wrongness cannot be separated from sociological notions of decision-making” (p. 121).

According to Tyler (1986) science has failed because it has not been able to “reconcile the competing demands of representation and communication” (p. 123). In his view science has failed because it needed a language that was both descriptively adequate (i.e., a language that could represent the world) and also communicatively adequate (i.e., a language that enabled consensus in the community of scientists):

Science chose an uneasy compromise, subjugating itself both to the discourse of work (politics and industry) and the discourse of values (ethics and aesthetics), but since politics and industry controlled the means of play and could threaten to withhold funds on which the game depended, science succumbed more and more to limitations on play imposed in the interests of its masters. (ibid, p.125)

The social constructionist critique moves beyond a focus on the claim of truth itself to an analysis of the ideological or motivational basis from which it derives. In

⁵ Galileo Galilei (1564-1642), the inventor of the telescope, was able to prove the Copernican system. His defence of this position eventually led, in 1633, to his being found guilty of heresy by the Inquisition. He spent the remainder of his life under house arrest.

particular, there is a challenge to the intent of the “truth teller to suppress, to gain power, to accumulate wealth, to sustain his or her culture above all others” (Gergen 1994b, p.36).

As noted at the beginning of this chapter, the impact of feminist scholarship has been profound in questioning the patriarchal and androcentric hegemony of both the social and natural sciences (Haraway, 1988; Harding, 1986). This challenge is no longer confined to feminists, as Gergen (1994b) noted other minority groups now also articulate their critiques of the taken-for-granted assumptions within science and society at large. He proposed:

[I]n spite of their guise of neutrality, all social scientific accounts harbour prescriptive implications. In specifying *what is the case*, other accounts are suppressed. Otherwise significant distinctions for certain persons in certain walks of life are obliterated. Scientific terminologies also carry with them evaluative connotations, subtly coloring the picture painted of those whom they portray. In their modes of explanation, blame and credit are also distributed; and in their methodologies, ideals for social interaction are subtly suggested. In effect, the languages and practices of the social sciences necessarily affect the society – for good or ill according to someone’s ethical or political standpoint. (p.xiv)

These critiques are not confined to just questioning the masculinist biases of science but question the very nature of language itself. Spender (1980), for example, described how men, as the dominant group, have not only dictated what constitutes reality but have also created the structures, categories and meanings of language. This process has been legitimated by reference to other males and generally excluded or subordinated women.

Critical theory

During the 1960s as postmodernism began to gain momentum in intellectual circles there emerged a new focus on critical theory. Kincheloe and McLaren (2000) described the intellectual shift:

Frustrated by forms of domination emerging from a post-Enlightenment culture nurtured by capitalism, these scholars saw in critical theory a method of

temporarily freeing academic work from these forms of power. Impressed by critical theory's dialectical concern with the social construction of experience, they came to view their disciplines as manifestations of the discourse and power relations of the social and historical contexts that produced them. The "discourse of possibility" implicit within the constructed nature of social experience suggested to these scholars that a reconstruction of the social sciences could eventually lead to a more egalitarian and democratic social order. (p.280)

Critical theory refers to a theoretical tradition that was developed by the members of what has become known as the Frankfurt School. These writers, who included Horkheimer, Adorno and Marcuse, used the principles of Marxism to critique Capitalist society. Their inquiry was characterized by an emphasis on Marxism as dialectical critique rather than as positive science. As Bailey (1994) noted, "The Western Marxists have developed a focus on questions of subjectivity, consciousness and reality, at the center of their interpretation of Marxism" (p.7). From this standpoint subjectivity and consciousness are seen as fundamental to the construction of social reality that cannot be reduced to epiphenomena in relation to the economic dynamics of society.

In considering the early origins of the critical paradigm, the label Frankfurt School is misleading. The use of the word "school" may be read as a unified approach to cultural criticism whereas there were significant differences in interest and emphasis among the key figures (Bailey, 1994; Crotty, 1998; Kincheloe & McLaren, 2000). Nor was this line of critique confined to Marxist theorists; Habermas (1971), for example, contended that all knowledge-seeking privileges certain interests over others. Notwithstanding the diversity in theoretical approaches, critical theory has drawn attention to the critique of power and dominance.

Resistance to oppression is the common theme in critical theory and its various forms such as Marxist, feminist, psychoanalytic, and queer theory. It has come to represent the *emancipatory* project; that endeavour to understand oppression in society through the development of critical insights into the nature of power imbalances and through this understanding transform it (Allen, 1985; Candy, 1989; Henderson, 1995).

Central to the understanding of oppressive power is Gramsci's (1974)⁶ concept of hegemony. The central notion is that dominant power is not exerted solely by physical force but also through the psychological influence wielded by cultural institutions such as the church, family, schools, intellectuals and the media. These institutions attempt to gain people's consent to domination through the persuasiveness of their depiction of a series of social relations being natural and inevitable (Kincheloe and McLaren, 2000).

Critical theory has been identified as a significant methodology for nursing research (Allen, 1985; Berman et al., 1998; Henderson, 1995; Holmes & Warelou, 1997; Manias & Street, 2001; Phillips, 2000). The development of nursing knowledge has moved beyond reliance on positivist methods of research, and the inclusion of the interpretative approach in the processes of knowledge creation has led to an emphasis, for a number of years, on one of the specific methods supported by this approach: phenomenology (Allen, 1985)⁷. Thus, a considerable proportion of the recent research effort in nursing has focused upon accounts of respondents' responses to particular circumstances. What is missing for the critical theorist is the inclusion of external features, which are significant in shaping the participant's reality such as social, historical, political, gender and economic conditions (Berman, Ford-Gilboe and Campbell, 1998; Candy, 1989). Thus, it becomes imperative to look beyond the perceptions to the conditions that influence such perceptions. As Cohen and Manion (1994) commented:

The very process whereby one interprets and defines a situation is itself a product of the circumstances in which one is placed. One important factor in such circumstances that must be considered is the power of others to impose their own definitions of situations upon participants. (p.35).

Tyson (1999) discussed the role of *discourse* in transmitting and legitimising power. Tyson ascribed a similar meaning to discourse as that of *ideology* contending

⁶ Not translated into English until 1971 the notion of hegemony was outlined in his *Prison Notebooks*, which he wrote from the time of his arrest, by the Fascist government in Italy in 1928, until his death in 1937.

⁷ Phenomenology is a qualitative research tradition that focuses on the lived experience of humans. The phenomenologist believes that the investigation of subjective phenomena reveals truths about reality (Polit, Beck, & Hungler, 2001).

that the two words can be used interchangeably, but that discourse emphasises the role of language as the vehicle of ideology. From this perspective, no one discourse can suffice to describe the complexity of a given culture:

For there is no *monolithic* (single, unified, universal) spirit of an age, and there is no adequate *totalizing* explanation of history (an explanation that provides a single key to all aspects of a given culture). There is, instead, a dynamic unstable interplay among discourses: they are always in a state of flux, overlapping and competing with one another (or, to use new history terminology, *negotiating* exchanges of power) in any number of ways at any given point at time. Furthermore, no discourse is permanent. Discourses wield power for those in charge, but they also stimulate opposition to that power. (p. 289)

Social constructionism and language

The influence of poststructuralism.

Earlier it was suggested that it is problematic to attempt to provide a single, unifying definition of postmodernism. This dilemma can also be applied to poststructuralism, to the extent that a number of authors appear to use the labels interchangeably leading to some confusion as to the distinction between the two. From the perspective of this work, however, poststructuralism is better understood as being one of a number of postmodern theoretical standpoints. Poststructuralism *per se* is not a single theoretical position (Baxter, 2002; Mackenzie, 2001; Paechter, 2001; Weedon, 1987). According to Foucault (1988a):

The premises of poststructuralism disallow any denominative, unified, or “proper” definition of itself. Broadly it involves a critique of metaphysics: of the concepts of causality, of identity, of the subject, of power, knowledge and of truth. (p.18)

The various forms of poststructuralism do, however, share certain similarities with respect to fundamental assumptions about language, meaning and subjectivity. It is a theoretical position that contributes significantly to our understanding of language’s constitutive role in social and psychological life and it is central to social constructionist epistemology that our understanding of the world is dependent upon language (Burr, 1995; Davis & Gergen, 1997; Edley, 2001a; Gavey, 1997; Gergen, 1994a; Shotter, 1993a;

Speer, 2001). Social constructionists are in sympathy with a poststructuralist view of language, which Phillips (2000) describes as a focus “on the instability of language” (p.366). Neither the structure nor the meanings of language are viewed as fixed; they are contingent on context, history, and both the sender and receiver. Language is unstable.

An overview of structuralism.

Poststructuralism emerged as a theoretical discourse in the 1960s in response to the perceived limitations of the structuralist project (Mackenzie, 2001; Peters, Hope, Webster, & Marshall, 1996). It is important to note, however, that as postmodernism builds upon modernism, poststructuralism does not reject structuralism per se but follows on and adds to structuralist insights. Structuralism originated in the theory of language of the Swiss theorist de Saussure, who conceived language and culture in terms of linguistic and symbolic systems.

The key concept in Saussurean linguistics relates to the nature of the linguistic sign. de Saussure (1916) conceived the linguistic sign as uniting a concept and a sound image, which he terms the *signified* and the *signifier* respectively. For example, the signs *tree*, *disease*, and *dog* consist of the mental concept plus the word, or spoken sound used to refer to it. So when we use the word *tree* we are referring to the concept of a tree and the meaning embodied in this word.

What is particularly important is de Saussure’s insight that the link between the signifier (spoken sound) and the signified (concept) is arbitrary. This does not appear to be a particularly profound assertion, particularly to those who speak more than one language. For instance, as de Saussure (1916) asks why prefer *soeur* to *sister*, *Ochs* to *boeuf*? The significance lies in de Saussure’s recognition that the concepts themselves are also arbitrary divisions. The world has been divided up into those things we term tree, dog, gender, health and so on; not only are these divisions arbitrary but also we cannot assume universality across all cultures. Whorf (1940, 2000) presented the example of the Hopi language to illustrate this point; a language in which lightning, wave, flame, meteor and puff of smoke are all verbs. For the Hopi events of a short duration cannot be anything but verbs. They have a classification of events by duration type, which not only appears strange to our way of thinking but also illustrates a paradox. We cannot impartially describe the universe because we require a classification

system, and once we have created such a system we see only those arbitrary categories (Spender, 1980).

The structuralists further built upon the Saussurean argument that “linguistic signs constitute a formal system that gain their value relationally from other signs rather than referentially through describing or denoting states of affairs in the world” (Peters, 2002, p. 52). Thus, signs themselves have no intrinsic meaning but acquire meaning from their relationship to other signs. If we consider the signifier *man*, it gains its meaning not from some intrinsic quality but through its difference and contrast with other signifiers such as racial minorities, sexual minorities and, above all, women (Kimmel, 1997).

Structuralism (and poststructuralism) is also anti-humanist. Humanism is the belief that the social and political world is solely due to human agency (Olssen, 2003). It assumes that the individual is a unified, coherent and rational entity who creates her or his own experience and meaning. It is an essentialist philosophy contending that there is a fundamental core in each person, which is unchanging (Burr, 1995). For structuralists the emphasis on agency ignored “the deep structures that enable agents to act in the first place - be they economic, psychological, mythical or whatever” (Mackenzie 2001, p. 335). Structuralism, therefore, discriminates between that which is apparent or exterior (discourse) and the interior forces that structure the shape and form of the discourse. The structuralists posited a belief in an objective approach to the understanding of the structure of language looking for *facts* that are embedded within the fundamental structures that underlie the *texts* (Gergen, 1994a; Zeeman, Poggenpoel, Myburgh, & Linde, 2002).

de Saussure (1916) also believed that even though the relationship between the signified and the signifier is arbitrary it is also immutable:

The signifier, though to all appearances freely chosen with respect to the idea that it represents, is fixed, not free, with respect to the linguistic community that uses it. The masses have no voice in the matter, and the signifier could be replaced by no other. (p. 28)

While this may explain how all users of a particular language are able to talk to each other, communicating with the same concepts (signifieds) and words (signifiers), it

does not explain how the meanings of words can change over time, and can also have different meanings.

Cutting loose: The challenge of poststructuralism.

The work of Foucault (1972) and Derrida (1967, 1976) amongst others challenged the scientific status of structuralism. It is contended that accounts of structure are themselves discursive and open to debate (Gergen, 1994a), that we are all immersed in language and text, which itself is polysemic and open to multiple interpretations (Baxter, 2002; Lehtonen, 2000; Paechter, 2001). Thus, the meaning of language is contestible with different languages and different discourses within languages constructing meaning in such a way that it cannot be perceived as stable or able to be known essentially (Dillabough, 2001; Weedon, 1987). To illustrate this notion we need only consider how meanings of masculinity and femininity vary between languages, cultures and throughout history (Connell, 2000a; Dillabough, 2001; Harrison, 2001; Kimmel, 1997; Weedon, 1987). Therefore, if meanings can change over time, from person to person and between contexts language becomes the “site of variability, disagreement and potential conflict” (Burr, 1995, p.41). If language is a site of conflict then *ipso facto* it is where power relations are acted out. In this aspect of poststructuralism lies its critical power: the challenge to, or deconstruction of *truths* about self or the world, that have been seen as unchallengeable gaining their legitimacy through dominance (Jones, 2001; Paechter, 2001; Peters, 2002). As Gergen (1991) explained, poststructuralists open up texts and cut meaning loose. This does not mean, as the critics of poststructuralism (and social constructionism) allege, that this leads to a nihilistic philosophy in which everything is meaningless. Poststructuralists argue, rather, that meaning is never final (Zeeman et al., 2002).

Deconstruction.

The concept of deconstruction owes in origins to the work of Derrida (1967). Derrida took poststructuralism from its origins in the study of literature to a position on the world in general, as part of the postmodern challenge to science. Derrida conceived of a *decentred* universe that was devoid of certainty and a subject for analysis by deconstruction. By writing he meant not only words and symbols on the page but also

cinematography, choreography, music, art, politics, sport, cybernetics and life itself. In terms of such a philosophy with respect to the construct of *truth* he wrote:

The “rationality” - but perhaps that word should be abandoned for reasons that will appear at the end of this sentence - which governs a writing thus enlarged and radicalised, no longer issues from a *logos*. Further, it inaugurates the destruction, but not the demolition but the de-sedimentation, the de-construction, of the significations that have their source in that *logos*. Particularly the signification of *truth*. (Derrida, 1967, 1976, p. 10)

To deconstruct a text is to explore the multiple and often contradictory meanings that permeate our language and, hence, our constructions of the world. Derrida made the point that all language is metaphorical and in this manner meaning shifts around. Metaphors shape what we do. We use them to make and defend our view of the world. Metaphors are not able to be taken back to some essential truth so deconstruction-what Sarup (1993) described as “close-reading” or “interrogating” a text-results not in a clearer understanding of the author’s intentions, but in a chain of texts each open to deconstruction. In this way the binary oppositions (for example, masculine/feminine, true/false) are revealed, and as argued earlier the establishment of binary opposition is an essential element in modernism’s pursuit of order and stability.

It is not enough, however, “simply to *neutralize* the binary oppositions of metaphysics” (Spivak, 1976, p. lxxvi); there must first be reversal of the “violent hierarchy” within the philosophical oppositions. In the next phase of deconstruction the reversal must be displaced and the winning term put under erasure (*sous rature*)⁸. Deconstructors show that the *privileged* term depends for its identity on excluding the other and demonstrate that primacy really belongs to the subordinate term instead. (Sarup, 1993). As Spivak (1976) in the translator’s preface to Derrida’s *Of Grammatology* explained, to deconstruct is:

[T]o locate the promising marginal text, to disclose the undecidable moment, to pry it loose with the positive lever of the signifier, to reverse the resident hierarchy, only

⁸ *Sous rature* is “to write a word, cross it out, and then print both word and deletion” (Spivak 1976, p. xiv). Because the word is inaccurate, it is crossed out, because it is necessary, it remains legible.

to displace it; to dismantle in order to reconstitute what is always already inscribed.
(p.lxxvii)

In Western culture there are many binaries and generally there is more value ascribed to one side or the other of the polarity. For example, we tend to honour the rational over the emotional, mind over body, order over disorder and leaders over followers, heterosexual over homosexual, and so forth. There is also a tendency for the dominant groups in society to claim the privileged pole (Gergen, 1991).

This is an important point in the context of this study because certain traits become associated with either pole of the binary opposition. For example, masculinity is characterised by instrumental and agnatic behaviours such as achievement orientation, assertiveness, decision-making ability, dominance, endurance, strength and power, whereas women are characterised by expressive and communal behaviours including; abasement, affiliation, deference, passivity and nurturance (Forrester, 1988). This has led to sex-role stereotyping and debate as to whether one gender or the other is more suited to a particular role, such as nursing. This theme will be discussed more fully later in this work; however, at this point the study turns to consideration of the relationship between binaries and essentialism.

“Snips of snails and puppy dogs’ tails”⁹: Essentialism in question.

Essentialism is the doctrine that objects have certain essential, or fundamental, properties that make them one kind of thing rather than any other. Social constructionism eschews essentialist practices, such as biological reductionism or determinism in relation to gender and sexuality or discourses which label particular groups of people in order to suppress difference in a manner that may not merely be homogenising but also pathologising (Sayer, 1997). According to Bohan (1997) essentialist views construe gender as:

[R]esident within the individual, a quality or trait describing one’s personality, cognitive process, moral judgement, etc. Thus, it is an essentialist stance to argue that “relationality” or a “morality of justice” is a quality possessed by the individual.

⁹ “Sugar and spice and all things nice that’s what little girls are made of, snips of snails and puppy dogs’ tails that’s what little boys are.” English nursery rhyme.

Essentialist models, thus, portray gender in terms of fundamental attributes that are conceived as internal, persistent, and generally separate from the on-going experience of interaction with the daily sociopolitical contexts of one's life. (p.32)

Anti-essentialism has a strong affinity with Derridean views of meaning (Sayer, 1997) not just in the process of deconstruction, which allows us to upset the binaries or blur the boundaries, but also through the rejection that things can be known in "full presence", i.e., known "by indubitable, immediate communion, absolutely present to the understanding with no possibility of error" (Maze, 2001, p. 402). Derrida (1976) provided us with the concept of *différance*, a combination of *difference* and *deferral*. A word has no meaning in itself, in the first instance, but gains meaning from its difference from other words. This is insufficient to provide meaning, however, as we must defer to other words to tell us what the meaning is. To explain this concept Gergen (1991) used the example of *democracy*. To understand this word we distinguish it from other terms such as *monarchy*, *dictatorship* and so on. Yet the difference between monarchy and democracy, i.e., that a democracy is not a monarchy is not enough to understand the term. We must also defer to other words such as *freedom*, yet to understand this word we must also defer to other words. We enter the infinite process of *différance*. Thus, language becomes unstable, as the words we use are ambiguous. As Gergen (1991) expounded:

Clarity and confidence can be maintained only so long as one does not ask too many questions, such as "what exactly is democracy...justice...warfare...love...depression?" and so on. When examined closely, all authoritative arguments- indeed all meaning-begins to vanish. (p.29)

The social critique

The preceding sections have described the ideological and literary-rhetorical critique of the belief that language is truth bearing. The ideological critique supports the proposition that it is self-interest, not the world itself, which provides accounts of the world. The literary-rhetorical critique removed the notion of objectivity from language replacing it with 'text.' The third scholarly movement of significance to the emergence of

social constructionism is the social critique, which contends that neither ideology nor textual history but social processes construct our notions of truth (Gergen, 1994a).

Language is not only “the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested” (Weedon, 1987, p. 21) but also it is where we *construct* ourselves. This construction of self, however, is not something that is achieved by individuals in isolation but is part of a social process. In the relationship with our surroundings and above all in the linguistic exchanges between each other we construct and reconstruct ourselves (Burr, 1995; Gergen, 1991; Rabinow, 1984; Shotter, 1989, 1993a, 1993b, 1997). Subjectivity is, therefore, neither unified nor fixed; rather it is, “precarious, contradictory and in process, constantly being reconstituted in discourse each time we speak” (Weedon, 1987, p. 33). This social constructionist view of self differs markedly with that of phenomenology, which holds that there is an essential invariant structure – an essence – that can be understood. Thus, alongside my participants, and the myriad of others with whom I have discussed this project, there is a process of co-creation. As Durrheim (1996) queried, how then do we distinguish between the correct and incorrect use of language?

Shotter (1989) described how there is a process of social accountability; established ways of speaking which we must adhere to in order to remain accepted members of society:

It is because of this-the moral (or perhaps better, the moralistic) requirement that we express ourselves only in ways approved by others-that we *feel* that our reality *must be* of a certain kind. It is not our actual experience that demands it, but our ways of talking which make themselves felt when we attempt to reflect upon our experience, and to account for it. In other words, what we talk of *as* our experience of our reality is constituted for us very largely by the *already established* ways in which we *must* talk in our attempts to *account* for ourselves - and for it - to the others around us. (p. 141)

This is congruent with Wittgenstein’s (1994) conception of the language game in which he replaces the *picture* metaphor of language with that of the *game*. Language games, he proposed, “are the forms of language with which a child begins to make use of

words” (p. 47). In the same way as children learn games so we learn about language. In learning to play it is discovered that rules govern each player and that there are unwritten social rules regulating conduct during the game, for example, cheating is not acceptable: “it’s just not cricket.” Wittgenstein’s premise was that words acquire meaning in a similar manner. For example, in my role as a clinical nursing tutor I was working alongside a group of Chinese students undertaking nursing education in Auckland in 2002 who were experiencing difficulty in establishing an effective mode of communication with a number of their elderly Pakeha¹⁰ patients. They were at a loss to understand the problem; they knew the words and thought they used them appropriately. They were not, however, using them in the mutual exchange (or game) required by their patients in the New Zealand context. They had to learn and practice such *rules* as smiling when they said “hello”, and that it also needed to be accompanied by “How are you?” The next move would then be a similar question from the other player that required a response before moving to the next level of the game. Such responses are legitimate in the word game of greeting, but the response “We shower now” to a greeting from the patient placed them outside of the game. Hence, as Wittgenstein states the language game brings into prominence “the fact that *speaking* of language is part of an activity, or of a form of life” (p. 47). Knowledge becomes a part of a social interchange and what we call knowledge is simply what we agree to call truth. By agreeing to the reality of a phenomenon, we construct that reality.

Researchers are now revealing how *self* is accomplished in the context of everyday talk and activity (Gough, 2001; Holland & Scourfield, 2000; Wieggers, 1998). Given that language is social and that meanings fluctuate across context it may be that we construct not *self*, but *selves*. How is someone who may be Pakeha, male, Jewish, gay, a nurse, an educator, a student and so forth to be sure of who he is within the constantly changing contexts of daily life? As Gergen (1991) pointed out how we define or describe ourselves occurs within different social contexts, and the inevitable differences between perspectives have implications for how we are treated, behave and define ourselves. Applying this understanding to gender we see that it is not something residing within, separate from the interactions of daily life, it is a transaction between individuals and

¹⁰ *Pakeha* refers to New Zealanders of European descent.

environmental contexts (Bohan, 1997). As West and Zimmerman (1991) revealed we do not have gender; we *do* gender.

Postmodernism has had a substantial influence upon recent advances in nursing epistemology. Glazer (2002), in her critique of the place of postmodernism in nursing knowledge, identified that between 1997 and 1999 alone 94 articles appeared in nursing journals making reference to postmodernism and that they were “typically approving.” She developed an essentialist argument that nursing theorists who adopt a postmodern position are espousing an antiscience position. In particular, she disparaged what she perceives as an uncritical adoption of postmodern approaches to the development of nursing knowledge. This has led to some debate within the nursing literature as to whether the profession is engaging in culture wars between the caring plus science path of nursing and the postmodern nurse-theorists (Glazer, 2002; Peters, 2002; Thompson, 2002).

The argument against the adoption of postmodernism by nurse researchers relates to three areas; the acceptance of multiple realities, moral relativism and a philosophy of rejection and destruction through the process of deconstruction (Stevenson & Beech, 2001). These objections to the postmodern are echoed in the opposition raised to social constructionism. In particular, its critics contend that social constructionism denies material reality, and adopts a position of moral relativism in which “anything goes.”

Beyond text.

There can be little doubt that Derrida’s (1976) famous assertion “There is nothing outside of the text” (p.158) has raised concerns that social constructionists deny material reality (Maze, 2001). For example, it has been argued that there is a real world *out there*, an ontological reality that provides grounds for preferring one belief to another (Bhaskar, 1989). In reply it has been suggested that the critics misunderstood constructionist propositions (Edley, 2001a; Gergen, 1999). Constructionism makes no denials of reality nor does it make any affirmations. To do so is to lock one into a particular account and be closed to other possibilities.

Edley (2001a) in his review of the debates surrounding social constructionism explained that social constructionists do not see language as the only reality; that the critics confuse ontological with epistemological pronouncements. He continued:

When they travel to conferences or go on holiday, for example, they consult their map books just like everybody else. They do not suppose that, say, Nottingham appears in the middle of the M1 motorway *because* it says so on the page and neither do they imagine that it somehow springs into existence at the moment it is mentioned. The way that constructionism upsets our commonplace understandings is much more subtle than this. Instead, a constructionist might point out that Nottingham is a city by virtue of a text (i.e. by royal decree) and that its boundaries –where it begins and ends-are also a matter for negotiation and agreement. The argument is not, therefore, that Nottingham doesn't really exist, but that it does so as a socially constructed reality. (p. 439)

Social constructionism: The refuge of the laissez-faire?.

Arguably, the most contentious issue is the accusation that social constructionism has no values, adopting a position of moral relativism. For example, as Gergen (1994a) pointed out, social constructionism can present a paradox for feminists. On the one hand it can be perceived as “implicitly feminist” because of its “challenge to traditional social hierarchies and the totalizing discourse of empirical science” (p.79). Yet others may see social constructionism as antifeminist because of its questioning of “feminist standpoint epistemology.” There is space for ambivalence. Social constructionism may provide a “new set of tools in the struggle for emancipation and political choice” (Speer, 2000, p. 519); however, this is set against the generally held belief that to adopt a feminist stance a political position is required from which to judge the validity of feminist claims. Nonetheless many feminist theorists and researchers have demonstrated that it is possible to locate oneself within postmodernism while being both passionate and politically informed (for example: Anderson, 2000; Bohan, 1997; David, 2000; Gavey, 1997; Glass & Davis, 1998; King, 1994; Webb, 1993).

The work of the American philosopher Richard Rorty has been particularly significant in reconciling postmodernism with political commitment. Returning to an earlier argument, it is not the world that is true or false but the way we describe it; descriptions which rely on language. While the world might exist independently of people, truth cannot. Rorty (1989) was interested in how people live and work with their own constructions of truth, constructed through “the words in which we tell...the stories

of our lives” (p.73). This is, also, the central concern of social constructionism: “...it is the contingent, really vague (that is, lacking any completely determinate character) flow of continuous communicative activity between human beings that we must study” (Shotter, 1993a, p. 179). These words that we use to describe who we are and our beliefs are what Rorty (1989) terms our *final vocabularies*. Thus, I am positioned as what he terms the *ironic* researcher. I must accept doubts and ambiguity about my own final vocabulary because I can't deny the impact that the final vocabularies of others have had upon me. Nor do I believe that *my* final vocabulary is closer to reality than the final vocabularies of others. I must admit to some misgivings to the word *final* applied to any position, and would argue rather that final denotes *at that time*, recognising from a social constructionist viewpoint that there is no finality. The more one knows, the more there is to know. Rolfe (2000) summarised this position, thus:

[J]ust as the postmodern ironist researcher rejects the scientific method as a metanarrative that claims to offer a justification for all other methods, while requiring no justification for itself, so she advocates for ironist research methods that are formulated in the full understanding that there is no logical basis for them; they are simply thought to be the best possible methods in the circumstances, and no attempt is made to impose them forcibly on anyone else. The ironist simply tries to describe her position in the most attractive way possible so that the listener might recognize it as being a better description of the world than that which she currently holds. (p. 69).

This position does not equate with moral quietism, i.e., not subscribing to a value system, rather it acknowledges that this is the best position *I* can adopt given my current knowledge.

As the language of science is not value-free and has been used to sort people into categories, which has resulted in the privileging of some people over others, then all scientific propositions should be questioned morally and politically. According to Gergen (1999) that is exactly the case: the constructionist critique of “the distinction between fact and value invites scientists-indeed, all of us-to speak out on issues of the good” (p. 231). Facts are no longer seen as value-free descriptions of *external* reality, but are part of the fabric of the *moral universe* in which they are constructed (Shotter, 1993). If knowledge and social action go together then facts are constructed for a social purpose

and their acceptance or rejection will be purposive (Lewis, 2003). It is not that social constructionists do not take a position, for each of us acts from a cultural position with its own traditions and values; we do not presume, however, they are universal. As Gergen (1999) explained, rather than selecting a victor from the various standpoints there is recognition that each position has legitimacy in its own terms; through the adoption of “relationally responsible language” (p.157) we are alive to what our speech and actions achieve.

Conclusion

In this chapter I have located the origins of social constructionism in a postmodernist critique of ideology, language and social process. I have described the influence of postmodernism, critical theory and poststructuralism in its development. In summary, social constructionism is an umbrella term that may include a number of research approaches which adopt one or more of the following beliefs:

- A critical approach to take-for-granted knowledge;
- Acknowledgement that knowledge is culturally and historically located;
- Knowledge is created and sustained through social processes; and
- Knowledge and social action go together.

Collectively these beliefs underpin a critical social constructionist methodology well suited to the study of gender and nursing. I have also identified myself as an *ironic* researcher; thus, this work is an attempt to better understand the world I inhabit, as a man and a nurse, and provide a description that might allow others to reconsider their current standpoint.

The following chapter will outline how this study proceeded. There will be attention to the ethical concerns, *co-researcher* selection and the role of discourse analysis in the data interpretation. I will explain why this method has been favoured over others sympathetic to a social constructionist approach. Importantly, I will outline my own location as a man and a nurse in this study.

Chapter Three: Theory to methodology

In turning to the actual study, the theoretical background to the data collection and analysis is now presented to provide the rationale for the chosen methods of data collection and analysis. The chapter begins by illuminating why discourse analysis is an attractive tool for the social constructionist. It then moves to a discussion of discourse and the emergence of contemporary understandings of discourse analysis. The chapter will outline the influence of Michel Foucault, Jacques Derrida, Ian Parker and feminist approaches to research upon this project.

Social constructionism and discourse

The social constructionist critiques of language, ideology and social processes described in the previous chapter have challenged the traditional view of language as truth bearing. While their location in the postmodern project imparts similarities, the critiques do differ in a number of respects. Gergen (1994a) suggested that the ideological critic's concern with the emancipatory project can lead to reluctance to surrender the belief that through language one can understand the true nature of things and in this manner be freed from oppression. From the perspectives of the literary-rhetorical and social critiques, however, there can be no objective or unbiased description of the nature of reality. The literary analyst will challenge, through deconstruction, the social account of reality. Similarly, the social analyst may cast doubt upon the literary standpoint that there is "nothing outside the text" (Derrida, 1976, p. 158).

The way forward with respect to reconciling the tensions between the three lines of critique and moving toward a unified standpoint, according to Gergen (1994a), lies in the third line of critique. He suggested that the social account offers advantages, through social constructionism, that allow us to move toward a reconstructed science. Gergen (1994a; 1999) further argued a commitment to social process can also nourish the ideological critique. He contended that the work of Foucault (1972, 1977, 1978) provided the link between social and critical analysis. For Foucault the central issues concerned the nature of power, how and by whom it is exercised. At the same time Foucault (1988a) contended, "I don't believe that this question of 'who exercises power?' can be resolved unless that other question 'how does it happen?' is resolved at the same time" (p.103).

Foucault's analysis revealed the link between language (in its various forms) and social process as a manifestation of power relationships. In the context of a movement toward a reconstituted science critical appraisal of language moves us beyond a simple elucidation of the biases beneath a particular discourse to scrutinising the societal consequences resulting from the existing modes of discourse. Thus, a central aim of critical analysis is the investigation of the process by which various forms of discourse become normalized and to querying whose interests are best served by such discursive patterns.

From the poststructuralist perspective it is through language that we construct the world and it is through human interchange that words gain their power to construct reality. As Phillips and Hardy (2002) summarised, "Our talk, and what we are, are one and the same" (p.2). The social constructionist argues the centrality of language in the construction of identity, social life and in mediating the relationship between the individual and society. Thus, discourse analysis becomes an appropriate social constructionist methodology.

The meaning of discourse

The modern study of discourse emerged in the 1960s, more or less concurrently in a number of disciplines in the humanities and social sciences (psychology, sociology, linguistics, anthropology, literary studies, philosophy, media and communication studies) although text and talk had been studied long before that in history, literature and the study of rhetoric by the great orators of antiquity (Potter & Wetherell, 1987; van Dijk, 1997). As a consequence of the differing theoretical positions of these disciplines a variety of approaches to discourse analysis can be found, including: analytical philosophy, linguistics, linguistic anthropology, new literacy studies, poststructuralism, semiotic, conversation analysis, ethnomethodological, Althusserian, Gramscian, critical discourse analysis and social constructionism (Macleod, 2002; Potter & Wetherell, 1987; Slembrouck, 1998). Given the plethora of theoretical positions it is difficult to provide a succinct definition of discourse and discourse analysis; as Potter and Wetherell (1997) noted when attempting to arrive at a definition of discourse, "terminological confusions abound" (p.6). The focus, for some researchers, may be as narrow as the study of a single statement or a conversation between two people, while for others it may mean all forms

of talk or writing or else just the way talk is meshed together. At the other end of the continuum, discourse is synonymous with the entire social order (Howarth, 2000; Potter & Wetherell, 1987).

The variety of approaches reflects the complex and contested nature of the study of discourse, such that “the meaning, scope and application of discourse is relative to the different theoretical systems in which it is embedded” (Howarth, 2000, p. 3). Thus, discourse has variously been described as:

- “A system of statements which constructs an object” (Parker, 1990, p. 191);
- “Practices which form the objects of which they speak” (Foucault, 1972, p. 49);
- “All forms of spoken interaction, formal and informal, and written texts of all kinds” (Potter and Wetherell 1987, p. 6);
- “Historically variable ways of specifying knowledge and truth” (Ramazanoglu, 1993, p. 7).
- “The network of social, political and cultural relationships, including those created by language, which provide the relays for the circulation and dispersal of power across and throughout the social structure” (Buchbinder, 1998, p. 8).

There are, then, a variety of understandings of what discourse is and just as those understandings can subtly differ so, too, can the meaning of “text”. Phillips and Hardy (2002) drew upon the work of Parker (1992) to produce a definition of the term which will also be adopted in this work, that “a discourse is an interrelated set of texts, and the practices of their production, dissemination, and reception, that brings an object into being” (p. 3).

Text.

Text traditionally refers to a piece of written language, i.e. a whole work such as a poem or novel, or a relatively discrete part of a work such as a chapter (Fairclough, 1995); however, from the perspective of discourse analysis this is only one dimension of *text*. While the emphasis is usually on language and linguistic texts, discourses can be realised in patterns of meaning that include visual and spatial arrangements (Fairclough, 1992, 1995; Parker, 1999). With respect to the process of discourse analysis when

collections of sentences, figures or images are referred to as *texts*, it is done to delimit an object of analysis and a text is, then, any “tissue of meaning which is symbolically significant for the reader” (Parker, 1999, p.4).

Writing becomes the model form for discourse analysis, which means that the investigator is involved in *translation*, either in describing the image in writing (Parker, 1999) or in the transcription of the spoken word into writing to permit analysis (Fairclough, 1992). The notion of translation in relation to the text will be returned to later in this chapter.

The social constructionist approach to discourse analysis

Burr (1995) suggested that from a social constructionist perspective this multiplicity of approaches to the study of discourse can be divided into two broad categories.

One approach has emerged from the philosophical tradition of structuralism and poststructuralism and is concerned with “issues of identity, selfhood, personal and social change and power relations” (Burr, 1995, p. 47). Within this approach there are differences between researchers with respect to their styles of analysis and underlying theoretical orientation, but what is shared is a focus on language as central to structuring and constraining meaning, and the use of interpretive, reflexive styles of analysis (Burman, 1991).

The second approach identified by Burr (1995) draws upon different traditions because its focus is upon the “performative qualities of discourse, that is, what people are doing with their talk or writing, what they are trying to achieve” (p.47). Within this tradition the focus is on how the accounts are constructed (for example, Potter & Wetherell, 1987) or upon the rhetorical devices that are used by people and how they are employed (for example: Billig, 1987). These approaches are less concerned with issues of selfhood, subjectivity or power but are more oriented to the use of language.

Given the number of orientations to the concept of discourse then it holds that there is no one method of conducting discourse analysis (Howarth, 2000; Paltridge, 2000; Wood & Kroger, 2000). Burr (1995) describes discourse analysis as an “umbrella” for a wide variety of research practices with different aims and theoretical backgrounds. Discourse analysis, she continues, “is unlike the majority of existing traditional methods

of social scientific enquiry, since it is not possible to describe it adequately in “recipe-type terms” (p. 163). There is, then, no *right* method for carrying out discourse analysis, however, there are theoretical considerations that are relevant to its application in a research context.

To summarize, Potter and Wetherell (1987) perceive discourse analysts as suggesting that:

1. Language is used for a variety of functions and its use has a variety of consequences;
2. Language is both constructed and constructive;
3. The same phenomenon can be described in a number of different ways;
4. There will, therefore, be considerable variation in accounts;
5. There is, as yet, no foolproof way to deal with this variation and to sift accounts which are “literal” or “accurate” from those which are rhetorical or merely misguided thereby escaping the problems variation raises for researchers with a “realistic” model of language;
6. The constructive and flexible ways in which language is used should themselves become a central topic of study. (p. 35)

In the following section I do not present a definitive methodology of discourse analysis but rather describe the theoretical considerations and methodological insights that have been used to provide a coherent set of research practices for this study. This work is positioned within the first of the divisions described above by Burr (1995): the endeavour to understand and describe questions related to personhood, personal and social change and the role of power relations within this context. The work that will occupy the remaining chapters of this study can best be described as deconstructive discourse analysis and has been informed by a number of authors, particularly Jacques Derrida, Michel Foucault and Ian Parker.

The emergence of modern discourse studies

Howarth (2000) describes three “significant transformations” that have influenced the theoretical orientations to the study of discourse. The first transformation in the study of discourse was essentially linguistic focusing on the “science of language”. The

primary concern is with the rules that govern language in use, the communication of beliefs and interaction in social situations (van Dijk, 1997).

The second phase in the modern study of discourse grew out of the focus in the social sciences in the 1960s and 1970s on structuralism, poststructuralism, hermeneutics and Marxism. In this perspective the concept of discourse includes a wider set of social practices and phenomena (Howarth, 2000). In this transformation the work of Foucault is particularly significant in introducing a concern with materiality and power into the study of discourse.

The influence of Foucault.

The French philosopher Michel Foucault has had an enormous influence upon the social sciences and humanities and the popularisation of the concept of discourse and discourse analysis as a research method can, to some extent, be attributed to the influence of his writings.

From his early work, generally termed the *archaeological* writings, Foucault contributed two major theoretical insights. First, he developed a constitutive view of discourse, which involves seeing discourse as actively constructing society on various levels. Thus, discourse constitutes the objects of knowledge, social subjects, forms of self, social relationships and conceptual frameworks (Fairclough, 1992). Foucault (1972) conceptualises discourse as a group of statements, which together construct a *discursive formation*:

We shall call discourse a group of statements in so far as they belong to the same discursive formation; it does not form a rhetorical or formal unity, endlessly repeatable, whose appearance or use in history might be indicated (and if necessary, explained); it is made up of a limited number of statements for which a group of conditions of existence can be defined. (p. 117)

According to Foucault (1972), the statements that form a discourse are related by a body of rules or *discursive practice*, which “constitute the conditions of their historical appearance” (p.48). Thus, the unspoken historic rules then determine “in a certain social, economic, geographic or linguistic area what can be said, how it can be expressed,

who may speak, where and under which dominant conditions” (Lehtonen, 2000, p. 42). Discourses are, therefore, not only constitutive but are also restrictive.

The second major theoretical insight was the recognition of the interdependency of the discourse practices of a society or institution. Thus, any discourse practice emerges from combination with others and is defined by its relationship with others. This is the property that Fairclough (1992) refers to as *intertextuality*, which “draws attention to the dependence of texts upon society and history in the form of the resources made available within the order of discourse” (p.195).

He used the example of AIDS to explain the way in which discourses can merge to create a new, or hybrid, discourse:

Another important focus is upon historical change: how different discourses combine under particular social conditions to produce a new, complex discourse. A contemporary example is the social construction of the AIDS disease, in which various “discourses” (e.g., discourses of venereology, of cultural “invasion” by “aliens”, of pollution) are combined to constitute a new discourse of AIDS. (p.4)

In formulating the concept of *an order of discourse* Fairclough (1995) drew upon the work of Foucault and uses the term to refer to the ordered set of discursive practices that are associated with a particular social domain or institution and the boundaries and relationships between them. Thus, different discourse types are ordered in relation to each other, and characteristically such, that there may be a dominant, that is to say normalized, practice and a dominated or marginalized practice (Fairclough, 1995).

In Foucault’s later work, or *genealogical* writings rather than describing the historical rules that determine discourses his concern is with the way discourses are shaped by, and in turn shape, social practices (Fairclough, 1992; Howarth, 2000). Foucault locates power in discursive practices and analysis must, therefore, look to “the specific detail of the discursive field in order to reveal the particular regimes of power at work in society and their part in the overall production and maintenance of existing power relations” (Weedon, 1987, p. 108). For example, Foucault has produced analyses of the ways in which power is exercised and individuals governed through psychiatry, the penal system and the discursive production and control of sexuality (Foucault, 1972, 1977, 1978). To illustrate this proposition Fairclough (1992) used the example of the

discourse of medical science. It is currently the dominant one in the practice of health care; it is contrasted against (and often competes against) various holistic alternative discourses (e.g., those of homeopathy and acupuncture). It is from the dominance of the medical discourse that doctors derive power:

Discourses do not just reflect or represent social entities and relations, they construct or 'constitute' them, different discourses constitute key entities (be they 'mental illness', 'citizenship' or 'literacy') in different ways, and position people in different ways as social subjects (e.g., as doctors or patients), and it is these social effects of discourse that are focussed upon in discourse analysis. (p.4)

According to Howarth (2000) the third phase in the development of modern discourse analysis has developed not only out of the work of Foucault, but also from that of Derrida and Marxist and post-Marxist thought. The scope of discourse analysis is widened to include non-discursive practices and elements. For example, Fairclough (1989; 1992; 2000; 2003) developed a method for analysis he terms "critical discourse analysis." His reworking of discourse theory draws together social theory and a linguistically-oriented approach. This more expansive form of discourse analysis includes the examination of political texts and speeches, as well as the contexts in which they are produced.

The approach to discourse developed by Fairclough is echoed in the work of Gee (1999) who differentiates between "Discourse" with a "big D" and "discourse" with a "little d":

This distinction is meant to do this: we, as "applied linguists" or 'sociolinguists', are interested in how language is used "on site" to enact activities and identities. Such language in use, I will call "discourse" with a "little d." *But* activities and identities are rarely ever enacted through language alone...When "little d" discourse (language-in-use) is melded integrally with non-language 'stuff' to enact specific identities, then, I say that "big D" Discourses are involved. We are all members of many, a great many, different Discourses.... (p.7)

The extra-discursive

Macleod (2002) identified that there is some debate over the place of the *extra-discursive* in discourse analysis. Wilkinson and Kitzinger (1995) define the extra-discursive as “material beyond the discourse analytic text, whether this is primarily characterized in terms of an ‘exterior’ world of social practices and their material effects, or in terms of an ‘interior’ world of subjectivity and intersubjectivity” (p.4). Holloway (1995), for example, in her theorization of an emancipatory practice of heterosexual sex suggests that it may occur within an extra-discursive space provided by the private domain within which so-called normal sex is practised. Macleod (2002) agreed with Wetherell (1995) that arguing for a strong ontological distinction between the discursive and the extra-discursive creates problems from both the methodological and epistemological perspective. First, in ignoring the constitutive role of discourse it denies the pivotal role of talk in constituting social relations and subjectivity. Second, there is a risk of a descent into cause-effect dualism; and third, it places one in the invidious position of having to constantly decide what is discursive and what is extra-discursive (Macleod, 2002). This dilemma is neatly side-stepped by Fairclough (1992) whose conceptualisation of the discursive event integrates the dynamic view of discursive practice and its relationship with social practice allowing space for emancipatory practice.

The influence of Derrida.

For Foucault (1991), the target of analysis is practices, with the “aim of grasping the conditions which make these acceptable at a given moment” (p.75). Practices are conceptualised as “places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted, meet and interconnect” (Foucault 1991, p.75). Exploring “regimes of practice” involves analysing their prescriptive effects regarding action and their codifying effects concerning the known.¹¹ Derridean deconstruction, as discussed in the previous chapter, is an approach to discourse that attempts to de-stabilise it. According to Burman (1990):

¹¹ What Foucault (1991) terms “jurisdiction” and “veridiction” respectively.

Deconstruction focuses on dominance, contradiction and difference: in highlighting the multiplicity of positions afforded by competing discourses and their contradictory effects, it enables us to envisage ways of disrupting the dominant discourse and to construct positions of resistance. (p. 209)

The purpose is neither to destroy the text nor assess it as to its truth-value. Instead, it questions discourses by exploring (deconstructing) them in terms of their claims of presence and their dependence on absences. This concept of the *absent trace* echoes the idea that discourses are both constructive and restrictive. As Macleod (2002) noted: “Discourse excludes what is simultaneously exterior and interior to it. ‘A’ relies on ‘not-A’, ‘being’ on ‘non-being’, ‘presence’ on ‘absence’ for their meaning, while at the same time subordinating the second term (not-A, non-being, absence)” (p.18).

A discourse accounts for other discourses through the contradictions contained within the discourse (Parker, 1992). In so doing, it creates the conditions in which ways of disrupting the dominant discourse and the construction of positions of resistance to undermine its presence can occur (Burman, 1991; Parker, 1992).

The notion of resistance is also present in Foucault’s theorization of the *reverse* discourse, which enables those who are subjected by a discourse to speak in her or his own right. For example, in the last chapter, Foucault’s (1978, 1990) example of the 19th century shift with respect to homosexuality was mentioned. From being merely a mode of sexual expression, open to everyone, there was the discursive production of homosexuality as a subject position:

There is no question that the appearance in the nineteenth-century psychiatry, jurisprudence and literature of a whole series of discourses on the species and subspecies of homosexuality, inversion, pederasty, and “psychic hermaphroditism” made possible a strong advance of social controls into this area of “perversity”; but also made possible the formation of a “reverse” discourse: homosexuality began to speak on its own behalf, to demand that its legitimacy or “naturalness” be acknowledged, often in the same vocabulary, using the same categories by which it was medically disqualified. (p.101)

Parker's criteria for discourse analysis.

To perform the actual discourse analysis, described in the following chapter, I was influenced by Parker's (1992) approach to discourse analysis. His ten criteria do not form a specific methodology for discourse analysis: they are guides.

Parker's (1992) first criterion, the notion that discourse is realised in text has been discussed earlier, however, the implications for the analyst is that everything has to be considered text and must be explored for the connotations, allusions and implications that are evoked (Zeeman et al., 2002).

The second of the criteria is that discourses are about objects. Macleod (2002) identifies two levels of objectification. First, objects are constituted through discourse, i.e., the naming of an object gives it reality. Foucault (Foucault, 1965, 1988b) used the example of madness as an object in the discourse of psychopathology in which, from the nineteenth century onwards, the statements that named, described and explained it constituted mental illness. The second level of objectification is where a discourse refers to itself or other discourses as if they were objects, e.g., the discourses of medicine, science, nursing, masculinity and so forth.

The third criterion is that discourses contain subjects. In the previous chapter the concept of interactive and reflexive positionings was described. A discourse creates space for a certain type of self; thus, to be positioned interactively means that one person positions another within a particular discourse, whereas reflexive positioning is where a person positions her or himself. Macleod (2002) noted that it is possible to be accorded both object and subject status within a discourse.

There is a strong link between Parker's (1992) third criterion and Foucault's (1972) formation of *enunciative modalities*. Fairclough (1992) identifies the main thesis with respect to the formation of enunciative modalities as the notion that:

The social subject that produces a statement is not an entity which exists outside of and independently of discourse, as a source of the statement (its "author"), but is on the contrary a function of the statement itself. (p. 43)

Thus, as Foucault (1972) wrote "the positions of the subject are also defined by the situation that it is possible for him to occupy in relation to the various domains or

groups of objects” (p. 52). In developing the example of the medical practitioner he also asked:

Who is speaking? Who, among the totality of speaking individuals is accorded the right to use this sort of language? Who is qualified to do so? Who derives it from his own special quality, his prestige, and from whom in return does he receive the assurance, at least the presumption that what he says is true? (p.50)

A discourse is a coherent system of meanings, according to Parker’s (1992) fourth criterion, which map a picture of the world, and provide ways of dealing with objections.

The fifth criterion is that discourse refers to other discourses. According to Parker (1992), a discourse will “presuppose other discourses to the extent that the contradictions *within* a discourse open up questions about what other discourses are at work” (p. 13). The implications for the analyst are to set different discourses against each other and see what objects they form, and to identify the points where they overlap.

The sixth criterion states that discourse reflects on its own way of speaking which beholds the analyst to identify and comment on the terms used within the discourse. Derrida (1967, 1976) argued that when we read a sign, meaning is not always clear. As was noted in the previous chapter, signs also refer to what is absent and carry the trace of the other. Thus, what is not said is also important and the implicit themes that are suggested by the absence of certain terms should also be investigated.

The seventh criterion is that discourses are historically located. Foucault (1972) rejected the notion of a line of historical inevitability and espoused the notions of transformations and discontinuities. Foucault adopts the technique of the Nietzschean historian who begins with the present and goes backward in time until a difference is located. The analyst then proceeds forward again, tracking the transformation, preserving the discontinuities as well as the connections. In this manner, the alien discourses are explored “in such a way that their negativity in relation to the present explodes the ‘rationality’ of phenomena that are taken for granted” (Sarup, 1993, p. 58).

Parker’s (1992) eighth criterion is that discourses support institutions (e.g., schools of nursing) and in so doing validate certain institutional discursive practices while marginalizing others (for example universities versus polytechnic institutes). The analyst

identifies the institutions that are reinforced when the discourse is used and those that are subverted when this discourse emerges.

The final two criteria are that discourses reproduce power relations and that discourses have ideological effects respectively. Parker (1992) substituted *ideology* for Foucault's *regimes of truth*. Both these criteria lead to analysis of power; the identification of who would want to promote or dissolve the discourse, and the manner in which the discourse connects with other discourses, how they sanction oppression and "prevent those who use subjugated discourses from *making history*" (Zeeman et al., 2002, p. 101).

Utilizing these criteria the analysis explores the construction of current social arrangements. The final two criteria allow us to question whether it is solely women who have not been seen in history. It is not in contention, as some historians have asserted, that often the role of women has been invisible (for example: Bunting & Campbell, 1990; Schultz, 1992). I would argue; however, that such invisibility is not confined solely to women. The dominant discourses that converge to create our historical knowledge are those of the social elite and these are most often the voices of men (Yuginovich, 2000). They are prominent by virtue of class and education. The discourse reflects their interests and their sphere of influence; on the European/U.S. axis (an axis that includes New Zealand) it is predicated in the gender order that has become known as patriarchy: a gender regime that subordinates women to the interests of men. The voices and narratives of those men who were not part of the dominant elite are, for the most part, unheard. Within patriarchal power structures, however, many men are also excluded from active involvement in the interplay of power relations through circumstances of class, education and race. Connell (2000a) argued that while "men in general gain the patriarchal dividend, specific groups of men gain very little of it" (p.203). He contended that groups of men, alongside women, are also victimised by an unequal gender order. To illustrate his treatise he cites the example of working class youth, gay men, Black men in the United States, South Africa and the Aborigine in Australia; to this list we could well add Maori men in New Zealand. Many men, as well as women have been rendered invisible in history.

The first seven of Parker's (1992) criteria for discourse have emerged from Foucault's archaeological perspective and form the structural component of the analysis.

The deconstructive aspect of the analysis has deferred to Derrida's (1976) deconstructive method and Parker's (1992) final three criteria, which in turn defer to Foucault's conceptualisation of genealogy.

As outlined in Chapter Two, Derrida's (1976) process of deconstruction requires interrogation of the text to reveal the embedded binary opposites, which in turn are violently reversed. In this manner alternative readings find space to emerge. Parker (1992) also employed the Derrida's (1976) device of *sous rature* in the following manner: (1) identify an opposition, and show how one is dominant over another; (2) subvert the opposition between the two terms by demonstrating that the privilege afforded the dominant term can be destabilised; and (3) sabotage the conceptual opposition by either extending the meaning of the term or alternatively employing a different term.

The displacement of objectivity

Researchers within what has been described as the traditional scientific paradigm claim truthfulness for their findings by adopting methodologies that suppose objectivity. As Burr (1995) asserted, investigators claim to, "stand back from their own humanity and reveal the objective nature of the phenomena under study without bias and without 'contaminating' the results with 'leakage' from their own personal involvement" (p.160).

Adopting a non-traditional approach to this research potentially creates two significant issues that potentially could lead to academic and personal censure. First, from an academic perspective I must be prepared to answer the criticism that my research loses objectivity. Poststructuralism, however, brings into question the extent to which objectivity is the hallmark of rigorous research. A body of work now exists that refutes the notion that to be *good* research it must be impartial and questions whether it can be realistically expected that the researcher remains detached from both the process and the outcome. Stanley and Wise (1993) argued, "the personal is not only the political, it is also the crucial variable which is absolutely present in each and every attempt to 'do research'" (p. 157). The researcher is influenced by background and position as to subject, methodology, and the findings that are selected for communication. The contemporary theory of knowledge acknowledges the effect of the researcher's position and perspectives, and contests the positioning of the researcher as neutral (Haraway, 1991).

For the social constructionist the notion of objectivity so valued by empirical science is no more than part of the discourse of science, which constructs a particular perspective on human life (Burr, 1995). Fairclough (2003) also addresses the question of objectivity:

[T]here are always particular motivations for choosing to ask certain questions about texts and not others. My actual motivation for asking the sorts of questions I shall ask...is the belief that texts have social, political, cognitive, moral and material consequences and effects. (p.14)

The influence of feminist research.

A number of authors (for example: Gavey, 1997; King, 1994; Olesen, 1994; Webb, 1993; Weedon, 1987) describe feminism's concern with the emancipation of women from the oppression of patriarchy. The research generated by this project utilizes methods that are non-hierarchical, reflexive and interactive (King, 1994). To the extent that this research also utilizes such methods it is arguable that it is influenced by feminist research, however, what is questionable is the extent which feminism *owns* such methods.

Feminism is, perhaps, better described as a perspective, not a research method (Joyappa & Self, 1996). If, however, feminist research "ought to be *on* and *for* women, and should be carried out *by* women" (Stanley & Wise, 1993, p. 30) then I am not engaged in feminist research and I cannot be termed a feminist. While it is not unknown for men to claim a feminist position, I do not feel comfortable adopting such a label. Yet when I read the first five of the following criteria formulated by Bernhard (1984, cited Webb, 1993)¹² I cannot help but think that I am engaged in a parallel process and where Bernhard uses the word woman I could replace it with man and the criteria would accurately reflect the ethos of this work:

1. The researcher is a woman;
2. Feminist methodology is used, including researcher-subject interaction, non-hierarchical research relationships, expressions of feelings, and concern for values;

¹² Bernhard, L.A. (1984) Feminist research in nursing research. Poster session presented at The First International Congress on Women's Health Issues, Halifax, Nova Scotia.

3. The research has the potential to help its subjects;
4. The focus is on the experiences of women;
5. It is a study of women;
6. The words “feminism” or “feminist” are actually used;
7. Feminist literature is cited; and
8. The research is reported using non-sexist language.

Allan (1997) described her engagement with feminist research (in this instance ethnography) in her study of the role of nurses in the field of assisted conception. She describes such research as “concerned with reflexivity, critical thinking about gender (examining taken-for-granted assumptions), how people are empowered to think and act, or simply action or praxis to change social relations” (p. 454). She continued her discussion of this approach:

[I]t is focused on women’s knowledge about the world from their own perspectives; that is, women’s knowledge ... I wanted a methodology that was woman-centred. I wished to access women’s knowledge and nursing knowledge ... and to understand the blocks to the expression of this knowledge in the clinical environment ... Feminist research that is reflexive emphasises the researcher’s awareness and use of her own experience of the research process as a woman. (p.456)

Once again, substituting woman with man the parallels with the aims of this study are striking. Applying the traditions of feminist theory argues for the inclusion of myself as the research instrument (Bent, 1993). This means that I actively involve myself as an informed subject, challenging my own-taken-for-granted assumptions about the field of study while simultaneously being an instrument generating the data not merely collecting it.

Endeavouring to articulate a male perspective I do not claim to be feminist, nor would I wish to for fear of engaging in the imperialist process that continues to subjugate women’s knowledge in the interests of men. I can, at least, be influenced by the discourse of feminism. I have no desire to be perceived as a revisionist who denies masculine hegemony; however, feminism’s focus on equality and justice for women should blind neither women nor men to the ways in which men are also oppressed by patriarchy. Nor

should it be used to restrict the view of what it can mean to be a man and limit the ways in which masculinity can be expressed.

Researcher - co-researcher interaction.

In the previous chapter, that social processes sustain knowledge was presented as one of the assumptions underpinning the social constructionist account. Therefore, the extent to which an account of the world or of self endures over time is not a function of objective validity but of societal processes. Language, as constitutive of knowledge, gains its meaning from the way it functions within patterns of relationship (Gergen, 1994a). Thus, our knowledge of the world arises through *activity* and from active involvement in that world (Shotter, 1989).

An important issue emerges from this assumption; namely, the potential to either assume or be ascribed power in the role of researcher. The researcher is part of a social process - constructing knowledge in interaction with the participants. Burr (1995) argued that from this perspective:

There no longer appears to be a good reason to privilege the account or “reading” of the researcher above that of anyone else, and this puts the researcher and the researched in a new relation to each other. Subjects’ own account of their experiences can no longer be given an alternative interpretation by researchers who then offer their reading as truth. (p.161)

The second potential area of risk, alluded to earlier, involves the degree to which I reveal my authentic self, a dilemma, which Cant and Sharma (1998) described as “professional boundaries and the problem of writing” (p. 258). Choosing to situate myself in the research in this manner means that I must accept that there will be those who may consider that I have overstepped the accepted boundaries of scholarship; however, I would argue the postmodern stance in which “politically informed researchers purposefully act within their research” (King, 1999, p. 474).

There may be others, too, who knowing me may challenge what I choose not to reveal. There will inevitably be tension between personal privacy and the need for the reader to situate and evaluate my place in the work. Platzer and James (1997) warn that researchers can be exposed to the charge of bias of “going native”, yet in this case I am

not *going* native: I *am* native. Paradoxically, this insider status may also lead to the potential for accusations to bias to surround this work, yet it may also allow for ease of access to and rapport with participants.

A warning against men researching men was signalled by Isaacs and Poole (1996) who wrote, "Men researching men is a situation said to be flawed by over-identification" (p. 41). They cite no other authors to support this contention; however, one has to wonder why men researching men is problematic when, as seen in the earlier discussion, it is considered desirable that women research women. If, as Walter, Glass and Davis (2001) suggested "being a researcher/participant increased the possibility to remain deeply embedded in the research process" (p. 269) it also follows, using their reasoning, that the researcher being a participant adds another dimension to the research.

As a man and a nurse I cannot pretend to be an impartial observer either while interviewing other men who are nurses and or while analysing the data. Horsfall (1997) argued that by remaining committed to distance and objectivity the researcher risks relegating the researched to a position of inferior *other*. Eschewing objectivity inevitably makes it exigent that I critically reflect on my own experience and practices and the extent to which my values and assumptions determine the direction of the research. Laying open an audit trail by tracking my own journey and critically reflecting on its relevance to my experience as a man who is a nurse allows the identification of areas of personal bias and to *bracket* them (Ahern, 1999). This approach to the work is inherent in the philosophy of reflexivity which Frank (1997) says involves the realisation that researchers are part of the social world they study.

Reflexivity.

Reflection on our forms of understanding is vital to our future well-being (Gergen, 1999, p.49).

Reflexivity provides a way forward to overcome the issues of loss of objectivity and bias, and use of self as researcher and researched, a process Heilbron (1999) asserted as a primary condition for intellectual progress and which is a feature widely employed in social constructionist work.

Reflexivity is a topic that has become widely discussed not only in social constructionism but also in much of the contemporary writing on qualitative research (Allan, 1997; Burr, 1995; Cant & Sharma, 1998; Gavey, 1997; Gergen, 1994a; Heilbron, 1999; Macbeth, 2001; May, 2000; Stanley & Wise, 1993). It is increasingly being practised in research by nurses and Lamb and Huttlinger suggested (1989) that nurses as researchers have “the special task of examining how they may have been influenced not only by their personal values and beliefs but by those associated with the culture of nursing and nursing research as well” (p.770).

Reflexivity is widely used both in social constructionism and discourse analysis. According to Burr (1995) there is no single understanding of or use of reflexivity in the research process. Nevertheless, several themes can be identified. In the first instance:

Reflexivity is used to draw attention to the fact that, when someone gives an account of an event, that account is simultaneously a description of the event *and* part of the event (because of the constitutive nature of talk). (p.161)

From this context emerges consideration of the involvement of the researcher and the effect this has on the research process; as Candy (1989) stated, “Social reality is both shaped by, and in turn shapes, the interpretations and perceptions of individuals” (p.6). Working within this framework, it is not only the experience of the participants in this research that must be considered but also the factors that shape this experience. The *knowing* position of the researcher in relation to the research participants needs to be considered (Goodley, 1999). This is not only in terms of the power ascribed to (or assumed by) the researcher outlined in the previous section, but also through the inherent danger that it becomes self-indulgent. It can become an exercise in which the personal confessions of the researchers—either of the reflexive positionings¹³ (the discursive positionings assigned to him/herself by an individual) or of their emotional investments—dominate the work (Davies & Harré, 1990).

The second issue that emerges is the recognition that social constructionism is not exempt from the critical stance it brings to bear on other theories (Burr, 1995). Thus, as

¹³ Positioning is the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines. There can be interactive positioning in which what one person says positions another, and there can be interactive positioning in which one positions oneself (Davies and Harré, 1990, p.48).

Gergen (1994a) noted social constructionists, “may employ self-reflexive deconstructions of their own theses, thus simultaneously declaring a position, but removing its authority and inviting other voices into the conversation” (p48). A social constructionist position considers that it is beholden upon all researchers to engage in a self-reflexive process: the continual questioning of one’s own position. Through this self-inquisition we abandon the security of previously cherished notions of right and wrong, truth and untruth, fact and fiction, and open a space for other possibilities to emerge. Gergen (1999) believes that this process is made possible by our being “polyvocal”, i.e., we are involved in multiple relationships-at work, at home, in recreation, and so forth – and we carry traces of these relationships. The influence of Rorty’s (1989) final vocabularies is felt. Continuing with Gergen’s (1999) reasoning:

[W]ith effort we can typically locate reason to doubt any proposition we otherwise hold as true, and see limitations in any value we think central to our life. Suppressed at the moment I “speak my mind”, or “say what I believe” is the chorus of internal nay-sayers. If these suppressed voices can be located and brought forth within the conversation of differences, we move toward transformation. (p. 162)

In Chapter One I stated, “As the process of text collection and analysis occurred these beliefs were challenged and reconstructed.” They continue to be reconstructed in the process of social interaction, as taken-for-granted knowledge and a stable reality is replaced with an unstable world that occurs as a result of communication between people. The notion that beliefs can be reconstructed is fundamental to Kelly’s (1955) thesis of personal construct psychology. *Constructs* are a means of discriminating between similarity and contrast; each construct is bi-polar, with an emergent pole and a contrast pole. The poles, however, reflect contrasting rather than opposite poles. This does not mean that individuals need to paint themselves into a corner or become victim of their own biography. The philosophy of “constructive alternativism” means that there will never be an inevitably *right* view of things, there will always be an alternative, “some of which may well not exist as yet” (Hardman, 2001, p. 42). We are no longer confined to one particular convention of understanding (Gergen, 1999), and are able to re-position ourselves and continually re-shape our worlds (Allen & Hardin, 2001).

From this perspective there is no claim to being *the* authority but a claim to being a voice in critical dialogue with others (Shotter, 1993a). It is my contention that this study provides a new lens through which to view nursing and the experiences of the men who choose to enter it. I am not proposing to replace one view with another, nor do I wish to be perceived as privileging one particular viewpoint. I will present an alternative interpretation that will emerge not only from the experiences of the men who have been interviewed for this study, but also through the analysis of the various texts which have been selected from a male perspective.

The final assumption of social constructionism, outlined in the previous chapter, stated that knowledge and social action interact as we seek ways to re-evaluate, reorganize and construct new ways of being. Thus, I can only propose that this work is one of many possible viewpoints, and that this multiplicity of perspectives is important if we are to accept the challenge of constructing new meanings and offer new possibilities for action that may transform our future.

Because the focus of this study is constructive and not neutral, I need to identify my position as researcher in relation to the project. Although, as Gavey (1997) pointed out “such identification is unlikely to capture the nuances and complexity of these positions” (p.59). My positions are currently: male, gay, Pakeha, nurse and educated in terms of my social location and poststructuralist in terms of my theoretical position. Although I am adopting *feminist* methods in conducting this research I cannot title myself *a feminist researcher*; returning to the argument promulgated earlier in this chapter, feminist methods are employed by women, with (or on) women, for women. Rather I am adopting feminist methods in a technical sense; however, I align myself with the position espoused by White and Johnson (1998) that:

[M]en have the habit of invading and controlling the legitimate concerns of women to achieve equality and emancipation, we would suggest that some men (and we would like to qualify ourselves in that group) share enough genuine interest in the concerns of women to participate in the egalitarian enterprise and its research methods. (p. 44)

Conclusion

In this chapter I have argued for discourse analysis as an appropriate social constructionist methodology for this study. I have described the emergence of contemporary approaches to discourse analysis and, in particular, the influence of Foucault in explicitly linking the analysis of power with the analysis of discourse. The influence of Derridian deconstruction, Parker's criteria for discourse analysis and the study's indebtedness to feminism is acknowledged. In particular, the influence of feminism has allowed traditional notions of objectivity to be replaced by a reflexive positioning of the researcher as an informed participant in the study.

This chapter has also illuminated the evolutionary process which has led to this study's final standpoint as a work of social constructionist discourse analysis, provided an overview of the intended aims of the study and described the beliefs that I held at the outset of the project.

The next chapter will continue the movement from the abstract to the practical by outlining the actual processes that occurred in the collection and analysis of the data.

CHAPTER FOUR: Undertaking the study

This chapter completes the transition from the abstract to the practical that was signalled in the last chapter. The theoretical and methodological issues discussed in the previous two chapters have provided the context for consideration of the research method.

The chapter opens by *signposting the journey*, laying open the audit trail with respect to gaining approval for the project and arriving at the criteria used for one part of the text collection, that of participant interview. The actual process of data gathering, primarily the collection of relevant written work and participant interviews, is described. Followed by a description of how the data analysis proceeded.

Approval processes

The proposal was first presented to the Faculty of Medical and Health Sciences Graduate Committee, University of Auckland, in February 2002. With the approval and support of this committee the proposal was presented to the University of Auckland Postgraduate Committee. The application was accepted provisionally for doctoral study in March 2002 with two conditions required in the first 12 months; (1) completion of the literature review, and (2) the gaining of approval from the University's Ethics Committee.

As described in the first chapter an extensive literature review was undertaken which lead to substantive changes to the project before ethical approval was sought from the University of Auckland Human Subjects Ethics Committee in February 2003. Approval was gained in March 2002 following required amendments to the wording in the Participant Information Sheet (Appendix A).

Text collection

Discourse analysis uses qualitative methods of data collection and analysis; therefore, statistical sampling and generalisation is abandoned. The various methods used to generate and collect data share family resemblances with historical, ethnographic and anthropological forms of research. Primary material can be gathered from a wide range of sources, which include newspapers, official reports, *unofficial*

documents such as pamphlets, organizational minutes and agendas, personal biographies and media representations such as televised documentaries and films (Howarth, 2000). Discourse analysts also use in-depth interviews and ethnographic forms of investigation such as participant-observation to supplement the texts.

Decisions regarding the limits placed on text collection are based on solely on pragmatic considerations regarding purpose and relevance (Macleod, 2002); however, text selection should ensure diversity and avoid homogeneity (Fairclough, 1992). Discourse analysts do, however, have to be sensitive to the theoretical postulates governing their research practices. For example, texts are not produced in a social interactional vacuum. Accounts are produced to address the interactional business considered relevant to the particular circumstances (Widdicombe, 1995). As noted in the previous chapter the activity of discussion involves the researcher and the participants in a process of mutually constructing versions of social reality. The researcher is not a neutral collector of text; however, Howarth (2000) cautioned:

[D]iscourse analysts using in-depth interviewing have to be aware of ways in which social subjects retrospectively construct narratives in particular ways, the role of the interviewer's own subjectivity in staging and organizing the interview, and the changing power relations between interviewer and interviewee. (p.140)

This research utilised a variety of texts, which can be divided into two main categories:

1. Pre-existing texts about gender and nursing; this included writings, both academic and non-academic, two films; and
2. Transcribed interviews with selected men who are nurses.

As the process of analysis and writing evolved it became evident that the pre-existing texts, which are mainly from non-New Zealand sources, were the primary source of data. The co-researchers, individually and collectively, were the human voices which illuminated the emotional responses to the discourses which impacted upon them. At times during the analysis they took the role of a *chorus* who, from the New Zealand perspective, illustrated, reinforced and challenged the emergent themes from the literature.

Written material sources.

In the pursuit of the material that appears in the following chapters of this study over 750 other pieces of written text were collected, read and in some way informed this work either in my thinking or in their explicit citing in the final work. These data sources include:

- Articles in magazines, newspapers, and journals (both academic and non-academic);
- Books;
- Poems;
- Archival material; and,
- Proceedings from the House of Representatives.

Not all these texts were collected and analyzed within the context of this study. Ten years of teaching nursing, including eight years of teaching a course which focused on the socio-political aspects of men's health meant that I had already collected, read and critically reviewed a substantial body of work before the project commenced.

Spoken discourse: Interviews.

The co-researchers¹⁴.

In the course of this study 20 interviews were conducted with 18 co-researchers. All were Pakeha and all, but one, had received their nursing education in New Zealand. Four were currently enrolled in university programmes; two in Bachelor of Health Science (Nursing) degrees and two in Master of Health Science (Nursing) degrees.

The co-researchers' workplace settings included clinical nursing, education, administration, midwifery, mental health, and the armed forces. This reflects the horizontal career distribution which was selected as I wanted responses from people who were "positioned differently" (Marcus, 1994). An analysis of the respondents' nursing qualifications, horizontal and vertical career distributions is presented in Table 4.1.

¹⁴ The term 'co-researcher' has been deliberately used to reflect the social constructionist position that social processes sustain knowledge and are integral to knowledge development.

Table 4.1

The co-researchers horizontal and vertical career locations

Horizontal career location		Vertical career location	
<i>Location</i>	<i>Number</i>	<i>Current position</i>	<i>Number</i>
Mental health	3	Staff nurse	5
General nursing (adult medical & surgical)	6	Charge nurse	3
Paediatrics	1	Student nurse	2
Emergency	1	Enrolled nurse	1
Gerontology	1	Lecturer	2
Education	4	Administrator	4
Midwifery	1	Clinical tutor	1
Armed Forces	1	No longer nursing	2

It can be seen from Table 4.1 that in terms of workplace culture I chose men who were also differently positioned in terms of the vertical career axis, thus, they ranged from students, to clinicians, through to Charge Nurse and above. The words 'above' and 'vertical' are used advisedly and is not to be read as the researcher positioning one work role and experience as superior to another. It refers rather to the traditional view that holds career to be a step-wise progression along a vertical axis.

In Chapter Two the second assumption underpinning social constructionism was described, which contends that knowledge is a product of a historically and culturally situated exchange between people. The construction of self is understood as a locally situated practice rather than a global truth (Harré, 1989; Sampson, 1989; Shotter, 1989). Bearing this in mind, I also endeavoured to have a wide range of age groups represented, from those who had recently completed or commenced their nursing education to one who was nearing retirement from the workforce having spent over 40 years in nursing. I reasoned that there might be interesting contrasts between the experience of the men depending on both age and the length of time they had been involved in nursing.

In terms of both the horizontal and vertical career axes, most of the respondents had been multiply positioned throughout their careers and some were holding several roles simultaneously. For example, the Enrolled Nurse (EN) was also currently a student in a nursing degree programme, some had worked both as psychiatric nurses and general nurses, and several had been in senior administrative positions but had moved either horizontally into education or vertically returned to positions as staff nurses. One was on the verge of moving out of nursing altogether. The mobility and fluidity in the respondents' careers is not reflected accurately in Table 4.1 where they are categorised according to their current (at time of interview) career positioning, which in two instances has meant that they are included in two vertical career categories.

The decision to limit the number of participants to 18 was not based on a sense that the data were sufficient with respect to whether anything new was being learned, but more on manageability in terms of being able to conduct a thorough analysis of the data. As Wood and Kroger (2000) observed for the discourse analyst:

The concern is not so much with exhausting categories as with identifying some of the ways that people use language and working through these in detail. So the notion of saturation in discourse analysis is much more elastic: The endpoint is not that one

stops finding anything new with further cases, but that the analysis of the cases considered to date has been thorough. (p.81)

Selecting the co-researchers

Certainly, my *native* status has facilitated the process of participant selection. I was able to tap into both formal and informal networks to select the participants in this study. Both purposive and snowball sampling have occurred. Some of the men who agreed to participate in my study were purposely selected because prior acquaintanceship made me aware that their experience would provide valuable insights. With respect to snowball sampling, discussions about this study with colleagues and others in the nursing profession led to the inclusion of some participants whom I had previously not encountered professionally; several of the participants also suggested others whom they thought I might be interested in talking with.

Such a sampling method does not pretend to representativeness, although in line with the recommendation of Biernacki and Waldrof (1981) the referral chains were controlled in an endeavour to ensure participants from a diverse range of professional settings. In this way the “sample includes an array of respondents that in qualitative terms, if not in rigorous statistical ones, reflect what are thought to be the general characteristics of the population in question” (ibid, p.155). It was an effective process in that there was no difficulty encountered in recruiting participants. No one, who was approached, declined the invitation to participate nor did any participant subsequently withdraw from the study.

Criteria for participation

Because the focus of the study was the experience of men who are nurses in New Zealand, participants were required to be men who had either undertaken their nursing education in New Zealand or who had spent a considerable portion of their nursing careers in New Zealand. The primary focus was to be on the Registered Nurse who is male. The title Registered Nurse is used in a generic sense here to indicate that the nurse has been awarded the right to registration in New Zealand by The Nursing Council of

New Zealand (Te Kaunihera Tapuhi o Aotearoa). In 1939 The Nurses and Midwives Registration Amendment Act created the title of Registered Male Nurse and men were able to be entered onto the register of nurses for the first time in New Zealand. Depending on the date of registration and the nature of their training, men have been variously able to become a Registered Male Nurse (RMN), Registered Psychiatric Nurse (RPN), Registered General Nurse (RGN), Registered General and Obstetric Nurse (RGON), Registered Psychopaedic Nurse (RPdN), or Registered Comprehensive Nurse (RCompN). Since the Health Practitioners' Competence Assurance Act (2003) came into effect all nurses registered under the Act are titled Registered Nurse and have conditions placed upon their scope of practice according to their qualifications. Men have also been admitted to the roll of nurses (Enrolled Nurse) by the Nursing Council of New Zealand.

As data collection proceeded I began to be increasingly concerned with the representativeness of the participant group. Aware of the "politics of location", I was seeking diversity in the range of nursing roles men inhabit (Koch & Harrington, 1998). On this basis I decided to include Enrolled Nurses, student nurses, and one man who had qualified as a nurse abroad but had been employed for many years in nursing in New Zealand. Eventually, the criteria for inclusion became: (1) employment in nursing in New Zealand, either currently or formerly; and (2) the recipient of, or in the process of gaining, a formal nursing qualification.

I acknowledge that there are many men making a significant contribution to nursing care through employment as caregivers or nurse aides, etc. I have deliberately excluded them from this study for two reasons: (1) I was interested in the participants' experiences of nursing education; and (2) a formal qualification allows more mobility within nursing, either horizontally or vertically, and this was also an area I wanted to investigate. Men employed in the caregiver role are more limited in terms of their scope of practice and their career development, therefore, they were not perceived as being able to contribute significantly to this particular study.

Gaining consent and maintaining anonymity and confidentiality

My initial contact with the prospective participants was made either by telephone or email. I briefly introduced myself and the study to the prospective respondent; if this

prompted an interest to participate a Participant Interview Sheet was sent (Appendix A). Before commencing the interview(s), written consent to participate in the research was obtained (Appendix B). The participants were provided with two options with respect to their involvement:

- 1) Face-to-face interview only, or
- 2) Provision of written personal written material in which they had reflected upon their nursing careers, followed by a face-to-face interview to discuss the material provided.

The participants were informed that they could withdraw from the study at any time up until February 2004 when it was anticipated that writing of the findings would commence. Consent for audio taping was obtained and at the end of the interview verbal consent for a second interview was gained from some of the men. This occurred when the first interview was found to be too short to do justice to the participant's experience. All participants received copies of their interview transcriptions.

Ethnicity, age, and educational qualifications were recorded status at the beginning of the first interview. Their current employment and details of previous work experience emerged as part of the interview process. In the interests of anonymity, pseudonyms were used when transcribing the interviews, in all subsequent writing, and discussions with my thesis supervisors¹⁵. Interview tapes and computer disc transcriptions were locked separately in two different locations. The consent forms were also locked and stored separately from the interview data.

The primary consideration of the researcher must be the safety of those who participate in the study alongside him and this has proved a dilemma on two counts. First, the number of men who are nurses in New Zealand is relatively small, therefore, it is possible - even with the best endeavour to ensure that the participants are not identifiable - that there will be some readers who may be able to identify, or at least assume they know the identity of, a particular participant. This has been especially problematic in the case of several of the participants who hold, or have held, either unique or prominent positions in nursing within New Zealand. I discussed this aspect verbally with all those participants for whom I considered the possibility of such

¹⁵ All names have been changed, including those used by the co-researchers when naming other people.

disclosure could occur and each one stated his comfort with the possibility of identification. Upon receiving a copy of the transcript no one withdrew or asked for any aspect to be deleted.

The second dilemma also related to possible identification of some of the individuals who were part of the narratives. I have tried to be mindful of the admonition of Cant and Sharma (1998) that the researcher “may be ‘in’ the written narrative as both a private and a professional person, but the professional person must also stand outside the story, exercising professional judgement on behalf of all concerned” (p. 249). It is to be hoped that the precautions taken on behalf of the co-researchers will also protect those spoken of in their stories from identification and potential harm.

Wellard and McKenna (2001) discussed issues surrounding turning tapes into text. Their review of the related literature revealed that little consideration is given to confidentiality issues with respect to the person transcribing interviews and the type of sensitive information to which they might be privy. This may make assurance of confidentiality more difficult. A further protection for the anonymity and confidentiality of the participants lay in the fact that I was the only person with access to the audiotapes and I did all the transcribing. The participants were verbally apprised of this at the time of the interview.

The interview process

The interviews with the participants were collected over a 9-month period, between March and November 2003. The majority of the participants were located in one major New Zealand city, but five were interviewed in two other locations. The interviews took place at times and venues selected as convenient by each participant. Efforts were made to ensure that the audio taping occurred in quiet surroundings that would be free from interruption. All the interviews involved hospitality of some sort; usually the sharing of coffee or tea but occasionally the interviews occurred before or after a meal. This was done in order to make the experience as comfortable as possible to encourage openness and self-disclosure from the participants.

The first two interviews, which occurred with men well known to the researcher, were intended to achieve two aims: (1) testing of the adequacy of the interview schedule (Appendix C); and (2) practice of being able to conduct a relatively naturalistic

conversational exchange which systematically covered the range of topics of interest. Feedback was requested following these two interviews. My note taking was clearly distracting and subsequently no written notes were taken during the interviews. It is arguable that the decision to not take field notes has limited the interview to only one component, that of sound (or its absence). Sandalowski (1995) suggested that facial expressions, body movements and gestures, tone of speech and length of pauses be documented in supplementary notes. Potter and Wetherell (1987), however, questioned the need for such documentation and suggest that attention to such fine detail is not crucial and can potentially hinder the readability of the transcript. The decision to not make field notes was made to facilitate the most natural conversational situation possible. Those first two pilot interviews also revealed that the taking of written notes took my focus away from the conversation to a concentration on the written word.

Most of the interviews were between 60-70 minutes in length, although one spanned almost two-and-one-half hours in total. Five agreed to follow-up interviews, which occurred in two instances. What was interesting in this process was that once the audiotape was turned off at the end of the formal part of the interview, many of the conversations continued for some time afterwards. At times this was a little frustrating for the interviewer owing to the richness and fascinating nature of what was being revealed. Hutchinson, Wilson and Skodol-Wilson (1994) remarked that the participants in the research process may benefit from self-acknowledgement, increasing self-awareness, catharsis and empowerment. It can be inferred from the laughter and the wide-ranging discussions that participating in the interviews was a mutually enjoyable and rewarding experience.

The format of the interviews was loosely structured and broad, open-ended questions were used to elicit the respondent's experiences or reflections about an experience. The interviews all opened with brief questions relating to biographical data; age and qualifications. The participant was then asked to describe the circumstances that lead to his decision to become a nurse. Subsequent questions tended to flow from what was being presented in the co-researcher's responses. I did, however, employ follow-up questions and probes in order to deepen my understanding of the co-researcher's responses. As Potter and Wetherell (1987) wrote, "It is not assumed that there is a single,

correct answer to a question and the interviewer's task is to ensure that the participant transmit the information completely and accurately" (p.72).

Generally, however, I tried to keep my interruptions to a minimum and allow the co-researchers free expression. For the first three or four interviews I followed the question schedule that had been devised as part of the application for ethical approval. As I developed confidence, I believed that such an approach restricted the co-researchers and the subsequent interviews were much more conversational and freer in the issues that surfaced. The interview schedule, although not always present physically, was a guide that enabled most of the interviews to cover roughly the same ground in terms of the issues raised, although not necessarily in the same order. When the interviewee seemed to have come to a natural halt in his description of an experience I would then ask another open-ended questions relating to the topics of interest; for example:

Grant: Yeah, I think we do. I do. When I start getting no vibes at work I think "What the hell is going on? Am I doing something wrong?" But I think men do.

Interviewer: To go off on a different tack for a moment, can you describe a situation where sexual harassment has ever been an issue for you.

While acknowledging that the focus was on listening to and recording the co-researchers' experiences, I was aware that I was in interaction with colleagues and wanting to minimise researcher-participant power differentials I did at times share from my own nursing and life experience. In this way there was to some degree reciprocity in the process. On several occasions, I found myself being briefly interviewed as interest was expressed in my experience.

Generally, I found that rapport was easy to establish with the participants. As Roy (2001), however, noted "in any social relationship there are some people it is easier to establish a rapport with than others, so too in interviews such as these" (p.67) and this proved true in this study. There were three interviews that I found particularly difficult; two, because the rapport did not come readily and one in which I found some of the experiences being described particularly disturbing as he described traumatic experiences in his early years of nursing. What struck me forcibly was the willingness of those interviewed to talk about challenging personal and professional experiences, not all of which presented the interviewee in a flattering manner.

Transcribing the interviews

There are a variety of transcription conventions, of varying degrees of complexity, employed in discourse analysis (Wood & Kroger, 2000). The various systems represent different features of speech, for example, intonation, stress, pauses and so on, with different degrees of detail (Fairclough, 1992). Nevertheless, according to Macleod (2002) most of the transcription systems emphasise readability and ignore nuances of pronunciation, speed and intonation. Sandelowski (1995) cautioned against the *recipe* approach to data management that could “lead to lack of creativity and violation of the spirit of qualitative research” (p. 371). Whichever system is adopted, according to Macleod (2002) the process is one of translation requiring:

[D]ecisions concerning where to place a full stop, a comma, a pause, inverted commas, *etc.* so as to reflect as closely as possible what I as listener hear, so that you as reader may “hear” the same thing when reading the material. (p. 21)

Wood and Kroger (2000) contended that there are some common requirements for making and using transcriptions regardless of the system utilised, particularly the need to make a thorough transcription. Thus, a transcription of all speakers’ contributions is required. Field and Morse (1995) also advocated word for word transcription. This includes the questions and comments of the researcher, which are included as context for the answers.

It is, of course, impossible for a reader to *hear* the recorded speech from the written transcript no matter how detailed it may be, and different listeners would possibly translate the spoken text into written text in different ways. Transcription, particularly in the notion of translation, also imposes an *interpretation* on speech (Fairclough, 1992). Consequently, no single authoritative version of a transcript is possible (Macleod, 2002; Wood and Kroger, 2000). All interviews were transcribed verbatim including all pauses, hesitations, repetitions, grammatical and syntactical errors and the narrative sections chosen for the first draft of the thesis were exact copies of the original transcripts. After a period of reflection and discussion with my supervisors it was decided that in many instances this hindered both the narrative flow and understanding. The material chosen from the transcripts for inclusion in the finished work was subsequently *re-interpreted*,

by the removal of hesitations, repetition and digression; grammar was introduced based on the accepted conventions and text added for clarification.

The system adopted for this study and examples of how the initial transcripts were re-interpreted for presentation is described in Appendix D.

Other spoken discourse.

As a dedicated filmgoer, for me, the viewing of a movie provides a weekend ritual, a social occasion with friends and, in this case, an opportunity to switch off from continual rumination on this study; however, during the period in which the interviews were being conducted a social outing with friends to view a critically well-received film by the Spanish writer and director Pedro Almodóvar (2002) *Hable con ella* (English translation: *Talk to her*) provided a fortuitous opportunity for further data collection and critical reflection on the theme of the problematization of male sexuality which is explored in Chapter Ten.

A second movie, *Meet the Parents* (Glienna & Clarke, 2000), which I happened to view, by chance, one evening during the writing period also proved a rich source of data, particularly, with respect to the discourse of the man in nursing as an “inferior” type of man.

Analysis

Literature analysis.

As previously noted on page 59 I had been engaged with the literature related to men and nursing over a number of years and from this comprehensive exploration I had identified the key themes as:

1. Nursing’s positioning as a *female* profession.
2. The ideology of hegemonic masculinity as a barrier to men as carers.
3. A professional response to men in nursing that was ambivalent.
4. A societal reaction to men in nursing that was largely negative.
5. Studies of men in nursing that focused on adherence to normative scripts of masculinity, particularly with respect to career development.
6. The problematization of men’s sexuality.
7. The construction of caring as a female attribute.

The interviews were undertaken to explore these themes from the perspective of men who inhabited these discourses.

Organising the interview data.

The interviews provided 278 pages of data. The analysis began by close reading and rereading of the material in order to sort the material into thematic “bites.” As I read the interviews I made rough thematic notes, giving each theme a key from those which had been identified previously during the analysis of the literature. A further reading and period of reflection allowed the identification of sub-themes, which were also allocated keys. The text was then re-read with the, now expanded, keys being noted alongside the pertinent sections of the material. The transcripts were then photocopied and the marked bits of text cut out. These were then sorted into collections according to the keys; organizing (or coding) the material by thematic keys was a precursory act to the actual process of discourse analysis and deconstruction. The analysis *per se* necessitated my reading and re-reading the groups of text pieces, as I simultaneously engaged in the conceptual work required by deconstructive discourse analysis.

Conclusion

This chapter has described the processes that have occurred in bringing this study to fruition. It commenced with laying open the audit trail with respect to gaining approval for the project and arriving at the criteria used for one part of the text collection, that of participant interview. The other types of text used in the analysis were described and the chapter concluded by providing an overview of the process of data analysis.

CHAPTER FIVE: Being a man

“Men, men aren’t nurses, real men aren’t nurses”; with these words Grant described the reaction of his friends and colleagues to his decision to become a nurse. Within the context of the Western gender order this chapter will describe what is meant by the notion of a *real* man. It will illuminate how a particular type of masculinity has come to be perceived as the exemplar of true masculinity in New Zealand. The exploration of the image of normative masculinity will provide the basis for the deconstruction of the contradictions and paradoxes that impact upon men’s involvement in nursing.

Defining masculinity

The structure at the bottom of the male psyche is still as firm as it was twenty thousand years ago. (Bly, 1990, p. 230)

In order to ascertain why nursing is not a proper role for a man, a working understanding, or definition, of masculinity is required. According to Connell (1995) in its modern usage the term “assumes that one’s behaviour results from the type of person one is” (p.67). Thus, a man’s masculinity is assigned according to his behaviour, but masculine behaviour is dynamic and a number of authors (for example: Coltrane, 1994; Connell, 1995, 2000a, 2000b, 2002; Kimmel, 1997) have questioned the notion, implicit in the quote above from Bly (1990), that masculinity is an innate, *essential* quality that imbues a man through the surge of androgens. According to Kimmel (1997):

Manhood is neither static nor timeless; it is historical. Manhood is not the manifestation of inner essence; it is socially constructed. Manhood does not bubble up to consciousness from our biological makeup; it is created in culture. Manhood means different things at different times to different people. (p.224)

Definitions of manhood change and as Connell (1987; Connell, 2000a) pointed out there is no one pattern of masculinity that is found everywhere. Therefore, we need to speak of *masculinities*, not masculinity. Different cultures, and different periods of history, construct gender differently. While this study subscribes to Connell’s theoretical

position with respect to the notion of multiple masculinities, the term *masculinity* is utilised because this study particularly focuses on the role of the hegemonic form of masculinity in creating the image(s) of the man who is a nurse.

In contemporary Western culture masculinity is frequently associated with physical strength, rationality, domination, competitiveness, sexual vigour, competitiveness, independence, aggression, control and power. These traits have been neatly summarized by Brannon (1976) in the following clusters of norms that define the male role:

1. No Sissy Stuff: The stigma of all stereotyped feminine characteristics and qualities, including openness and vulnerability.
2. Be a Big Wheel: Success, status, and the need to be looked up to.
3. Be a Sturdy Oak: A manly air of toughness, confidence and self-reliance.
4. Give'Em Hell! The aura of aggression, violence and daring. (p. 12)

According to Brannon the most salient facet is the proscriptive norm against anything feminine. The other three denote positive proscriptions for activity and an instrumental orientation. Thus, a man must be powerful, successful and wealthy, enjoying the status associated with such these elements. A man must be in control of his emotions, and present an aggressive and heroic façade to society at large.

From a semiotic perspective, masculinity is a relational concept; it is defined not at the level of the personality, but through a system of symbolic difference. Therefore, as Kimmel (1997) asserted, not only is our knowledge of what it means to be a man fluid but our definition arises from “setting our definitions in opposition to a set of *others*” (p.224). In particular, men are defined through opposition to womanhood regardless of race, class, age, ethnicity or sexual orientation. According to Connell (1995):

A culture which does not treat women and men as bearers of polarized character types, at least in principle, does not have a concept of masculinity in the sense of modern European/American culture. (p.68)

This dualism and the creation of identity through opposition with otherness has been an important feature in the construction of modern Western masculinity (Flannigan-Saint-Aubin, 1994; Mosse, 1996; Weeks, 1985). According to Buchbinder (1998) the polarized, or binary discourse, positions men as not only constructed through

their opposition to women, but also as part of a discourse in which transgressive homosexuality conflicts with normative heterosexuality. As Weeks (1985) commented, the male identity is maintained through “the constant threat of warding off threats to it. It is precariously achieved by the rejection of femininity and homosexuality” (p. 190).

In Europe, prior to the eighteenth century women were not regarded as different from men, but more as inferior examples of the same character (Connell, 1995). Women and men were not perceived as possessing qualitatively different characters, which was a development of a bourgeois ideology which emerged in the late eighteenth century. This was the node from which a stereotype of masculinity emerged, one that is still recognisable today (Mosse, 1996). The Western concept of masculinity is therefore a relatively recent concept and derives from a culturally specific way of thinking about gender.

Sex role theory

With respect to contemporary understandings of masculinity an influential field in the development of a social science of masculinity has been role theory and its application to gender through the concept of sex roles. Sex roles can be understood as patterns of social expectation; norms (or stereotypes) for the behaviour of men and women. The sex role is a widely held, taken-as-given part of everyday life; however, as Connell (1995) highlighted it is a relatively recent concept. In the late 1920s a new theoretical base for researching gender was developing in social anthropology with the emergence of ethnography as a method of study. From the work of early researchers an understanding of the relativity of gender emerged. For example, Mead (1935, 1955) observed in New Guinea:

I found three tribes all conveniently within a hundred mile area. In one, both men and women act as we expect women to act-in a mild parental responsive way; in the second, both act as we expect men to act-in a fierce initiating fashion; and in the third, the men act according to our stereotype for women-are catty, wear curls and go shopping, while the women are energetic, managerial, unadorned partners.
(preface to 1955 reprint)

The idea of gender relativism and development of the concept of the *social role* in the 1930s was instrumental in the popularisation of the concept of *sex roles* in the 1940s and 1950s (Buchbinder, 1998; Connell 1995, 2000, 2002). With respect to its application to the study of gender, role theory has most commonly become synonymous with the notion of the sex-role stereotype: the generally held beliefs about the traits and abilities possessed by men and women. Male sex roles came to be defined as *instrumental*, whereas female sex roles were typed as *expressive* (Parsons & Bales, 1956). Thus, men have become characterized as strong, aggressive, competent, objective, dominant and ambitious, while women have been attributed with the traits of warmth, caring, nurturing, compassion and sensitivity (Egeland & Brown, 1988). Such polarity underlies the belief that some occupations are more suited to one gender than the other. Nursing is, of course, the outstanding example of a sex-typed occupation and numerous studies have described the association between sex-role stereotyping and nursing (for example: Choon & Skevington, 1984; Egeland & Brown, 1988; Fitzgerald, 1995; Fottler, 1976; Hesselbart, 1977; Holroyd, Bond, & Chan, 2002).

Adopting this approach to the study of gender there are always two sex roles in any cultural context: male and female, and gender differences are conceived of as innately given (Coltrane, 1994). The difference between sex and gender is largely ignored. West and Zimmerman (1991) suggested that *sex* is a “socially agreed upon biological criteria for classifying persons as females or males” whereas, *gender* is “the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one’s sex category” (p. 14). They maintained that roles are “situated identities - assumed and relinquished as the situation demands - rather than master identities” (p.16). Unlike roles, such as doctor or nurse, gender has no specific site or organizational context. Thus, they argued, gender is not a role, nor a series or traits but rather gender is something “we do”; it is the product of human action.

Connell (1995) identified three problems with sex role theory in its use of normative definitions, i.e., assumptions about what should be. First, normative definitions recognize that difference occurs at the individual level, but in treating masculinity as the blueprint for men’s social behaviour a paradox occurs. It does not necessarily equate with what actually happens at the level of face-to-face interaction. Very few men match the blueprint of toughness and independence embodied in the rules

outlined earlier in Brannon's (1976) description of masculinity. No one man can measure up to such a model; therefore, what is normative about a norm hardly anyone meets?

The second problem is that a purely normative definition provides no understanding of masculinity at the personal level. There is an unsustainable assumption that role and identity correspond, that gender is "resident within the individual, a quality of trait describing one's personality, cognitive process, moral judgement, etc." (Bohan, 1997, p. 32). This assumption draws sex role theorists into essentialism, which Bohan reasoned produces models which:

[P]ortray gender in terms of fundamental attributes that are conceived as internal, persistent, and generally separate from the on-going experience of interaction with the daily sociopolitical contexts of one's life. (p.33)

The fundamental attribute, or essential quality, is an arbitrary choice; essentialists may not agree upon the choice of essence. Yet, this arbitrarily chosen attribute becomes the core upon which "to hang an account of men's lives" (Connell, 1995, p.68). Feminism has challenged thinking and expectations with respect to gender and the notion of gender stereotypes has also been questioned by the emergence, in the 1980s, of social constructionism. According to Bohan (1997), however, with respect to understanding women a group of popular approaches are based on essentialist premises (for example: Belenky et al., 1986, 1997; Gilligan, 1977, 1982; Noddings, 1984). Bohan (1997) summarized these models as suggesting that girls and women have different experiences than do men and boys and that these experiences produce distinctive modes of thinking, judging, and relating. From a deconstructive perspective these models not only identify the binaries, for example, male/female, assertive/passive, and so on, which are associated with gender but they also reverse them to validate women and to claim their perceived qualities as primary.

It has been asserted that women, as an oppressed group, have developed the ability to exist in two worlds: their immediate reference group and that of the dominant group: men. Thus, women become skilled in:

[S]ensitivity to the expectations and the responses of others; this vigilance is manifested as a morality of caring, as a sense of self grounded in relationships, and as subjective and connected knowing. (Bohan, 1997, p.34)

Herein, resides the third problem with sex role theory identified by Connell (1995): the dichotomy of male and female creates an exaggerated focus on the differences between men and women, which obscures the effect of race, class and sexuality. Sex role theory fails to adequately account for issues of power both between the genders and within gender divisions.

While it might be tempting to construct an image of man as victim, from the perspective of postmodern feminist standpoint epistemologies it risks complicity with those who would avoid acknowledging the dominance that men have exercised over women. It is more productive to focus on what Kaufman (1994) described as “men’s contradictory experiences of power.” Connell (1987, 1995, 2000a, 2000b) applied Gramsci’s (1974) concept of hegemony to the study of masculinity. He highlighted the fact that typically some expressions of masculinity are more honoured than others. Some are actively dishonoured; for example, homosexual masculinities in modern Western culture and others, such as disempowered ethnic minorities, are socially marginalized. He employed the term *hegemonic* masculinity to describe the form of masculinity that is culturally dominant in a particular setting. In New Zealand, indeed throughout Western culture, it is arguable that the hegemonic form of masculinity is white, heterosexual and middleclass. The dominance of a hegemonic form of masculinity can lead to men feeling both powerful and powerless. Kaufman (1994) explains this contradiction, thus:

Although most men cannot possibly measure up to the dominant ideals of manhood, these maintain a powerful and often unconscious presence in our lives. They have power because they describe and embody real relations of power between men and women *and* among men: Patriarchy exists as a system not simply of men’s power over women but also of hierarchies of power among different groups of men and between different masculinities. (p. 144)

What is particularly salient is the privileging of heterosexuality and the subordination of homosexuality by hegemonic masculinity (Connell, 1995; Corbett, 2001; Lock & Kleis, 1998; Mosse, 1996). This is actualised in the work place by what Butler (1990) terms the “heterosexual matrix”:

[A] hegemonic discursive/epistemic model of gender intelligibility that assumes that for bodies to cohere and make sense there must be a stable sex expressed

through a stable gender (masculine expresses male, feminine expresses female) that is oppositionally and hierarchically defined through the compulsory practice of heterosexuality. (p. 151)

Heterosexuality governs Western culture today and any challenge to normative heterosexuality is met with efforts to obliterate the differences (Flannigan-Saint-Aubin, 1994; Mosse, 1996). In the twentieth century the most extreme form of eradication of such differences was seen under the National Socialists in Germany. Not only did they persecute Jews, blacks and Gypsies following the passage of the Nuremberg racial laws, but they also identified *asocials* who were seen as countertypes to the normative stereotype and thus a threat to Aryan society. The asocials included vagrants, habitual criminals, beggars, the physically and intellectually handicapped and homosexuals; they were included with those destined for extermination.

While such extreme measures to negate otherness are no longer in place legislatively in Western nations, discrimination remains part of the everyday experience of the homosexual. As Connell (1995) noted such discrimination, which includes political and cultural exclusion, cultural abuse, legal violence, street violence, economic discrimination and personal boycotts, positions homosexual masculinities at the bottom of the masculine gender hierarchy.

This positioning has considerable implication for men who are nurses. Within this framework, men entering *female* occupations such as nursing, pre-school teaching and hairdressing do not conform to the script of hegemonic masculinity and risk having their gender identity questioned. By choosing a workplace role that is considered unmanly they become associated with effeminateness and homosexuality (Nordberg, 2002). This is the matrix within which nurses who are male - particularly those who are general nurses - construct both their masculine and professional identities, and in which they experience gender with women, other men and with men who are nurses.

Although Connell's conceptualisation of hegemonic masculinity provides an elegant framework within which to situate this analysis of the experience of men who are nurses, it has not been received uncritically. Connell replaces Gramsci's description of ideology, which shapes hegemony, with a system based on the power dynamics of class, race and sexuality founded in a patriarchal system. Dudink (2004) argued that this risks

“privileging” patriarchy and lends itself to avoiding a focus on how power came to be gendered. Holter (2002) also warned against an uncritical acceptance of the concept of hegemonic masculinity, or what he terms a “gender-class” model. He contended that this Anglophone perspective, while useful, has little to say about change other than at the individual level. There is no focus on how men can become “an active force *for* gender equality” (p.4). Dudink and Holter, working in non-Anglophone environments, debated the assumption implicit in hegemonic masculinity that the patriarchal dividend is universal. They mooted that the study of masculinities requires the investigation of its real-life variation in an historical context. As was seen earlier in this section, however, Connell does not argue that all men are *primus inter pares*. He also contended that it cannot be assumed that there are stable structures of masculinity and the changes in conceptual masculinity reflect a dynamic historical process.

A brief history of Western masculinity

Earlier it was asserted that the modern stereotype of Western masculinity began to surface at the end of the eighteenth century and, in keeping with Mosse’s (1996) warning against ignoring the contribution of previously held ideas of masculinity, to understand the current pattern of masculinities we need to look back over the period in which it came into being. Connell’s (1995) historical analysis revealed that the construction of the modern concept of masculinity was shaped, in particular, by three themes: the unprecedented growth of European and North American power, the creation of global empires and the global capitalist economy, and the inequality of gender orders in the colonized world.

The modern gender order began to take shape in the North Atlantic region, concomitant with the emergence of the modern capitalist economy, during the period from about 1450 to about 1650. A profound cultural change took place that produced new understandings of sexuality and personhood in metropolitan Europe. The spread of Renaissance secular culture and the Protestant reformation, created an upheaval in the long-established and potent ideals which ruled people’s lives. The power of religion to control the intellectual life and understandings of personhood and of sexuality was challenged and losing its pre-eminence in people’s lives: “Marital heterosexuality displaced monastic denial as the most honoured form of sexuality” (Connell, 1995, p.

186). This shift emphasised the role of the family structure and, with the husband as its head, marital heterosexuality became intrinsically tied to the structure of patriarchy and heterosexuality became compulsory as part of this family life.

There was a new emphasis on individuality and the concept of the autonomous self. Influenced by the philosophy of Descartes, reason and science were divorced from the natural world and emotion. Masculinity was equated with culture and rationality and a Western world-view in which European nations saw themselves as the bearers of a reason, which must enlighten the savage world, emerged. This created “a cultural link between the legitimation of patriarchy and the legitimation of empire” (Connell, 1995, p.187).

Empire building.

Empire (or colonization) was initially a gendered enterprise, a result of the segregated men’s occupations of soldiering, sailing, trading and administration (Connell, 2000). The armies that subjugated the peoples and nations that became the European empires were male, as were the bureaucracies that maintained them. The imperial ideology was masculine in its goal of conquest, subjugation and control; an explicit link between violence and masculinity was created. Connell (1985) suggested that the men on the colonial frontiers “were perhaps the first group to become defined as a masculine cultural type in the modern sense” (p. 187). He cited the example of the Spanish “conquistadors” who were not only removed from customary social relationships but were brutal in their search for land and the exploitation of the country’s natural and human resources. This development, the creation of overseas empires by the European nation states, will be shown to have had a significant influence on the development of masculinity in New Zealand.

A further key development in the growth of European and North American power, which was also linked with the colonial impetus, was the growth of cities that were not only the centres of commercial capitalism, but also were a new setting for everyday life (Connell, 1995). The growth of the cities was accompanied by two other important processes: enclosure and industrialization.

Enclosure and industrialisation.

In the early 1500s a social upheaval began that created paupers of the peasantry. During the Middle Ages the village commons were the primary social units in England. The peasantry comprised a village community of shareholders who farmed the majority of the land on a collective basis. In response to new economic forces, principally making land available for sheep and the newly profitable wool trade the common land began to be enclosed. Supported by Acts of Parliament, land that had been used for generations by subsistence farmers was enclosed into grazing land for sheep. The enclosure revolution impoverished and suppressed the peasants, while the lords and large landowners made fortunes.

Industrialization completed the enclosure process. The millions of peasants dislodged from the commons were forced to migrate to the newly industrialized cities. There they began to sell their labour in the market system. The factory rather than the farm became the new centre of life. The industrialised city was an essential element in the expansion of bourgeois society and the construction of the modern image of masculinity.

Mosse (1996) suggested that emergent middle-classes drew upon previously held ideals of aristocratic honour, and the Romantic revival of the early nineteenth century allowed the Medieval concept of chivalry to persist-albeit in an altered form-into the present. Thus, a man became defined by values such as loyalty, righteousness, prowess, sobriety and perseverance. These qualities, accompanied by a studied avoidance of sensitivity, nurturance and emotion, were the prerequisites for an ideal of heroic manhood (Brown, Nolan & Crawford, 2000; Mosse, 1996). Popular neo-Romantic novels by authors such as Sir Walter Scott and the influential writings of Thomas Carlyle, above all in *On heroes, hero-worship and the heroic in history* (1841), exemplified the moral commitment to life and death in the pursuit of heroic manhood. Victorian Britain was a fertile ground for development of heroic manhood such as the suicidal charge of the Light Brigade in the Battle of Balaklava during the Crimean War

and the action of the sailors and soldiers of the *HMS Birkenhead*¹⁶ in 1852, who established the precedence of “women and children first.” Such examples of heroic manhood were celebrated and valorized in poems such as Tennyson’s (1854) *The charge of the Light Brigade* and Kipling’s (1896) *Soldier an’ sailor too* which contains the line, “But to stand an’ be still to the *Birken’ead* drill is a damn tough bullet to chew” (para. 5) The construct of heroic manhood persisted and in the 20th century was celebrated in masculine courage that was devoted to a higher purpose: in most instances the causes of their respective nations (Mosse, 1996).

The emergence of the European male stereotype in New Zealand.

Mosse (1996) argued that the British Empire was the arena in which Victorian character was tested and reinforced. In New Zealand this was exemplified by the display of imperial solidarity that was displayed by mobilization for *heroic* deeds in the Boer War in the late 19th century and subsequently in the two World Wars in the 20th century (Phillips, 1987). Male violence was channelled into service for the Empire and, during more peaceful times, into sport — particularly rugby.

According to Connell (1995), at the end of the 19th century team sport was being developed through the English-speaking world as a test of masculine status. Thus, the exemplary form of masculinity that emerged in New Zealand reflected the interplay between “the changing social relations of a settler population, the local state, the British imperial system and the global rivalry of imperialist powers” (ibid, p. 30).

It was suggested earlier that one of the major contributing factors to the growth of modern masculinity was the inequality of gender orders in the colonized world. This was certainly evident in New Zealand’s colonial history with respect to the Pakeha male.

The primary impetus for the arrival of European men in New Zealand from the late 18th century onwards was the exploration and exploitation of the country’s natural

¹⁶ On 26th February 1852, the soldiers aboard the troopship HM Transport *Birkenhead* set the precedent of “Women and Children First” as naval protocol throughout the world. When the ship foundered and sank legend has it that the troops stood to attention as the ship sank rather than swamp the few lifeboats that were able to be launched that contained their wives and children.

resources as part of the capitalist economy: whales, seals, gold, timber and land. Living conditions were harsh and the work was physical; learning to *rough it* became the hallmark of masculinity. This ability to adapt to challenging circumstances became a source of pride, and has been fundamental to the development of a specific underlying *hard* man culture that permeates the male stereotypes and values seen today. A culture which McGrane and Patience (1993) described as masculinist, racist and secular. New Zealand was defined as a *man's country*, which provided opportunity for “men with a stout heart in a stout body” (Phillips 1987, p.15). Strenuous, muscular activity became an essential element in defining a *real* man:

The humblest labourer, who earns his bread by the sweat of his brow, is held in higher honour than the haughtiest of fine gentleman who spend a dronish existence in doing nothing. (Wakefield, 1889 cited Phillips 1987, p.16)

Given the isolated and often harsh conditions in which the men laboured, during difficult moments they would have to rely on themselves or turn to other men for support. Mateship and the tacit knowledge that you could rely on your mates became an essential survival mechanism; male bonding became an integral element of a homosocial masculine culture. The core elements of the male culture were derived from the bonding that occurred in the gangs that cleared the land, in the shearing shed, gold mines and coal mines of rural New Zealand; they were reinforced in the public house, on the rugby field and in the wars fought on behalf of “Mother England.” A stereotypical image of the New Zealand male emerged which Phillips (1987) summarized as:

A rugged practical bloke – fixes anything, strong and tough, keeps his emotions to himself, usually scornful of women. Yet at heart a decent person, loyal to his mates, provides well for the wife and kids ... (backcover)

This stereotype has attained almost mythic dimensions and is encapsulated in the iconic figures of Colin *Pinetree* Meads, Barry Crump, Fred Dagg and Wal Footrot¹⁷.

¹⁷ Colin Meads is arguably New Zealand's most famous former All Black (the national rugby team), Barry Crump, author, characterised in his own life the New Zealand male stereotype, Fred Dagg was the comic alter ego of John Clarke who satirised the rural New Zealand male and Wal Footrot was the eponymous hero of the popular comic strip *Footrot Flats*, which also drew upon the rural New Zealand male stereotype for humorous effect.

These icons are rural based and belong to a generation that defined itself by “rugby, racing and beer.” While this stereotype has been assailed in recent times by urbanisation, immigration, feminism and the gay movement it has been a potent force in the development of the image of the kiwi male and provides a direct link back to this nation’s colonial past.

Mateship was transformed into an unspoken credo that you don’t *dob* in your mates, i.e., report on your work colleagues, even in situations of professional misconduct. Bart outlined his experience of this as a psychiatric nurse in an environment where violence against patients was “an accepted culture”:

The times that I saw it, I surmised very quickly that if you objected to it you would never work in that environment again, and I actually saw that happen. I saw a young chap [] he’d hit the wall a few times, and I remember him coming in with blood running down the side of his face, and the young chap there on student placement, who objected strongly to his treatment was told bluntly to fuck off and mind his own business. Needless [to say], he never went near that ward again, when his time was up there, it was “Thank you very much, don’t call us, we’ll call you.” It was a matter of my own personal decision never to do that sort of stuff myself, but also to be aware of it and if you kicked up too much of a fuss about it then you would become ineffective, because you would be marginalized and put out of the field.

Work hard and be a good boy: Capitalism and the gender division of labour.

Under the influence of Protestantism, the individual conscience could be exercised without the need for priestly intervention. Individualism emphasised self-reliance, achievement and competition, which in turn supported the development of modern capitalism (Brittan, 1989). Weber (1930) described the development of the “Protestant work ethic” whereby men would pursue an occupation as a moral imperative. Andrew describes the importance of the work ethic when he was a student nurse:

I excelled clinically in every which way, shape or form. I had one sick day in the whole three years [] I look back on it, it was part of my Lutheran upbringing: work

hard and be a good boy. That was natural, ingrained, it was almost genetic if you like [] it was meeting the requirements of my strong, rural, Lutheran family upbringing, being a good boy, because that's all that matters.

His words reflect an ideology that expects a man to be a hard worker. This theme is not only an important masculine construct but also, as will be discussed in Chapter Nine, a way in which men who are nurses endeavour to prove their value and gain acceptance in the world of nursing.

Being the "breadwinner"

Men have, by and large, accepted and conformed to a role which commits them to lifelong, full-time paid employment with all the advantages and disadvantages that this role entails. (Hartnett & Bradley, 1986, p. 215)

The first question that must be asked when considering the above quotation is why have men accepted the role and conformed to the requirements of the role of being in full-time paid employment? The answer surely lies in the ideology of patriarchal society which expects men to take responsibility for providing financially for a family.

Gamarnikow highlighted the complexity inherent in attempts to analyse the sexual division of labour. From the standpoint of *naturalism* labour processes are construed as masculine or feminine with direct reference to biology, as in motherhood, or owing to putative gender attributes. Capitalism, however, has also played a significant role in the sexual division of labour; the growth of cities and global expansion have been factors in the construction of the present pattern of gender-labour relations.

Men became the majority of the employees in the growing industrial system. There were several reasons for this. First, by the middle of the nineteenth century child labour had been limited in most industrialised countries, and second, in a time when pregnancy was frequent and often dangerous due to poor diet and lack of sanitation women were perceived as less reliable workers. According to MacInnes (1998) the demands of pregnancy and childcare lead to women being "construed by men as not being able to contribute to political or economic life" (p.17). Men having less demand placed on them with respect to reproduction were able to take advantage of that freedom such that the

balance of the sexual division of labour was in their favour overall. Thus, the sexual division of labour became a system favouring men, where:

Males and females routinely perform different activities or occupy different social roles, receive material rewards and have access to contrasting amounts of power and status because of their sex. (MacInnes 1998, p.1)

Although men as a gender enjoy the benefits of a patriarchal system, those benefits are not shared equally. Because of their physical strength men were also seen as ideal for the physically demanding work in mines and industry: work places, which have the highest rates of industrial accident and death. Interestingly, in the UK, the reformers-who had been successful in having child labour laws enacted-at the end of the nineteenth century were advocating laws to keep women from the factories in order to protect them from the dangers of the workplace. This development situated within an ideological system in which the heterosexual family is central lead to the need to ensure men a *family wage*, i.e., the minimum wage capable of supporting a family. Over time, industrial work became nearly synonymous with men's work, and so too did being the breadwinner become central to the masculine identity. This "duty to care" is significant in the lives of men.

According to the *Jobs Rated Almanac* (1992, cited Farrell 1993) , which ranked 250 jobs from the best to the worst based on a combination of salary, stress, work environment, prospects, security and physical demands, men almost exclusively occupied twenty-four of the twenty-five worst jobs. The only one that was not male-dominated was professional dancing which has a more equal gender balance. Many of these jobs are physically dangerous, such as in the timber industry or socially undesirable, for example, rubbish collecting. Men die at far higher rates in occupational accidents than women, for example, yet little consideration is given to the impulse that compels men to endure such occupations: the expectation to provide for a family.

Farrell (1993) suggested that many men are trapped in these jobs, or even those with much higher rankings because of, what he terms, "sacrifice-to-feed": "This 'sacrifice-to-feed' is the male form of nurturance. In every class, men with families provide their own womb, the family's financial womb. They provide their bodies" (p. 111).

For men as a gender, feminist analysis has highlighted the privilege of patriarchy; however, the notion of men's power is paradoxical. The unequal distribution of power leaves many men feeling powerless. The disadvantages of accepting the patriarchal gender distribution of labour may, for many men, outweigh the advantages.

According to Gallop (1997) men are characterised by objectivity and distance which is consistent with a model of separation and detachment, which she suggested are a "defence against qualities of warmth, connection, interest and 'caring about'" (p. 37). She is partly right and men have learned to "defend" against such gentler emotions because if they allowed them access then men might reconsider the adoption of the *male* role, which includes being employed full-time, because of the realisation that the personal cost is too great. Beyond the physical morbidity and mortality that may ensue from men's labour, there are also psychological costs: the time spent in the workplace has led to emotional distance from their families and themselves. Men are perceived as being less in touch with feelings, when it is possible that they are less likely to articulate their feelings and needs because they believe that such things are to be sacrificed in providing for their families.

Equally for women the societal forces that require them to adopt the stay-at-home parenting role can come at high personal cost; however, when women *choose* that role they are less likely to be exposed to social disapproval. This allows, for example, Amanda Billings to write in a letter to the Editor of *Metro* (2003):

And, to be honest, my dream includes some rather outdated and idealised features, the most important of which is the working husband who brings home the bacon while I have time to paint, act and sing with my kids. (p. 10)

It has been contended by MacInnes (1998) that we are seeing the "gradual death of the male breadwinner ideology" (p. 53). He argued that in countries where women form a substantial part of the labour force, male breadwinner ideology has all but collapsed in terms of popular support for its central tenet.

MacInnes (1998) is premature in asserting that the breadwinner ideology has collapsed. There may be a weakening of the ideology; however, discussion in later chapters will suggest that the association still remains a potent force in men's working lives.

Maintaining the bread winner role in nursing

In the movie *Meet the Parents* (Glienna & Clarke, 2000) one of the concerns of the future father-in-law is how a male nurse will be able to support his daughter. The combination of the male role as a breadwinner plus the low pay of nursing, have been suggested as contributing factors to men's under representation in nursing (Halloran & Welton, 1994; Meadus, 2000; Poliafico, 1998; Villeneuve, 1994). It is argued that women's roles in society are generally less valued (Cummings, 1995; Jacox, 1997), as a corollary, the notion that nursing is an extension of women's "natural" role, which will be explored in the following chapter, has created a situation in which nursing is considered of low value (Williams, 1992). George identified this as problematic for nursing in terms of the struggle for an appropriate wage structure, for "remuneration that reflected more than, you know, domestic servitude."

It is arguable that the role of breadwinner has been as powerfully gendered as that of the mother, so much so that boys learned of the expectation for them to go out into the workplace at a very early age in order to support a family. Holmes (1987) interviewed four fifteen year old boys about their attitudes to the nursing profession. They perceived it as a hard job, demanding long hours and most significantly as poorly paid. One of the boys, Paul, asked, "How could someone afford to support a family on the pay?" (p. 30). In this study, Phillip first seriously contemplated becoming a nurse in the late 1990s but his perceived financial responsibility to his wife and child precluded it. As he says, "I couldn't. I needed to earn an income, and I couldn't be a student at the time." Five years later following separation and the sale of the marital home he was able to undertake the student role and it was the associated loss of income that was the greatest challenge for his parents to accept: "I think it was more of a shock that I had suddenly decided to go back to school more than I was going to be a nurse, "Wow, how are you going to afford to do that?"

A number of the men commented about what they perceive as the poor pay of nursing, particularly for those men who have primary responsibility for financially supporting their family. According to Bart, "It wasn't a job to go into with a basic wage as a breadwinner." Jock expressed a similar sentiment:

Certainly nursing doesn't pay particularly well, so I guess for a large number of men in nursing if they want to support their family they do tend to move up the ranks because the higher level nursing positions pay more.

Within nursing it has been suggested that adherence to the breadwinner role may ultimately be to men's detriment. It is argued, in the UK, that as more men enter the register they will be part of an "ageing" profession in which they will face increased competition from both female and male colleagues for decreasing career opportunities in the NHS (Buchan, 1995). Professor Eric Caines of Nottingham University's Department of Health Care studies also contended that the men need to adapt because women will no longer need or want them to maintain the traditional role, "Women will become independent, economically, sexually and reproductively. It was those needs that forced men into traditional roles" (Naish, 1996, p. 30). The concept of men being "forced" into a traditional role as the primary source of financial support for a family dovetails neatly with the discourse that has constructed caring as natural for women which has "locked" them into that role (Orme, 2001). Both men and women in breaking away from traditional occupational roles suffer personal and occupational sanctions.

Conclusion

This chapter has briefly described the emergence of the normative image of masculinity in the Western world and New Zealand. It has suggested that many men are trapped by a normative stereotype, which requires them to avoid any characteristics typed as feminine, to be successful, self-reliant and demonstrate masculinity in displays of strength. It argued that the breadwinner ideology remains a potent force for the mapping of men's working lives and their relationships with women. The themes that have emerged in this chapter will reappear in later chapters in relation to the decisions men in nursing make with respect to their careers and the reaction of others to their choices.

The following chapter will, in contrast, explore the construction of the general nurse as female. It will describe the emergence of nurses as angels, mothers and handmaidens; associations which have become a powerful disincentive for men's involvement in the profession because of the strength of the prohibition against the male exhibition of characteristics which have become typed as female.

Chapter Six: The image of the nurse

The meaning of *nurse* and its relationship to the male experience is the subject of this chapter. I will argue that the nurse has been constructed as female, but that this is a relatively modern construction that emerged in the nineteenth century. Historical evidence, albeit brief, will be provided to support this contention and will critically analyse three powerfully gendered symbols, the angel, the mother, and the handmaiden, that have been used to construct nursing as women's work.

What is a nurse?

Everyone thinks they know what a nurse is. She is a young woman who wears a distinctive uniform and a crisp white cap and works in a hospital looking after sick people. (Salvage, 1985, p. 1)

Children today are not part of an era when the word train evokes a mental image of a steam-belching locomotive yet pictures are still drawn and pinned on walls, which subscribe to this image. Although, the description of a nurse provided above, is dated with respect to the contemporary appearance of a nurse, it is one that is often reproduced when a physical description is required.

The potency of this image was reinforced during a presentation given by a female lecturer in nursing studies on issues in Norwegian healthcare in 2004. The slides for the presentation were created in PowerPoint2000, and a feature of this software package is the ability to download "clip art" onto the slides, i.e., pictures or graphics to enhance the visual impact. During the discussion of the role of nurses in contemporary Norway, the image presented in Figure 6.1 appeared: a remarkable facsimile of the image described by Salvage (1985) at the beginning of this chapter. Even though contemporary nurses work in a variety of settings, in a diverse range of clothing styles and colours, and are neither necessarily female nor young, this image is so resilient that a nursing academic used it to graphically portray the nurse.



Figure 6.1. A popular image of the nurse (Microsoft Corporation, 2000).

This was not the only image of nurses provided by PowerPoint2000. The programme provides twenty-nine images; while not all are dressed in white uniforms and caps, all are recognisably female. When male images do appear there is nothing that distinguishes them as nurses; they could equally well be doctors, physiotherapists or orderlies.

There are other salient features about the above image that are associated with the construction of the popular image of a nurse. The clothing is white denoting, in the Western world, purity and the demure neckline suggests modesty. The features are calm, with the eyes downcast, and the hands are clasped in what could be interpreted as a submissive or attendant posture suggesting a co-operative maid servant or hand maiden waiting for orders. The nurse is constructed as female, modest and servile.

Another significant feature of the facial features is the lack of clearly identifiable race. The creators of the various images of a nurse available in PowerPoint2000 may not perceive the gender of a nurse as being anything other than female, but the race of this figure is not unequivocal: she could be either Caucasian or Asian. This may be the result of a simple economic rationale to ensure acceptability throughout the market place, but it could also be interpreted as a response to a worldwide discourse that constructs nurses as female.

The image presented in Figure 6.1 and the description provided by Salvage (1985) merely depict the physical appearance of the nurse: the image of a nurse is also redolent with spiritual and moral attributes. Kalisch and Kalisch (1982a; 1982b; 1983) conducted extensive research on the portrayal of the nurse by the North American media. They identified six periods within which distinctive images of nurses can be seen which Warner, Black and Parent (1995) used as the basis for their analysis of the image of nursing (Table 6.1).

From the perspective of discourse analysis what has been achieved is the formulation of *interpretative repertoires*. Potter and Wetherell (1987) defined interpretative repertoires as “basically a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events” (p. 138). Edley (2001b) makes the point that interpretative repertoires are “relatively coherent ways of talking about objects and events in the world” (p. 198); thus, distinct ways of thinking and talking have arisen which limit what it is possible to say (or not say) about nurses.

Table 6.1

The construction of the image of the modern nurse

Time period	Image	Attributes
1854-1919	Angel of Mercy	Honourable, moral, spiritual, self-sacrificing ritualistic.
1920-1929	Girl Friday	Faithful, dependent, co-operative, long-suffering subservient
1930-1945	Heroine	Courageous, chivalrous, fearless, humanitarian
1946-1965	Mother	Maternal, compassionate, unassertive, submissive domestic
1966-1982	Sex Object	Sexually promiscuous, self-indulgent, cold uncaring
1983-present	Careerist	Intelligent, progressive, assertive, sophisticated empathetic

Note. Adapted from Warner, C. G., Black, V. L., & Parent, P. C. (1995). Image of Nursing. In G. L. Deloughery (Ed.), *Issues and Trends in Nursing* (2nd ed., pp. 390-411). Philadelphia: Mosby.

Kalisch and Kalisch's (1982a, 1982b, 1983) and Warner et al.'s (1995) analyses do have a distinct North American bias, but given the pervasiveness of the mass media from the United States of America it can be argued that the periods and images they identify are relevant in most of the English-speaking world, and possibly beyond. Applying their analyses to the image presented in Figure 6.1, it appears to combine the attributes of both the "Angel of Mercy" and the "Girl Friday": both pure and subservient. What is striking intertextually is the hybridisation of the two images, each dominant in a different historical period, to construct an image which implies that being faithful and patient is also associated with the angelic nature of a good nurse.

The nomenclature in Table 6.1 clearly associates the first four periods of modern nursing with women. The last two periods, labelled sex object and careerist could be interpreted as gender neutral; however, they are loaded words that more likely carry negative connotations about women and their changing role in society. Certainly, the traits associated with sex object are negative. Although those used to describe the careerist are more positive, the period immediately following the second wave of feminism in the 1970s in which women began to pursue a more active role in the professions was one in which there was negative reaction to the "career woman" in some quarters.

Table 6.1 provides a convenient typology upon which to base an exploration of the construction of the image of nurses and nursing; however, it would be unwise to hold rigidly to the time parameters – the images overlap and spill over into the various time frames and coalesce so that the contemporary nurse carries with her (and him) the echoes and flavours of those former images. For example, the image of the "Angel of Mercy" was still present in New Zealand in the late 1950s, as this 1957 letter to the *Auckland Star* attests:

When a man's strength is gone, when his courage is failing, it may make all the difference whether his nurse is a man or a woman and who would want a male nurse messing about when he could suffer in the presence of ministering angels?"
(Letter to the *Auckland Star* cited in Brown, 1994, p. 132)

The writer of this letter draws upon a number of stereotypes associated with gender and nursing: the association of man with strength and the metaphor of the nurse who is female as a ministering angel. The placement of the adjective "male" in front of the title

nurse and the suggestion that somehow what a man who is a nurse does is merely “messaging about” implies that he is an inferior type of nurse. This phrase can also be interpreted as implying some form of impropriety with the author drawing upon a discourse of sexuality: the construction of the man who is a nurse as homosexual.

In this chapter, and those that follow, these discourses will be explored and deconstructed in order to describe the processes of social construction which in creating – and continuing to create – the nurse as female lock both women and men into proscribed gender roles. This chapter will critically discuss three of the images identified in Table 6.1: the Angel, Girl Friday and the Mother. It is contended that these three images, in particular, have been instrumental in constructing an image of the nurse as female, and conversely delineated nurses as “not male.”

Before the “Angel”

Historical consciousness is interested in knowing not how men, people or states develop in general, but, quite on the contrary, how this man, this people, or this state became what it is; how each of these particulars could come to pass and end up specifically there. (Gadamer, 1976, p. 116)

Nursing as a *natural* role for women is a relatively recent phenomenon that emerged in the 19th century (Halloran & Welton, 1994; Mackintosh, 1997; Poliafico, 1998). In particular, the work of Florence Nightingale and the international pervasiveness of Victorian values have played a pre-eminent role in the gendering of nursing (Christman, 1988; Donahue, 1985; Halloran & Welton, 1994; Masson, 1985; Meadus, 2000; Poliafico, 1998). In order to understand how and why nursing has become a predominantly female occupation it is useful to explore men’s involvement in the history of nursing and the changes in their relationship with nursing. A comprehensive description and analysis of the history of men in nursing is yet to be written.

A brief history of men in nursing.

The discussion now turns to an outline of the history of men in nursing in order to provide the historical context for this study of men who are nurses. While brief, it provides some historical *snapshots* to dispel the myth of nursing as a traditional female role. There is a focus on a particular historical node, the Victorian era, which was arguably the nexus at which nursing and women became associated. As well, the discussion will situate the New Zealand experience within the global discourse of gender and nursing.

Men in nursing before the Common Era

When endeavouring to trace the history of nursing it is often difficult to distinguish nursing from medicine, as there is a common past in the earliest attempts of mankind to cure illness and tend the sick. The evidence that exists from pre-literate society, such as carvings, drawings, and sculpture, suggests that the role of healing was intertwined with spiritual beliefs. From the documented legacy of some early civilizations, such as the Egyptians, Babylonians and the Hebrews, there is evidence of relatively sophisticated medical and public health knowledge; while functions are described that we would now call nursing it is not clear who performed them (Donahue, 1985).

The earliest documented trace of men in nursing appears to emerge in India in the 3rd century BCE. The Government of the Emperor Asoka built hospitals that employed doctors and nurses: the nurses were male (Masson, 1985). While Western health care has long credited Hippocrates of Cos (460-370 BCE) as the “father of medicine” through the establishment of a rational basis for medicine, perhaps, he should also be called the “father of nursing” (Levine & Levine, 1965). Hippocrates’ writings (*Corpus Hippocratus*) demonstrate that men were trained to carry out any treatment or therapy ordered by the physician (Cyr, 1992; Levine & Levine, 1965).

The Common Era prior to the Crimean War

The role of men in nursing in the western world becomes easier to distinguish in the Common Era and two influences have played a pre-eminent role in the evolution of modern nursing and men’s involvement in the care of the ill: Christianity and warfare.

The foundation of the monastic movement in Christianity created not only centres of religious learning and devotion, but also centres of healing; nursing the sick was an important function of the monastic ideal. This was reflected in the Benedictine rule, “Before all things and above all things care must be taken of the sick” (Donahue 1985, p.127). Even before the establishment of the monasteries as centres of healing, however, there had been groups of men dedicated to the care of the sick, such as the Parabolani Brotherhood which originated in Alexandria between 253-268 BCE in order to seek out and care for those suffering from the plague (Painton, 1994).

With respect to warfare, men had long been involved in caring for the sick and wounded; for example, men were trained to nurse the soldiers of the Roman Empire (Foreman, 1997; Valentine, 1996). The Crusades, however, created an environment in which these two strands coalesced with the creation of the military, religious and lay nursing orders. The most well known of these orders were the Knights Hospitallers of St. John of Jerusalem, the Teutonic Knights and the Knights of St. Lazarus (Donahue, 1985). The men of these orders not only provided care to the sick and injured but were also required to protect the hospital if it came under attack (Polifiafico, 1998).

Arguably, the most famous association of nursing and warfare lies in the figure of Florence Nightingale (1820-1910). Before she went to the Crimea, male orderlies nursed the British soldiers, although they had no training, except through experience and by working closely with surgeons (Brown, Nolan & Crawford, 2000). In the American Civil war, men were also involved in caring for the sick and injured; the confederate army designated thirty men per regiment to care for the wounded and remove those from the field who could not walk (Pokorny, 1992). The title of *nurse*, however, was only awarded to the women organized by Dorothea Dix, who was appointed Superintendent of the Female Nurses in the Union Army by the Secretary of War (Schultz, 1992). As well as those employed by the armies to care for the fallen there were also groups of male volunteers on both sides who also served as nurses. The most famous of these was the poet Walt Whitman (1819-1892). He is unusual in that he left a personal account of the care of the sick during the Civil War from a male perspective: two collections of poems *Drum-taps* (1865) and *Sequel to Drum-taps* (1865-6) and a memoir *Specimen Days in America* (1887). One of his most famous poems from this period is “The Wound Dresser”, which 150 years later still resonates as it describes activities and emotions that

nurses continue to experience. Whitman's ability, as a man, to undertake such nursing and to display the tenderness and empathy inherent in the poem raises questions as to how and why during the United States at this time and in Victorian England a belief emerged that men were unsuitable for, and even incapable of, such caring? This notion has been very persuasive creating a barrier to men's involvement in nursing.

Nursing care in colonial New Zealand

For the European settler 19th century New Zealand was essentially a man's country. The first colony-wide census occurred in 1851 and revealed that there were only 776 European women for every 1,000 European men (Phillips, 1987). It was a frontier society in which men were often engaged in work that was physically demanding and dangerous. These men had to be adaptable in order to cope with physical discomfort, which included broken limbs, lacerations and illness. If these men required medical or nursing care in the isolated conditions of the frontier they would have had to turn to one another.

The Provincial Government established four hospitals in the 1840s, all in the North Island. These hospitals were not easily accessible for those working and living outside of the centres in which they were located. The management of these early hospitals was under the direction of a "master" or "matron", and there was a mix of both males and females, mainly without formal training, providing the nursing care until the late 19th century (French, 1998).

The arrival of Nightingale-trained nurses in New Zealand in the late 1870s was welcomed by Dr. Duncan MacGregor, Inspector-General of Hospitals in New Zealand, he noted in Parliament in 1887 that such nurses were "well-trained, intelligent and lady-like, evidently drawn from a class very much superior to the old-fashioned hospital nurse of former times" (Appendix to the Journal of the House of Representatives, 1887, p. 3). The arrival of the Nightingale-trained nurses heralded the beginning of the *modern* period of nursing: a period in which men were not associated with the title of nurse, and there was an increasing strength in the association between nursing and women's work. This discontinuity in men's visibility in nursing was also seen in the US and Great Britain during this period (Brown, Nolan and Crawford, 2000; Poliafico, 1998).

The emergence of the modern image of nursing: a female profession

Nightingale is credited with being the instigator of the modern era in nursing and certainly she was particularly influential in two significant late 19th century movements in nursing which have had a major influence on its present status: professionalisation and feminisation. She is well known for her work with the wounded in the Crimean War (1854-1856), from which she returned to Britain as a national heroine. This prompted the British Government to form a committee to “give expression to a general feeling that the services of Miss Nightingale in the Hospitals of the East demanded the grateful recognition of the British people” (Masson, 1985, p. 61). The money received enabled the Nightingale fund to be established which was used to found the Nightingale Training School at St. Thomas’s Hospital, London. In 1860, fifteen probationers were selected from those who applied to the advertisements seeking young ladies for nursing training. The probationers had to be 25-35 years of age, produce a character reference from their family doctor and they had to be able to pay for their own training. The dual requirement to be ladies of character and of sufficient means to pay for their education excluded both women and men of the working classes.

The training school became regarded as the authoritative source of guidance and advice by other hospitals; however, according to French (1998) Nightingale was “probably less concerned with what tasks they did or the training they had as nurses, than with what sort of person they were and how they conducted themselves” (p. 38). Nightingale believed that sexual morality preceded all other virtues: to be a *good* nurse was to be a *good* woman (Gamarnikow, 1978).

The requirement to be a good woman was a reaction to the disreputable occupation of nursing in the mid-19th century. The public image of the nurse at this time was vividly captured in Dickens’ (1843) novel *Martin Chuzzlewitt* where he introduces the character of Sarah Gamp, who was described as a *monthly nurse* or midwife. He described her, thus:

She wore a very rusty black gown, rather the worse for snuff, and a shawl and a bonnet to correspond [] The face of Mrs. Gamp-the nose in particular-was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits. Like most persons who have attained to great eminence in their profession, she took to hers very kindly; insomuch, that

setting aside her natural predilections as a woman, she went to a lying-in or a laying-out with equal zest and relish. (p. 302)

Herdman (2001) questioned the reality of this portrayal arguing that the nineteenth century nurse reformers in the United Kingdom used this negative image to impugn the character of working class women, and presumably men, who provided nursing care. This was the first phase of the professionalisation of nursing; an attempt to transform nursing into “a respectable middle-class occupation through a strategy of negation and exclusion” (ibid, 2001, p.6). There is evidence that, even in the 19th Century, not everybody subscribed to the portrayal of the nurse as an uncaring drunkard, as the following testimony from the late 1890’s attests:

The social status of the sick-nurse has undergone many curious changes during the last twenty or thirty years. Thirty years or so ago a trained nurse was a rarity, and when sickness broke out in a family the patient was usually nursed by a relative with the assistance of an old servant or a superannuated charwoman. Even in our large general hospitals the state of affairs was not very much better, and the nursing staff consisted chiefly of uneducated women who, however well-intentioned, were practically untrained. They were in the main honest and trustworthy, the only serious charge that could be brought against them being that they were addicted to the use of spirits, and had a constant habit of sampling the patient’s whiskey or brandy. (Trimble, 2002, para. 3)¹⁸

While the anonymous author of the above extract also suggests that these women were partial to partaking of the patients’ alcohol, they are portrayed as honest, although “untrained.” This contrasts with an earlier statement in this same work that, “Every physician recognizes the importance of good nursing.” This highlights one of the key factors to the reforms that occurred in nursing: the need for trained nurses. A second

¹⁸ This extract was taken from a web article presented by *Emergency Nursing World!* This article has published verbatim extracts from the book *Ambulance Work and Nursing: A handbook on first aid to the injured with a section on nursing, etc.* This book was published in Chicago by W.T. Keener & Co. in the late 1890s from a British work published by Cassell & Company, London. No author is given. The book was found in the library at The Medical Center (sic) at The University of California San Francisco.

significant factor was the evolution of a feminist movement that advocated the extension of the middleclass women's role beyond the confines of marriage and the home.

Nightingale was a strong advocate for women, and was allied to the feminist protest against the enforced idleness of women. Her work *Suggestions for Thought* (1860/1991) contains the text *Cassandra*, which is central to 19th century feminist thought (Poovey, 1991). It captures her frustration with the status and expected role of women. The frustration of many middle and upper class women was fertile ground for the establishment of an acceptable women's profession. The development of the nursing profession represented, to some, an instalment in the emancipation of women. Nightingale, however, unlike other feminists of her time spoke the language of duty, not rights and accepted the Victorian idea of divided spheres of activity for men and women (Reverby, 1987). She advocated for woman to be trained as nurses through a disciplined process that developed their womanly virtues while demanding strict compliance to orders passed on through a female hierarchy.

Abel-Smith (1960) has suggested four gender-related factors as important influences in the success of the development of nineteenth century hospital nursing as envisaged by Nightingale. First, it appealed to the romantic or dedicated sort of woman in an age which offered them few occupations; second, it represented almost the only practicable form of escape from the parental nest; third, private nursing offered reasonable financial rewards compared with other alternatives; and fourth, some experience of nursing became recognised as one of the accomplishments of a young lady. These factors were underpinned by an idealized image of womanhood that was constructed during the Victorian era: a good and virtuous woman whose life revolved around the domestic sphere of the home and family. Domesticity and motherhood were portrayed as sufficient emotional fulfilment for women, and this, coupled to the belief that nursing was an extension of women's domestic roles, was decisive in establishing the nurse as a gendered symbol (Evans, 1997; Miers, 2000). Nightingale's nurse was decidedly female:

Every woman, or at least almost every woman, in England has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid-in other words, every woman is a nurse. (Nightingale, 1859, 1980, p. v)

With these words Nightingale firmly asserted a *natural* link between womanhood and nursing, but these words also imply a sense of duty, i.e., the idea that nursing is a woman's responsibility to her children and other family members.

The Nightingale School produced Matrons and these women, Nightingale's lady-pupils, became her disciples in propagating her methods and beliefs throughout the world dominated by the Victorian Empire: New Zealand, Australia, Hong Kong, India and areas of Africa and South-east Asia. Her methods were also adopted in the United States and, in turn, American and British nursing was influential in Latin America. A Western model, thus, became established as the dominant paradigm for modern nursing. This paradigm did not cut across barriers of class or gender. As the Nightingale schools were established in other parts of the world, they brought with them their prejudices. A number of authors (for example: Adams, 1969; Burns, 1998; Dingwall, 1977) described the impact of Nightingale and her disciples in the erection of institutional barriers to men's involvement in nursing.

The exclusion of men from general nursing in New Zealand.

Notwithstanding any improvement in care that may have derived from the arrival of the Nightingale-trained nurses, by the end of the nineteenth century men were no longer a significant part of the nursing workforce in New Zealand. This was described by Dr. MacGregor, in an 1901 address to Parliament as a "revolution that has been part of a world wide movement" (Appendix to the Journal of the House of Representatives, 1901, p.2). He noted with respect to the gender balance in nursing:

The last few years have brought a great change in the organization of our hospitals. Formerly our hospitals were for the most part served by a mixed staff of male and female nurses. Gradually this has been altered, so that now in almost all our hospitals, large as well as small, the nursing staff consists of female nurses only, male nurses being still retained to help in the care of such cases as are unsuitable for females. (*ibid*)

The next step in the professionalisation and gendering of nursing in New Zealand was the enactment of the Nurses Registration Act 1901. It was followed three years later by the Midwives Act 1904. The Nurses Registration Act 1901 was a significant milestone

in the development of nursing as a female occupation and for the future of nursing education in New Zealand as it excluded men from entering the profession. As Miers (2000) commented about the analogous situation in Great Britain, it was a simple solution to any challenge from men in nursing to what was now established as the gendered order in health care: ignore them.

In 1925 the enactment of the Nurses and Midwives Act combined the legislation pertaining both Registered Nurses and Midwives into a single Act. It was further amended in 1939 to permit the registration of men on the Male Nurses Register. This was largely in response to a shortage of nurses as only single women were selected for nurse training. According to Dunsford (1996):

Trainee nurses had to be single. This was partly because of the requirement to live in the nurses' home but also because it was a tenet of nursing that the dedication to duty and service required of a nurse would be hindered by a marital relationship. (p. 37)

This practice continued into the post World War II era and Dunsford (1996) cited a 1947 Department of Health survey that revealed that 27% of student nurses left before completion of their training in order to marry.

It took a further six years from the enactment of the Nurses and Midwives Registration Amendment Act 1939 before a formal training course for men was established. Between 1945 and 1950 four training hospitals for male nurses were opened. Whereas women had three-years of training, the men were only offered a two-year course, which comprised 18 months geriatric and 6 months acute nursing. They received no education with respect to the care of women or children. They were, to all intents and purposes, second-tier nurses. Although they had a greater scope of professional practice than the untrained orderlies and porters who had previously provided much of the routine physical care for male patients under the direction of female nurses, they were in fact *male* nurses, i.e., men who were trained to care for other men. Thus, they could replace female nurses in providing the nursing care for men. In 1945 the Hon Mr. McIntyre, Member of the Legislative Council, during the second reading of the Nurses and Midwives Bill, was supportive of the notion of men as nurses: "I think that male nurses will be a valuable addition to the professional staff of our hospitals". He did,

however, add the rider, “Of course it is understood that there cannot be male nurses in the same training school as female nurses, neither is their course of training required to be of such a high standard as registered nurses” (New Zealand Parliamentary Debates, 1945, p. 358).

The “male” nurse: An inferior type of nurse

In the 1920s men were perceived as of being little value to nursing. For example, Miss Muir, the Matron at Christchurch Hospital, had the following to say about the usefulness of men as nurses:

- 1 In normal times, there would not be enough work to warrant the employment of a staff of trained men nurses. The hospital here is not big enough, does not offer enough scope, as there are few violent cases that our nurses cannot deal with. There might be periods in which there would be nothing for male nurses
 - 5 to do, for weeks, perhaps months. All that is really required is done by the men we have on the place, who use their common sense and obey instructions.
- (New Zealand Nurses Association, 1925, p. 133)

The statement that if there were no “violent patients” there would be nothing for the male nurse to do (lines 2-5) positions the man as being no more than instrumental, providing strength when a patient, presumably male, becomes violent and perhaps to lift the heavy. Although, even that assistance was not always welcome; one nurse when asked for her opinion on the value of men in nursing was, thus, reported in *Kai Tiaki*¹⁹ : “A strong broad-shouldered nurse said that she thought men nurses would be a nuisance. “When I can’t handle a violent patient”, she said. “I think I shall retire from the profession” (NZNA, 1925, p. 134).

As well as the provision of physical strength, and being able “to follow orders”, the men described in these extracts were also employed in the nature of valets or attendants who performed such physical tasks as may have been considered offensive to the sensibilities of a woman. In the words of Dr Fox, the Medical Superintendent of Christchurch Hospital: “When any objectionable people come in the nurses get help. There

¹⁹ The journal of the New Zealand Nurses’ Association.

is no difficulty in this, as any of the porters and attendants perform such services (NZNA, 1925, p. 133).

Dr MacDonald, the Medical Superintendent of Wellington Hospital, supported his colleague's view:

None of us want to see nurses doing revolting work which can be done by male orderlies. [] With regard to V.D. [venereal disease] patients, we have a staff of three male attendants looking after these. These orderlies have been trained under doctors and have been on the staff for years. As far as D.T. [delerium tremens] patients are concerned, we do not get many of these cases during the whole year, and in every instance male attendants looked after them, the nurses, of course, having charge of the treatment. (NZNA, 1925, p. 134)

The intention in these two extracts probably draws upon an earlier Victorian discourse in which women are imbued with both superior moral sensibilities and the need for physical protection from the more brutal, i.e., masculine aspects of life. The tone in these extracts, however, appears patronising to the modern-day reader. They also demonstrate a degree of contempt for the working class men of lower education who inhabited the more menial role of *attendant*. There is a strong implication that the exercise of strength and the performance of unpleasant tasks is more suited to this class of person. This discourse was still evident in 1945, during the debate with respect to the second reading of the Nurses and Midwives Bill; exemplified by the Hon. Mr McIntyre's comment:

Anyone who has had anything to do with hospitals will know that there are many jobs the female nurses have to do which they should not be called upon to perform. Male nurses will be very useful to carry out those jobs. (NZPD 1945, p. 358)

These extracts demonstrate an order of discourse that is both sexist and classist. A discourse, in which the male medical practitioner and, to some extent, the female Matron, are invested with an authority that permits them to exercise such judgements without question. From the perspective of this study what needs to be marked is the realization in these extracts of a gender discourse in which men's subject position is one of both power and powerlessness. Clearly, the men who are referred to as attendants in these extracts

occupationally, at least, hold an inferior subject position to both the male doctors and the female nurses, who are in charge of their practice. This theme, men's unequal experience of gender power, which was highlighted in the previous chapter, is one that has considerable implication for this study.

What these extracts also reveal is the way that gender and class intersected to create a healthcare hierarchy in which there were two layers of men: those above nurses, that is to say, doctors and those below them, attendants, porters and, as will be discussed later in this chapter, male patients. Female nurses occupied a position between these gendered, class layers and protected the exclusiveness of their intermediary position in the hierarchy.

The training for male nurses remained one year shorter than that of females until 1957; however, educational segregation in the schools of nursing continued into the 1960s. During the 1950s, the men began to push for a three-year programme of training as originally set out in the Act of 1945. They were also concerned about the quality of education and wanted students to be trained at "A" grade hospitals. The Director General of Health was lobbied and with support from two female Members of Parliament, Mabel Howard and Dame Hilda Ross, the three year curriculum was offered in 1958 followed by training in "A" grade hospitals.

While both male and female now had a three-year course leading to registration, a significant distinction remained between the men's and the women's education: the curriculum for men still did not include any theory or care of women and children. The men's curriculum had a much greater emphasis on geriatric and genitourinary nursing. This was, of course, restricted to the study of the male genitourinary system and its corresponding disorders. Similarly, they were only able to study the male reproductive system.

Ian, who commenced his training in the early 1960s, was in the first intake of men into his particular training school. He described the sense of difference that being on a separate register conveyed, "In those days you were a male nurse, it had to be emphasised by everybody." This feeling of being different appeared to have made a profound impact on Ian, and it was a theme he returned to later in the interview:

- 1 Perhaps, I need to stress again that we were made to feel odd.

Interviewer: You were made to feel odd, by whom?

Ian: By the hospital personnel, because you were not allowed to nurse women or children, keeping in mind we were training as male nurses on our own
 5 register. It was stressed from day one that we would not be nursing women or children. Quite an interesting comment was made, “We were not to have grand ideas. If we were lucky enough to complete our training, we could never hope to be anything other than staff nurses.

Men may now have had a place in nursing, but it was subordinate, and it was nowhere near women and children (line 6). The prohibition with respect to men caring for women and children, plus the segregation of men and women, both in the training schools and also their respective curricula, described on the previous page, illustrates a discourse that sexualises men. Table 6.1 identifies a sexual image of the female nurse as a sex object, whereas men, in this instance men who are nurses, are constructed as sexual predators. Thus, if women are constructed as the objects of desire then it is men who are expected to desire them. Not only do their female colleagues need to be protected from them, but also female patients and children. This theme, the sexualization of the man who is a nurse, will be explored in more depth in a following chapter.

It wasn't until 1973 with the establishment of schools of nursing offering a comprehensive nurse education in two Technical Institutes that men were able to participate in the full range of nursing education. As there was no provision in legislation for comprehensive nursing education they were constituted as “experimental programmes” under the provisions of the Nurses Act 1971. The experimental status of these programmes was lifted in 1977 with the amendment to the Nurses Act. Thus, it was not until the late 1970s that men were once again able to participate in the full scope of nursing activity in New Zealand.

Even though the training for both men and women was integrated by the time Warren commenced his nursing education in the early 1980s, the sense of difference remained to the extent that he was unclear exactly what form his registration would take:

1 I can remember starting nursing and getting the booklet, I forget what the booklet was, but it was some kind of association thing and it had registered general and obstetric nurse and registered male nurse and I can remember

5 looking at it and thinking, “Oh my God, I’m not going to be the same nurse as everybody else, I’m going to leave this course.”

Interviewer: Was there a sense of being different?

Warren: And not wanting to be different.

Warren expressed a strong desire not to be perceived as different; however, not only did the fact that men originally had a shorter training course than women confer difference but the use of the antecedent label *male* that is attached to the word nurse (line 4) is also significant in conveying difference. The word female is never placed in front of the word nurse to describe a woman who is a nurse. The effect of this is to *other*, to imply that that men’s role and abilities are different to those their female colleagues who are never asked “Are you a female nurse?” In this way two types of nurses are created: *real* nurses (who are female) and male nurses who are perceived as inferior in ability as nurses and, as will be argued in the following chapter, as men. Not only does the use of the qualifier male confer difference, but according to Egeland and Brown (1988) it also implies that they are men who are outside the norm. Fitzgerald (1995) argued that this distinction is unnecessary and queries why men are not just called nurse as well. Furthermore Groff (1984) argued that the label is insulting:

Male nurse. That hurtful phrase, the demeaning hyphen, the suggestion that one is a sub-type of nurse, akin to an orderly, whose practice is restricted in ways we mustn’t discuss: I would like to ban it from the world’s vocabulary. (p.62)

The use of word “sub-type” in the extract above reflects the discourse that positions the man who is a nurse subordinately to the nurse who is female. There is probably not a single man who is a nurse who hasn’t been asked by a patient, “Are you a *male* nurse?” In the patient’s use of that phrase the man who is a nurse is reminded of his difference.

Men in nursing in New Zealand: “Stepping away from the mainstream.”

Even though by 1977 all institutional barriers to men entering the nursing profession in New Zealand were removed, men have not re-embraced the profession in large numbers. As was noted in Chapter One the proportion of men in nursing is largely unchanged since 1990.

Of the eighteen men interviewed as part of this study only four stated that they had entertained any thought of becoming a nurse while they were still at school, and only three went directly into nursing education after leaving secondary school. Allan described his initial experience when he started to explore nursing as a career option in the early 1980s:

I was interested in being a nurse and went to a careers day at City Tech and I was nervous that day. It was a sort of multi career option day and my plan was to be there for the nursing component. When they asked the nurses, the people interested in nursing, to get up and go to another room I watched more than a hundred young women do so and stayed in my seat and when they asked for accountants or something I got up with that group and went home-there were no men.

Charles, who left school several years after Allan, talked about his teenage belief that nursing was not a viable a career option for men:

1 It sort of started about 1996, I started to think about nursing ... yeah, but, it wasn't really something that I thought of to do as a male. It was something that when you do career options at school, it is never offered. It is never presented to males. It is always a girly thing to do.

5 *Interviewer:* Do you think that if it had been presented at school when you thinking about career options that it would have interested you?

Charles: It would have interested me, but I don't know whether I would have done it at that stage.

Interviewer: Why not?

10 *Charles:* Why wouldn't I have done it at that stage? Because, I guess, it is stepping away from mainstream a little bit.

Interviewer: Is that something to do with the "girly" thing.

Charles: Indirectly, yeah. It was that stepping away from the mainstream.

Interviewer: Mainstream?

15 *Charles:* Mainstream, in taking on a career that a male would not normally take on.

In the above extract Charles describes nursing as being “away from the mainstream” and he reiterates this several times (lines 11 & 15). Mainstream can be viewed as being synonymous with *malestream*, that is to say, the dominance of a male hierarchy which subjugates the interests of women to those of men, and in doing so marginalises women and the work that they do. If the world of nursing is perceived as being outside the malestream then it becomes a realm of lesser power. Hearn (1999) described the role of malestream organisations: “Malestream organisations and their control are the main political arenas by which men maintain power in the public worlds and the main areas of accumulation of men’s resources in the public worlds” (p.3).

Given the existence of such a world view it is then not surprising that, as Charles states in line 3 on the previous page, nursing is not suggested as a career option for young men, and may even be actively discouraged as was Bruce’s experience:

I remember talking to my Dean and a few of the teachers and they were really anti me leaving school and going nursing and very clearly the reason was that they saw potential for me to get a bursary and didn’t want me to leave school and they wanted me to pursue some areas in science.

Bruce’s experience reflected a malestream attitude that perceived nursing as of lesser importance than science, an area of intellectual pursuit that has been strongly associated with masculinity. Nursing is doubly devalued: on one hand its importance is downgraded because of its association with women’s work and, on the other, because it is not seen as an intellectual pursuit. This belief draws upon a discourse that sees nursing as an extension of the duties of the housewife and therefore relegates nursing to the sphere of the domestic. It is a view, moreover, that is not completely androcentric; for example, Kane and Thomas (2000) describe an uneasy relationship between nursing and feminism owing to the 1970s women’s movement devaluing nursing and other feminised professions:

Feminists alienated many nurses as they sought to break down barriers in male-dominated professions and encouraged young women to pursue careers in medicine rather than nursing. As a result of this lack of respect for the nursing profession, nurses who made significant contributions to the women’s movement were identified as feminists, not nurses. (p. 18)

Returning to Charles's words (page 108), what is striking in that extract is not just the identification of nursing as a female occupation but also the use of the word girly in connection with it. It can be interpreted in three ways; first, as denoting something that is typically female in character, or as being more suitable for girls than boys. Second, it also suggests a patronising and dismissive attitude to both women and nursing. Third, there is the association that the word has with sexually provocative magazines, the "girly magazine." It is not possible to accurately infer a sexual connotation from his words and no other utterance during his interview sexualised nurses; however, it is possible to infer that Charles, at the very least, has assimilated popular notions that nursing is women's work and is trivialising it by the use of the word "girly." His relationship with nursing is ambivalent: interested yet dismissive.

It was notable that there was coherence between the respondents with respect to the association of nursing with women's work as this notion appeared in all the interviews. For Robert, this belief was so strong that he thought that a man would not be even allowed to apply:

Going through high school I thought about it and because it was a job that women did thought I would be excluded from it, and even though I wanted to do it, when I left school I went and worked in a garden centre.

Edward, who was in his early 20s when he entered nursing school in the mid 1980s, looks back on it as "being an unusual choice." He elaborated:

1 I look back on it as being a - excuse the generalization - but as a rugby
[playing], outdoors person it just didn't seem to fit the context of a male and
going and making and doing that change...

Interviewer: Are you saying that there is some association with it as being
5 women's work?

Edward: Oh, I think it is very much a feminine role.

In this extract not only is there the link to nursing as women's work again, but in line 2 there surfaces an illusion to a dominant stereotype of the New Zealand man: the rugby playing, outdoor man. This is a stereotype that will be discussed in more detail

later in the following chapter, as not only does it define itself in opposition to women but is a potent barrier to men's entry into nursing in New Zealand.

In line 6 Edward used the word "feminine" and he returned to this at a later point: "There's times that I have ... fought, and to my embarrassment, fought that feminine side of nursing and being seen as feminine."

In using the word "fought" in this context he articulated his struggle with the notion that by choosing to enter a woman's profession he becomes by association less of a man: "being seen as feminine." Charles also alluded to this, when he commented, "They assume that for you to be a nurse you must have female traits somewhere."

Even in light of the re-evaluation of gender roles that was instigated by feminist scholarship and protest, all of the respondents believed that the notion that general nursing is women's work remains prevalent. When asked why there are still so few men entering the profession Mathew responded:

- 1 Oh, I think because of a number of reasons. There is the stereotypical reason to start with that nursing is still seen as a female role and that it's paid accordingly. I mean, we don't get as much money as equivalent services. Police and teaching are doing better than us, so it's not attractive, it's not a big
- 5 money earner and, I guess, the other stereotypical beliefs about the role. I don't think males are necessarily drawn to the idea of bed baths or cleaning bedpans and that sort of stuff. They're all sort of female roles aren't they? (laughs). Obviously, we're talking stereotypically here.

Again the relationship between women, domesticity and nursing emerges (lines 7 and 8). Robert, when asked the same question, stated simply, "I suppose it's because the old attitude still prevails: it's women's work."

The "Angel of Mercy"

The label *Angel* links the modern era of nursing and the significant role that Christianity that has played in its evolution. The traits identified in Table 6.1 that have been associated with this image also reflect a strong spiritual component: honourable, moral, self-sacrificing and ritualistic. Similarly, the word *sister*, used as a title for a senior female nurse, reinforces the connection between the religious and the feminine.

As *brother* denoted a male who was a member of a religious community, *sister* was used to describe a female member of a religious community: someone who had taken the vows of poverty, chastity and obedience. These words are portentous and their association with nursing reinforces an image of nursing as a spiritual vocation. Building upon this notion, Kane and Thomas (2000) suggested that the work of the Nightingale nurse could be described as a “ministry” or “consecrated” service. Reverby (1987) in her historical analysis of womanhood and nursing in North America cited the words of a nurse educator who wrote in 1890: “Young country girls are drawn into the work by the glamorer (sic) thrown about hospital work and the halo that sanctifies a Nightingale” (p.16). The use of the word “halo” reinforces the angelic image; in Christian sacred art holy persons, usually saints, were depicted with a halo reflecting a glow of sanctity emerging from the head. Not only are female nurses angels, but they also associated with saintliness.

There is an interesting paradox inherent in the association of nurses with angels. Angels were originally understood, from the Old Testament of the Bible, as celestial beings who when they assumed corporality came as men. According to the Catholic Encyclopaedia on-line (2004) nine orders of angels exist and examination of their respective roles (Table 6.2) suggests that the concept of angels is one that has also been reconstructed into a female image in the popular imagination.

From the typology presented in Table 6.2, the roles associated with the various orders of angels, for the most part, suggest strength and in some instances warrior-like qualities; these are not gentle beings. The orders of Angels most compatible with being associated with nursing, and hence reconstructed as female are 5 and 9: the Virtues and Angels, who are defined respectively as the Guardian Angels who perform miracles on Earth and the servants of God. This was a popular image associated with female nurses; an example of which was evidenced in the debate during the first reading of the Hospital Nurses Registration Bill (1901) where the Hon. Mr. Walker stated:

Well, of course, there is no one who has ever come across a modern hospital nurse in any shape of form [] who cannot but realise what a guardian angel she is to all who come under her influence. (New Zealand Parliamentary Debates, 1901, p. 179)

Notably, the Hon. Mr. Walker does not include *male* nurses within the roll call of guardian angels. There is logic in the assumption that the work of nurses, such as Nightingale and the many other women who followed to the Crimea, could be viewed as performing miracles, particularly given the significant decrease in mortality among the British wounded after the arrival of Nightingale and her nurses.

This image remains strong today, and there are, for example, many websites dedicated to this notion and books written that reinforce this imagery²⁰. One of the websites viewed while trying to investigate how this association originated refers to the work of those nurses who went to the Crimea. The title of this website is *Angels and Orderlies*.²¹ What fascinates about such a title is the casting of the work of the (female) nurses as angelic, while the work of the (male) orderlies warrants no such association. The word *orderly* while denoting “a male cleaner in a hospital” (Allen, 1990, p. 836) is also defined as “obedient to discipline; well-behaved; not unruly” (ibid, p. 836); therefore, no significance is given to the work of the orderlies because it is *expected* behaviour. It was taken as given that they would risk their lives in retrieving the wounded; but that a woman should choose to work with the war wounded takes on the aura of divine or angelic intervention.

²⁰ A brief search at Amazon.com reveals titles such as, “Angels in Africa: A memoir of nursing with the colonial service”, “Angels of Mercy: district nursing in South Australia 1894-1994”, “Angel Wings: AirEvac nursing”, and “Florence Nightingale: Avenging angel.”

²¹ <http://www.melcombe.freerve.co.uk/source/nurselist.htm> Downloaded from the world wide web, 24/04/04.

TABLE 6.2

The orders of Angels

Order Number	Title	Role
1	Seraphs or Seraphim	Highest order of Celestial Beings, who are closest to the throne of God and sing his praises.
2	Cherubs or Cherubim	The Warrior Angels, who guard Eden.
3	Thrones	The familiar recipients of God in themselves
4	Dominations	Appoint those things which are to be done.
5	Virtues	The Guardian Angels who perform miracles on Earth.
6	Powers	Guardians of Order, who attempt to ensure order in the World.
7	Principalities	Protect religion and protect nations under their care.
8	Archangels	The messengers of God.
9	Angels	The servants of God

Girl Friday

The image of the nurse as “Girl Friday” with the attributes of faithfulness, dependence, co-operation, subservience and being long-suffering (Table 6.1) would appear to be analogous with the notion of the nurse as the *doctor's handmaiden*. Garmanikow's (1978) argued in her analysis of the nursing profession in relation to the sexual division of labour in a patriarchal society that because it was women who entered nursing, nursing became subordinate to (male) medicine:

Professional power relations were overdetermined by the patriarchal relations implied in the sexual division of labour: hence the subordination of nursing-whose tasks were defined and practices limited-to medicine. The justification for this division of labour in health care drew upon existing representations around “naturalism” within patriarchal ideology. (p. 103)

According to Garmanikow (1978), Nightingale entrusted nurses with two functions, “nursing the room”, and “assisting the doctor”; she drew upon Nightingale's (1882)²² words: “Nursing is putting us in the best possible conditions for Nature to restore or to preserve health. The physician or surgeon prescribes these conditions – the nurse carries them out” (p. 105).

This model of subordination to medicine was strengthened by the move of sickness care from the home to the hospital. According to Valentine (1996), when nurses were working in the home, they were independent practitioners working in collaboration with the physicians but being paid by patients, but as they moved into hospitals they became controlled by male administrators and physicians who devalued their work. It has been suggested (Collière, 1986; Gamarnikow, 1978) that hospitals became symbolic homes:

Health institutions borrowed their model from the bourgeois family where the father dominated and performed the role of decision-maker (doctor, administrators), while the mother's [nurse's] expected role consisted of “serving” activities, carrying out the wishes of the father. (Collière 1986, p.103)

²² “Training of nurses and nursing the sick and poor”, reprinted from Dr. Quain, *Dictionary of Medicine*.

The image of the (female) nurse as Girl Friday persists into the present day and, in the New Zealand context, may explain some of the Medical Practitioners' resistance to nurses expanded scope of practice. This is seen, in particular, in resistance to current proposals for change to the legislation to allow Nurse Practitioners prescribing rights (albeit limited) and the negative response from the Medical Association when the topic of nurse anaesthetists was raised. It would appear that a belief that the nurse's primary role is that of assisting the doctor remains strong. For example, David (2000) described her professional role thus, "As a nurse, I am the physician's administrative assistant and mother to the patients" (p. 85). Not only does David (2000) draw upon the image of the nurse as Girl Friday but also draws upon what is possibly an even more potent image: of the nurse as Mother. According to Miers (2000), "Of all the images of womanhood available to women, none is more dominant than that of the mother" (p. 31).

Mother

In the previous section the analogy of the hospital as a symbolic home was introduced; Gamarnikow (1978) expanded this comparison to include the patient as the symbolic child of the doctor (father) and nurse (mother):

In the bearing of a nurse toward her charge there must be something of the indulgence of a mother for her child; that is why women are better nurses than men ... It is astonishing what can be done with gentleness, especially when dispensed by a woman, and as the medical man is there, I think it would be well if the so-called firmness, when needed, were left to him. She can always invoke the physician's orders for the refusal of any unreasonable request. (*Hospital*, 28 April 1984, p. xxxv, cited Gamarnikow 1978, p.110)

The (male) patient has been constructed as a child, "When a man is seriously ill he is practically as helpless as a child, and can neither think nor act for himself" (http://enw.org/1895_Nursing.htm). This construction is still relevant today, seen in television advertisements for over-the-counter remedies for coughs and colds, such as the current television advertising campaign for "Robitussin®", that depict both the children and the helpless father being cared for by the mother. The Robitussin®

homepage (<http://www.robittussin.ca/> retrieved 05/08/05) advertises its products as “Recommended by Doctors, Pharmacists, and ‘Dr. Mom’”.

The construction of the hospital as an extension of the home is an apt analogy; however, in terms of the traditional hospital environment, Collière’s (1986) and Gamarnikow’s (1978) models are too simplistic. They ignored the very real power of the Matron in the hierarchy that dominated the life of the nurse. For example, Ian recalls the power that Matrons and sub-Matrons wielded:

There was etiquette for everything [] One of the etiquette rules was whichever nurse saw supervisors or Matron enter the ward, you had to abandon what you were doing, go up, and the words were, “Excuse Sister, please.” Go back and find Sister and then Sister would come up and they would stand there surveying the scene until they had done, bed by bed, a round. In one of the wards, there was a two-bedded and a four-bedded wing and a passage way, and the ward Sisters were there and sub-Matron [] and this particular day, came in, turned left and got into, apparently, the second cubicle and apparently my trousers, shoes and socks were just below the curtains. I was there bed bathing somebody, and the first I knew about it, I was hauled over the coals because I didn’t go and excuse the ward Sister. I wasn’t even aware that anyone was there. I was really hauled over the coals, because that was the height of bad manners. Really, it was quite unjustified.

A more realistic analogy is that of the hospital as a family where both the mother (Matron) and father (physician) expected obedience from their dutiful daughters (nurses). The patient’s relationship with the nurse is more that of a younger sibling. The nurse at the bedside certainly wields power over the patient, but like siblings, at times there is collusion to protect the sister (nurse) from the parents (nursing and medical hierarchy).

The image that emerges from Ian’s story is, of course, another of the images of nurses: the nurse as a battleaxe. Interestingly, this powerful image is not one that emerges explicitly in the analysis presented in Table 6.1 (page 92). Paul discussed the stereotyping of “strong women nurses” as battleaxes when describing the role models available when he entered nursing in the late 1970s:

When you think about strong women nurses they tend to be stereotyped into the ward sister, the matron who is a real battleaxe, but they're not necessarily strong in a professional sense, so there weren't, at that time, a lot of role models of strong professional nurses. You could find them; there was no doubt about that. There were people in nursing organisations and in advocacy roles with clearly strong personalities but a large number were very much the handmaiden type.

Beyond the iconography of nurses as angel and mother, Paul's words reveal that in her professional role the nurse was constructed in, and restricted to, two subject positions: the battleaxe or the handmaiden. The first of these roles allows the exercise of power; the second only allows subrogation to the needs and demands of others.

Gamarnikow (1978) argued that the construction of the doctor-nurse relationship upon gender lines and in mimicking the patriarchal family extends patriarchal exploitative relations into the non-familial labour process. This allows the integration into patriarchy of women who were not married (as nurses often were not) and subordinates them to the interests of men. This analysis of the ideology of the sexual division of labour; however, does not account for the role that class has played in the construction of the female hierarchy within nursing. Nightingale and other nursing leaders often came from elite backgrounds; by seeking to restrict entry into nursing to *ladies* through the erection of educational and financial barriers they ensured that the power structure in nursing was based on class structures. According to Pringle (Pringle, 1998) upper-class women, having trained as nurses, secured key hospital positions by cultivating powerful friends, of their class, on hospital committees and in government. They were able to develop a hierarchy in which upper- and middle-class women were able to continue to exercise the power that their class afforded them within the workplace.

Mothering and the man in nursing.

The ideology of motherhood emerged in the Victorian Era Motherhood was considered a sufficiently fulfilling role for a woman and became a constructed identity as opposed to a biological function and was associated with an idealised image of womanhood, which involved passivity and submissiveness (Miers, 2000).

While the constructed image of the mother, and subsequently the nurse, as passive and submissive may originate in the Victorian era, one of the biological functions of mothering and its association with nursing is far older. The derivation of the word nurse comes from the Latin word *nutrix*, meaning nursing mother, and correspondingly the Latin word for nursing is *nutrire*, or to nourish (Fitzgerald, 1995). The spelling and the meaning have changed with time to take on a broader definition other than mothering and nourishment, but the relationship between mothering, nourishment and nursing remains with us. One of the significant meanings of the word is the action of placing the child upon the female breast to suckle for milk. As one of the male participants in Dombeck's (2003) study stated, "I see myself in an occupation named after a feminine function that I am biologically incapable of performing" (p. 360). Beyond the role of the breast for physical nourishment there is also the association with emotional nourishment: numerous images exist in which a head is laid upon the female breast in order to seek solace and comfort.

Women, as mothers, have become associated with an ethos of gentle caring and nurturing, while in contrast the father is associated with a more authoritarian and punitive role. Mathew describes how these associations can work to his advantage in his therapeutic role:

1 *Interviewer:* Does it ever bother you that men who are nurses are seen as different from women who are nurses?

Mathew: It is actually a wonderful tool for me because once you overcome their expectations they suddenly realise that you are not a classic male figure.

5 I guess you are seen as a father or a male-dominant figure that is generally less caring than mother role and more authoritarian and less kind. Once people's expectations of you are not met and they suddenly realise that you are actually supportive and caring and that you have a more feminine, motherly, maternal role to play then you actually form a bond much quicker
10 [] and yeah, I've noticed that I can form trust relationships very quickly because people become very relieved when I am not a classic male in the way I relate to them.

Interviewer: Why do you use the word feminine in association with caring?

Mathew: Oh, I guess it's because I think of male and female as my dad and

15 mum. Mum was very – feminine is not a good word is it? Maternal is a much better word.

Interviewer: So you associate caring and nurturing –

Mathew: With female, definitely.

If the word “classic”, which Mathew used in lines 4 and 11, is interpreted as meaning “remarkably typical” (Allen, 1990, p. 208) then it can be inferred that in referring to the “classic male” (line 11) he evoked a stereotype; in particular, the stereotypical image of a father. In line 6 he used the word “authoritarian”, and in Western culture there has developed a strong association between authority and fatherhood (Miers, 2000). Judeo-Christian beliefs have linked authority with God the Father, and this linked to seventeenth century Enlightenment ideas concerning reason and freedom has constructed the father as being both the source of reason and the source of discipline. According to Siedler (1988): “Within an Enlightenment tradition reason is set in fundamental opposition to nature-our emotions, feelings and desires. In the family the father is to be source of reason, he is also to be the source of discipline” (p. 272).

Mathew described the impression that a particular man, who was the Head Nurse of the hospital where he worked as an aide, had on him and his influence in his decision to become a nurse:

He was important [] I have suddenly realised that he was actually very much part of the decision. Yeah, he gave me positives, pointed me in [that] direction, and I hadn't up until this point really been aware of that (laughter).

Interviewer: What were some of the characteristics of that man that stood out for you?

Mathew: Um ... I guess he was NOT MY FATHER! He was not a father figure, he was not authoritarian. He was a warm, caring person that had a very good reputation as someone that was fair and caring and um you know supportive and you could always trust him to be fair.

The gender division of labour constructed the father as the head of the household and provider and the mother as carer and housewife. He is not attributed with feelings of

warmth or caring or, it could be argued, permitted to demonstrate such attributes; therefore; when they are seen (as in Mathew's example) they are surprising. The association of mother with housewife is also important in creating the image of the female nurse. In Warren's words, "It's easier for a woman to be a nurse because they are brought up to be good housekeepers, which some of nursing is." This was a theme to which he returned later in the conversation, "I wonder if nursing has become a 'femalely' kind of 'doey' thing and it's all about housekeeping and that kind of stuff." The use of the suffixes "ly" and "ey" (which echoes Charles's earlier use of girly) convey a sense of diminishment and trivialisation. It reveals not only the association with what is perceived as women's work and hence its ascribed lower value, but also the tension between the intellectual competencies of the university educated professional nurse and the domestic tasks that nursing sometimes involves.

Nursing as women's work: A world-wide paradigm?

At the outset of this chapter it was suggested that the facial features of the nurse depicted in Figure 6.1 were neither unequivocally Caucasian nor Asian and that this may suggest a worldwide view that nursing is women's work. The argument presented, to this point, that nursing is generally perceived as women's work has drawn upon the words of the respondents in this study and other textual sources from the United States, the United Kingdom, Canada and New Zealand.

Evidence from other countries, also suggests that the view of nursing as women's work is widespread. For example, Armstrong (2002) asked a group of Australian men whether they had thought about nursing as a career. Of the six respondents none had considered nursing as a career and two of them still identified it as a female occupation. Lindsay (54) asserted, "Back in my day, in the days of button up boots, blokes never became male nurses – it's a ladies job" (p. 26) and David (19) commented:

I think society sees it as more of a female occupation, for women or men who are gay. It's sort of soft and comforting, and I think it's seen as being more for women. I mean when you're sick you usually get nursed by your mother, don't you? (p. 26)

In a study of Chinese nursing students in Hong Kong (Holroyd et al., 2002), nursing was described as a gendered female profession because of its association with

the “responsive and nurturing image of Chinese women” (p.295). The authors of an Israeli study (Krausz, Kedem, Tal, & Amir, 1992) stated that, “the requirements and expectations incumbent on nurses, namely, neatness, warmth, supportiveness, helpfulness to others, and willingness to sacrifice, give salient expression to nursing’s feminine character” (p. 389).

A paradox emerges from the study by Krausz et al. (1992) when they attributed “sacrifice” to the feminine character. What is striking about this appropriation is the numerous war memorials throughout New Zealand, and presumably in other Christian countries, which attest that, “Greater love hath no man than this, that a man lay down his life for his friends” (John 15:13). Of course, *man* in this context should be read as *humankind*; however, as was noted in Chapter Five, there is a long tradition of expectation that men will physically sacrifice themselves for others, which is inherent in the code “women and children first.”

In Scandinavia, too, the association between nursing and feminine endeavour exists. In an interview in *Sykepleien (The Nurse)*, the Norwegian nursing journal, Aud Blankholm, who was at that time the leader of the Norwegian Nurse’s Association (Norsk Sykepleierforbund), attested:

1 Selvfølgelig ønsker jeg flere menn velkommen i rekkene. Men det er
forskjeller på menn og kvinner som alltid vil bestå. Omsorgsyrkene vil alltid
være kvinnedominerte, uansett utviklingen. Kvinnene har naturgitte fordeler
her, som det er lite å gjøre med. Og når menn i så liten grad har prøvd seg i
5 yrket, er det fordi de er mer bevisst på at de skal ha seg et yrke, en jobb, der
man skal hente utkomm for en hel familie. ("Aud Blankholm", 1987, p. 50)

1 Of course, I would welcome more men into the ranks. But there are
differences between men and women which will always exist. The work of
caring will always be dominated by women, irrespective of evolution. Women
have been given an advantage by nature here, which there is little to be done
5 about. And when men, to some small degree, have attempted such work, it is
because they are more conscious that they need work, a job, with which a man
is able to ensure that his whole family is comfortably off.

In these relatively recent words, the idea of a natural link between caring, nursing and women is maintained. Blankholm holds no possibility for change: in line 2 she reiterated the word “alltid” (always) allowing no hope for the differences between men and women to be overcome, or for men to take on a greater caring role. This bleak view contrasts markedly with other, more recent, work emerging from Scandinavia demonstrating that change is occurring. Holter (2002) argued that “when doors are opened up for men” they choose new options, and he cited the example of 70%-80% of men in Norway who now choose to avail themselves of the parental leave available to them.

This hopeful example of change in men’s relationship to caring is an appropriate point at which to move to the next chapter which will discuss why men choose to become nurses.

Conclusion

This chapter has provided a brief analysis of the evolution of the contemporary construction of the nurse as female and three of the subject positions that have emerged: mother, angel and handmaiden. It has been argued that men’s limited involvement in modern nursing is not a consequence of nature nor is it supported by evidence to suggest that this is owing to tradition.

This chapter has also reviewed the history of men’s involvement in general nursing in New Zealand and argued that men were actively excluded from the profession and that when they were admitted they were constructed as “inferior”. The next chapter continues the discussion of men’s involvement in nursing by considering why they choose to enter into nursing’s ranks.

CHAPTER SEVEN: Why men become nurses

During my high school years, in the early 1970s, I was considering future career directions. At that time I knew nothing of nursing's history other than a popularised version of Florence Nightingale as the *Lady of the Lamp* and given the strength of the belief in nursing being women's work, as described in the previous chapter, it is not surprising that nursing was not my early career choice. I was not alone.

A number of authors have reported that few men consider nursing as a career option during their school years and are more likely to enter the profession later in life (Armstrong, 2002; Johnson, Goad & Canada, 1984; Mannino, 1963; Marsland, Robinson & Murrell, 1996; Okrainec, 1994). The same proved true for the men who participated in this study: only two, Bruce and Allan, applied for entry into nursing school upon completion of their high school education and, as noted in the previous chapter, Robert considered it but did not apply because he thought that his gender would preclude him.

This study now turns to a specific focus on these men's decisions to turn away from *malestream* occupations and outlines the significant factors involved. Analysis of the transcripts identified five thematic groupings with respect to the decision-making process: formative experiences, the *Call*, expediency, fulfilment and personal acquaintance with a nurse.

Formative experiences

Lemkau (1984) conducted a study to investigate why some men choose atypical occupations rather than sex-typical occupations²³. The results indicated that in comparison to those employed in sex-typical fields (S's) those employed in atypical professions (A's) demonstrated lower adherence to traditional sex-role expectations with respect to sex-typical household responsibilities and greater "tender-minded emotional sensitivity" (p. 110). The A's also reported, more frequently, having had working mothers, distant relationships with their fathers and having been positively influenced in their career choices by women. They had also more frequently experienced a death of a

²³ Lemkau (1984) listed sex-typical occupations as including: accountants, architects, engineers, farm managers, pharmacists, clergy and financial officers. The atypical occupations were: physical and occupational therapists, nurses, dieticians, librarians, elementary school teachers and day care workers.

first-degree relative, a parental divorce or separation and frequently mentioned such stresses as sensitising them to their nurturant and emotional capabilities.

As I read the study I wondered how many other men in nursing would identify with this study as I did. While Lemkau (1984) did not specifically investigate men who are nurses, the study is relevant to understanding men who are nurses.

Her findings that family stressors played a role in the A's career choices would appear to be supported by the results of Phillips' (1997) study. In investigating whether the psychodynamic findings of "reparation" and "compulsive caring" were motivating factors for entering nursing Phillips (1997) found that nursing students had a significantly greater number of "recollected adverse experiences" (p. 42) in their childhood and teenage years. More importantly to understanding men who choose nursing, when males and females were analysed separately there was a higher level of significance obtained for the males.

The distant father.

In the course of the interviews for this study Mathew volunteered the information that his father was a "quite abusive, physically and emotionally abusive person." He was clear that his childhood experiences contributed significantly to his career choice; many of his decisions in later life, both personally and professionally, he attributed to being a reaction to his father. He has striven throughout his career to not be seen as a "classic male figure", i.e., a male-dominant figure: more authoritarian and less caring than the mother.

The previous chapter described the construction of the traditional father figure in Western society as an authority figure emotionally distant from the work of caring. The duties of fathering were limited to being the household provider and to educating children to control their feelings and to accept behavioural control based on rational feelings (Miers, 2000). Mathew considered being able to counter stereotypical expectations a "wonderful tool" in his professional role.

The authoritative father was not a theme that emerged strongly in the conversations with these men. Other than Mathew, the only man who talked about his father consciously influencing his career choice was Grant. While at school he wanted to be a doctor; he described what happened shortly after obtaining School Certificate:

Anyway, to cut a long story short, I went home from work one Friday - I was working in a grocery shop during the holidays-and there was an advert out of the paper put in front of my plate: Health Inspectors jobs in Wellington-students to apply. So dad just cut it out and put it there and never said a word. I knew what was happening, so I applied and got it.

Sensitisation to nurturant abilities.

Mathew was sure that his early experiences with his abusive father opened him up to being a more sensitive person with a strongly formed belief in the importance of advocacy:

I remember on multiple instances I used to stand up for both my mum and my siblings and tell him off for being a nasty man and getting thrashed because I did so. That sort of formed me as a person [] I developed a very strong advocacy role when I was a kid and I used to advocate for my siblings and try to intervene when things were not fair and I was torn to shreds over wounded animals. It was just all too much for me to see a cat or a dog being mistreated. Perhaps I should explain that was where my advocacy [originated] and I see [] one of the fundamental roles of nursing being an advocate for clients in whatever context you are in. So that's where my advocacy developed and then it was an outlet in nursing and I saw it as a natural thing when I went to work at the psychopaedic hospital.

Mathew was able to articulate quite clearly “the defining moment” when he decided to become a nurse. He was 18 years old, on the dole, with no ambition other than to play music and surf “for the rest of my life.” He took a job as an aide in a psychopaedic hospital because the dole was not providing him with enough money:

I remember when I made the decision to become a nurse that was very much part of the whole thing fitting together and me feeling, yeah, this is the right thing. The defining moment was when I was working as a hospital aide at a psychopaedic hospital and I was caring for mainly autistic kids and there was one particular child that I was trying to get through to, not because I was being professionally caring or anything [] and one day I found this um funny swing apparatus in one of the cupboards and I asked the staff what it was and they said, “Well, you can hang it up

in the gymnasium and they can swing from it as they apparently respond to it.” So I took it down and strung it up and I pushed her and got the fright of my life because she just suddenly burst into this peal of clear laughter. It’s bizarre the things that are important to you but that was actually the moment that I got a huge amount of reward out of getting this four-year old autistic kid that had not responded to anybody, not her parents, nobody and suddenly she just burst out into laughter and every time we took her down from then on she just burst out laughing [] I got such a reward out of that I suddenly felt so joyful ,you know, suddenly I had got the big payback for the care that I had given and so I thought I really want to learn about this I want to see if I can do this more often so I decided that I would do nursing.

Arguably, in line with Phillips’ (1997) proposal, Mathew was experiencing a sense of reparation, or compensation, for the difficulties encountered in his relationship with his father.

Elements of Grant’s history also lend support to Lemkau’s (1984) treatise that the loss of someone close sensitises men to their nurturing abilities. The death of his wife four years before he entered nursing school he identified as a factor in the decision-making process: “... the more I thought, well maybe I could because of Carla’s death and family bereavements.” The other family bereavements were the death of his grandfather and the deaths of his parents: his father at age 57 from heart disease and his mother from cancer of the gall bladder. He described himself as having “an affinity with death-people who have terminal illnesses.” He was sure that these experiences were why he chose a career pathway that eventually led him into nursing and ultimately hospice work:

Probably the whole stems [from] ... when I was thirteen my granddad died [] of throat cancer [] And our doctor-I remember quite clearly, Thomas, there were fourteen grandsons; I was in the middle of the age group, and I was the only one who would go and see granddad – he rang up one night, I was at a youth meeting, and said, “Is Grant there?” [] “I think he needs to come now and see granddad.” [] Now I don’t know why, but I always remember that death, even now.

Several others also related personal experience of death and illness during the course of the interviews. For Carl the death of both his parents was significant. They died the year preceding his entry into nursing school, during a period in which, following the completion of a Bachelor of Commerce, he was “exploring what he wanted to do in the long term.”

Ian’s father died when he was seventeen and he saw this, along with being hospitalised as a child, as influential: “Sitting with him and things you sort of get some idea of the mystique, I suppose, about the wards.” His use of the word *mystique* is evocative and one that Luke echoed in describing the psychiatric hospital in which he trained: “... There was always that kind of mystique about it, [a] kind of aura.” Allan also alluded to the mystique or allure of the hospital as part of the influence in his choice of nursing: “I had a historic knowledge that I wanted to work in a hospital in that physical building and the image it held for me. I was never clear what role that might involve.” The hidden processes, or mysteries, that went on in hospitals caught the imagination of these men and drew them to nursing.

Bruce had also been hospitalised as a child: “I had a minor operation on my foot and I was actually cared for by a student nurse, a female student nurse, and I thought that it was something I would probably like to do.”

It is interesting that in describing the experience of being hospitalised Bruce highlighted that a “female student nurse” cared him for. It might be expected that in choosing an atypical occupation, such as nursing, one would more likely to be influenced by finding a member of one’s own gender in the role. Thus, for Phillip, it was not only the experience of his son’s illness but also encountering a nurse who was a man that was significant: “There was a male nurse on his ward, probably about my age at the time, and [I] spoke to him about it and [he] said it was ... he really enjoyed it.”

The “Call”.

Bruce related that he had friends and a sister who were nurses and therefore some knowledge of the role, but the most salient factor appeared to be what he termed “a Call”, which entailed “a sense of duty, a way to make a difference, [to do] something meaningful in the world.” Allan also described a family connection to nursing:

- 1 I certainly know a number of family friends who are nurses and a couple that come to mind are very compassionate, gentle, caring women that I think quite highly of, that I always remember liking as a child. A couple of those women I identify with [a] caring role and manner, I suppose. So that interested me.

His description of the nurses with whom he was acquainted as compassionate, gentle and caring (line 2) echo the image of the nurse as an Angel, which was discussed in the previous chapter, and the associated notion of nursing as a vocation. Although he did not use the word *call*, Allan was clearly motivated by a sense of altruism: “I can clearly remember that for a long time [] I had some connection to relief and disaster work in third world countries and that always held interest for me that I wanted to pursue.”

This theme, altruism or being of use to humanity, coupled with the deaths of his parents, was part of the motivation for Carl. He turned to nursing after several years as an accountant: “So I thought about what I wanted to do and I was thinking VSA – Volunteer Service Abroad – I was quite keen on [that] and I thought nursing would be a good way to get into that.” Carl also described nursing as a way “to feel useful”, a statement that is congruent with Grant’s comment that it enabled him to put “something back into society.” In hearing these men speak about being *of use* there is a sense of subscription to the idea of nursing as a vocation dedicated to the service of mankind. Bruce’s use of “the Call” has considerable spiritual resonance and in the Christian world is often used to denote a feeling of God requiring one’s service. So for some of these men the language they used to describe their relationship with nursing is connected very closely with that image of nursing which emphasises the attributes of spirituality and self-sacrifice. It could be argued, therefore, that for these men what Crawford, Nolan and Brown (1998) described as the “link between the spiritual life and caring work” (p. 212) is an important factor in their decision-making.

Expediency

Bart described the type of motivation discussed in the preceding section as a “very ideal, soul-saving sort of notion.” His description of what then happens to such people

when they entered into psychiatric nursing in his era suggests that considered such motivation to be naïve:

- 1 I saw people who literally just left [in] one day. They took one look at what they were doing, turned a shade of green and headed for the door. And the other end of the scale, I think, is the person who came in with a kind of very ideal, soul-saving sort of notion, who would either leave or get that knocked
- 5 out of them really quickly. A bit like people who tend to ... all those professions really [like] social [work], probation, psychology come in with that idealism, soul-saving notion and pretty soon lose it or leave.

The expressions “turned a shade of green” (line 2) and “knocked out” (line 5) create an image of a strong visceral reaction to the loss of ideals. They describe an almost physical reaction to the cognitive dissonance between idealism and the actual ethos of the workplace. Which in Mathew’s case was exactly the response:

It really changed me in a lot of ways. I went from eleven-and-a-half stone up to seventeen stone in six months, just because that was all I did, sit in my room at the nurses’ home and eat. It was shocking and you know I didn’t have the guts to, or courage to, move out of it; because I didn’t know what alternatives there were.

This was an environment which Mathew termed “dehumanising” and one in which it would be hard to remain faithful to one’s original ideals. Mathew was “devastated” by his first experiences as a Registered Psychiatric Nurse, where he felt “trapped, in that this was a horrible situation and felt really traumatized by it.”

Bart’s viewpoint could be considered a cynical one, but it can also be interpreted as realistic given the milieu of psychiatric nursing in the 1970s:

It needs to be put in the context of what the mental hospitals were like. These were places where there was one ward over there where they would go in and hose people down from the rafters because that is where they had been climbing. The deteriorated people they would muck down at night like barnyard animals, give them a glass of cheap whiskey and send them off to sleep, and in the morning one of the patients would come along, rake out the straw like a barnyard and take it off to be composted down in the gardens.

For Bart such conflict between idealism and reality was never an issue. His description of the circumstances leading up to his entry into psychiatric nursing suggests that his decision was expedient:

It was a job available at the time, pretty much purely and simply. I had an aunt who worked at Community Hospital; she told me that it wasn't a bad job, that you made good wages there. I'd just flunked out of university, so [I] rolled up to the door and asked for a job.

One of the most unusual reasons for choosing nursing was provided by Andrew, who thought nursing would be a way in which he could avoid being sent to war:

I had this amazing obsession, if you like, with war and hostilities and I knew that people who had valid, good, professional qualifications, as a rule, don't get marched off to the front line and shoot people. And nursing was a little bit of an intrigue in view of the fact that in my mind it was deemed to be relatively safe. Anyway, I went off and I became an enrolled nurse. I was supported by my employer to go off [] to become an enrolled nurse, and then I realised the flaw in my methodology was that as enrolled nurses you were medics and were actually the frontline people in the war environment. I've since grown up out of that process.

He also perceived nursing as "something that I did quite consciously as a means to get me some sort of qualification in a small country town." He subsequently went on to become a registered nurse and then a midwife.

This notion of expediency, or of being suited to the end in view, can also be seen as an underlying factor for those who chose nursing because of the opportunity to be of service to others. Nursing *per se* was a means to achieve their goal, be it Volunteer Service Abroad or working in third world countries: nursing was an avenue to personal fulfilment. These men, who viewed nursing as expediting their desire to contribute to humanity, have remained in the profession whereas Bart, who viewed nursing purely as a "job", used the qualification to allow him the financial freedom to return to university and pursue other academic and career options.

Warren, like Bart, also saw nursing as a vehicle to another more desirable career, in his case as a flight attendant, but he has remained within the profession: "Here I am at

an age [i.e., middle-age] and I've got a job and it's too scary to leave." Mathew also used the word "scary" with respect to moving away from nursing when the reality of psychiatric nursing impacted upon him so devastatingly: "I didn't know what alternatives there were [that were] less scary really."

For Warren nursing provides security rather than personal fulfilment. He is the only man in this study whose words suggested that continued involvement in nursing is based on a financial security need; however, there are other authors who have reported such attitudes among men who are nurses. For example, Perkins, Bennet and Dorman's (1993) study of men in the US who chose nursing revealed that financial security was a motivating factor for some. One man said, "I was a fireman and a part-time EMT [Emergency Medical Technician] and did not wish to grow old in a low paying, physically exhausting job" (p. 36), and another related that he wanted "to have a decent, reasonable scholarly trade earning a reasonable, liveable wage" (p. 36).

Warren and those men cited from the study by Perkins et al. (1993) perceived nursing as a job that could provide financial security. This contradicts the argument from other authors (for example: Cyr, 1992; Holmes, 1987) that the fact that nursing is low-paid is one of the factors that makes the role unattractive to men. There is also a theme in the nursing literature that asserts that because nursing is linked to women's work, which is undervalued, then nursing is also undervalued and, hence, underpaid (Carter, 1994; Cummings, 1995; Hartnett & Bradley, 1986; Jacox, 1997; Williams, 1989, 1992). It is striking, therefore, that in the second of the quotes above from Perkins et al. (1993) that the man involved has not subscribed to a low-status image of nursing. On the contrary his words suggest that he values the role beyond just monetary security when he described it as "decent" and "scholarly." The juxtaposition of scholarly and trade is interesting. The word trade conjures up a more manually oriented job than does the label profession, which one might expect to be linked with the word scholarly. It suggests that his view of nursing is that of the knowledgeable practice of a practical occupation.

The centrality to manhood of being the breadwinner and the association of nursing and women's work has conspired to ensure that nursing has not been a career choice that is attractive financially. Robert considered this to be one of the barriers to men's involvement in general nursing: "Probably originally because it wasn't paid that well, so

that's why men didn't go into nursing". Certainly, it was one of the reasons why Phillip didn't come into the field until some twenty years after he had originally thought of it. As he says, with respect to being married with a young child and entering into nursing, "I couldn't, I needed to earn an income, and I couldn't be a student at the time".

Paradoxically, the breadwinner role also keeps some men in nursing. Edward became a nurse when he was single; however, some years later he decided against a career move into medicine, "I know I could have made it, but I would have worked pretty hard, and I thought [of] the cost to my kids". While the "cost" that Edward alluded to may be financial, it may equally be emotional with respect to the decrease in time available together as a family if he were to undertake medical studies.

Johnson, Goad and Canada (1984) cited a US report that highlights that after graduation 85% of men stay in nursing permanently, compared to about 35% of women. We can only speculate to the extent that these statistics reflect the pressure to be the main income earner as part of the male role and for women the pressure to take time out from their careers in order to be the primary caregiver to children. Other authors have suggested that the low economic value of nursing has kept men out of nursing (Halloran & Welton, 1994; Poliafico, 1998; Villeneuve, 1994). Recent research in the UK challenges this. Hemsley-Brown and Foskett (1999) contended that pay is not a significant factor in the decision to choose or reject nursing as a career, and that by late primary school most young people have rejected jobs, including nursing, based on negative perceptions about the occupation. Other authors, too, reported the importance of attitudes to nursing as being a significant factor in young people's motivation to choose nursing (for example: Grossman & Northrop, 1993; Mendez, 1991; Vaz, 1968).

The decision-making process is multifactorial and salary is only one of the factors involved. What emerged from the interviews in this study is the suggestion that for single men, salary is a less significant barrier to entry than it is for older men and married men contemplating career change. This group may be deterred because of perceived (and actual) responsibilities to adhere to their masculine role as breadwinners. This could also explain, to some extent, why nursing appears to attract more homosexual men. There is no statistical evidence to support such a belief, however, numerous authors attest to this belief (for example: Dingwall, 1977; Fisher, 1999; Hayward, 1994; Mangan, 1994; Ralliss, 1990). If it is a valid perception, it is interesting to speculate the

extent to which gay men are freer to choose careers that may be emotionally rewarding rather than being constrained to choose a career because of financial remuneration.

Nursing as fulfilment

The cost of nursing is your life. Everything else that is not nursing falls short of it (“Allen” cited Knepfer, 1989, p. 213).

A common theme through most of the narratives of the men who participated in this study was that nursing provided personal fulfilment. In listening to, and reading their narratives what emerged was the sense that they perceived nursing as providing greater possibilities for personal satisfaction than other professional roles. For example, as Charles said about his former job as a technician, “I was finding it very boring. I was finding there was nothing, I wasn’t getting anything out of it at all.” Jock was “a bit stuck in a rut and I decided to move on [] and I really wanted to get a better qualification.” Ian, at 21, “didn’t quite know where I was heading”, while Grant was “disenchanted.” Carl, summarised well the feelings these men expressed when he labelled his former job, a “dead end.”

Paul, on the other hand, worked as a medical orderly while completing an undergraduate degree in psychology and found at the completion of it that he wanted to become a nurse, like the others, because of the greater possibilities he thought would be available to him:

- 1 I decided that I wanted to do my nurse training because the medical orderly position was slightly different to what it is now in the sense that I worked on a ward and the Charge Nurse let me do pretty much anything provided there was a Registered Nurse around, so I did dressings and drugs ... I was pretty
- 5 much left to my own devices.

While there are no legal constraints with respect to an orderly being allowed to perform such duties as the administration of medication, there are implications with respect to safety, professional scope of practice and risk management. Be that as it may, for Paul the autonomy he was permitted (lines 3-5) provided an incentive to becoming a nurse. The freedom he enjoyed as an orderly was in marked contrast to his experience

upon graduation where he went to work “in what would have been regarded at that time as one of the toughest wards in which to work.” The personality of the Charge Nurse and the lack of autonomy made this a difficult place to work:

She was seen as a strong personality-the battle-axe personality. I have very little respect for her professionally, very little. Ninety percent of what she did was not based on any evidence whatsoever. It was based on rote learning; there was very little thought that went into it. It was very task-oriented. I could go on.

Even though Paul entered nursing because he saw the scope for greater professional and personal opportunities to some degree his story can also be aligned with those who were motivated by some degree of altruism; his original intention in studying psychology was to become a social worker.

The narratives provided by these men reflect Denzin’s (1989) proposition that men and women giving meaning to their lives inform the narratives of biography. This meaning is not solely a private experience but can be a public performance in which experience is matched with culturally available narratives, scripts or transformational possibilities (Crawford et al., 1998). Arguably, the thread that is common to the accounts of these men who have chosen nursing because of a search for meaning, personal fulfilment or a way of providing service to humanity is the value of caring. This construct will be discussed in more depth in Chapter Twelve, which focuses on men, nursing and care.

Personal acquaintance with a nurse

Although nursing is popularly seen as a women’s occupation it is likely that the barrier this creates to men entering the profession is diminished by personal acquaintance with nurses. Eleven of the men who participated in this study were personally associated with nurses either through friendship or kinship before they became nurses. Of these eleven, three had personal or family friends who were nurses, while the others were related to nurses.

It might be assumed that given close links with nurses these men became nurses because they were encouraged to do so. While some described positive, or at least neutral reactions, from family members, this was not necessarily the case. Andrew, for

example, described a negative reaction from his father initially, even though there were a large number of nurses in the family:

I have a large nursing background in my family and two of dad's sisters and several of my female first cousins, my male first cousin [] and so we had quite a track record of nurses, but my dad he saw nurses as being fairly loose, almost on a par with being prostitutes, I would imagine. He did say that, several years down the track when I was having quite an argument with him: they were poor homemakers, poor housekeepers and that sort of stuff. So I don't think he saw it as a very glamorous profession. Now, however, he is exceedingly proud of me. He has grown a lot too.

Grant's two daughters were both nurses and he received encouragement from one and not the other. Although the disapproval from one of his daughters may have had more to do with his age and lack of educational qualifications beyond School Certificate than his gender:

1 So the children then were all teenagers and I thought I'd stay at the job until
 our youngest guy finished school because it was quite a well-paid job. So in
 1985 when John finished school I was disenchanted with the job: not happy
 and not achieving anything. So I was talking about this with my daughter,
 5 Amelia, one day and [she] said, "Why don't you go and be a nurse, dad?" I
 said, "Oh, don't be silly. I don't want to be a nurse, silly." She said, "Yeah, I
 think you should be a nurse." So our other daughter, Beth, who was living in
 town I mentioned [it] to her. Beth had finished polytech the year before²⁴,
 [she] said, "You will find it very difficult, father." So really that was enough
 10 for me to go and be a nurse, I was determined at that stage. Amelia had
 sowed the seeds, okay?

Three discourses of masculinity intersect in this extract: first, the breadwinner role (lines 1-3); second, a discourse that constructs men as *not-nurses*, so that the very notion becomes "silly" (lines 6-7); and finally, the discourse of masculine competitiveness. The

²⁴ Having graduated as a nurse.

competitiveness emerged when Grant's other daughter, Beth, voiced doubt (line 9). It provided the final incentive; he became "determined" in the face of opposition.

The opposition that Luke encountered was not related to nursing *per se*, but to the nature of the nursing he chose:

I don't think it was so much [nursing] ... You see my sister did her nurse training, so it wasn't nursing they had any concerns about. It was more about the fact that it was psychiatric nursing that they felt a little apprehensive about.

Interviewer: Do you want to elaborate on that?

Luke: It was the whole myth around psychiatric illness. The psychiatric institution, I mean Community Hospital, was always something you passed if you were going down Brown's Road but you never really ever dared to veer off the road and see what was happening in that place, [] that lack of understanding, I guess, of what psychiatric care and processes were all about really. So, I think my family had more issues around that whole concept than the fact that I was going into nursing as such.

What makes the reaction of Luke's family so salient in the context of this study, as will be seen in Chapter Eleven is that psychiatric nursing has been the one area of nursing that has not been constructed as women's work and a nursing environment into which men have been welcomed.

Conclusion

The ideology of nursing as women's work is strong and for men to overcome such a powerful dogma they generally need to be invested with powerful motivation beyond merely seeing it as a suitable occupation if they are to enter, and remain in the profession. Five thematic groupings have been identified as significant in these men's decisions: formative experiences, the "Call", expediency, fulfilment and personal acquaintanceship with a nurse. These factors, however, do not necessarily operate in isolation and the reasons for becoming nurses are complex and multifactorial.

With respect to continuing in the profession, *expediency*, appears to be the weakest factor unless it is coupled with an idealism that results in nursing being the way to perform a more desired role rather than being merely a means to earn a wage.

The next chapter explores the societal and professional reactions to the male decision to enter nursing.

CHAPTER EIGHT: Reacting to the man in a nurse's uniform

This chapter highlights two paradoxes within nursing: first, a discourse that constructs the man who is a nurse as androgynous, while simultaneously exploiting male strength; and second, a discourse which is critical of the man who is a nurse because of a perception that he adheres to the male stereotype. This is set against a call for more men in the profession in order to overcome a projected shortfall in nurses and arguments that increased numbers of men in nursing may raise the status of the profession.

Crossing the gender divide

Isaacs and Poole (1996) examined the stories of three Australian men who became nurses. One of their respondents, Dave, made the following observation:

1 It's (nursing) not exactly masculine is it?

(I) What do you mean?

Masculine? I was a big tough boy when I was at school, till about year 10, and there was a mix up on what I did in a subject and I got stuck into literature,

5 and I'd never had such trouble in my entire life, it just blew my energy out of the water ... as for being a nurse, it was a bit of a laugh down at the pub. They came up with all the wimpy things and any such line about a dress and little nurse hat and that sort of stuff ... My brother just couldn't get over the fact that I was going to be a nurse. (p.43)

In lines 6-8, Dave describes being the butt of his friends' jokes at the pub with the implication that he would be wearing women's clothing, "a dress and little nurse hat." What makes this extract so pertinent in the context of this study is the role that the uniform plays in constructing the image of the nurse as female. In Chapter Six it was seen that both written and pictorial images of the nurse still most commonly depict a female in a distinctive uniform to signal the occupation, gender and associated attributes. Although the traditional nurse's attire of a white uniform and accompanying cap is no longer current in many countries it remains a potent image. The role of clothing in creating the image of the nurse as female is salient and it surfaced in the

narratives of several of the men in this study. Warren recalled being sent to the infected wounds ward as a student nurse:

- 1 I do remember on my first day-we had to wear these nurse's gowns – when
 you walked in you had to put on one of these gowns to protect you from the
 infected wounds; somehow either my bugs were going to leap onto their
 wounds or their wounds were going to leap onto my uniform and run home
 5 with me or something [] I can remember fluffing around with it and one of
 the patients, an older guy, because I worked down the men's end most of the
 time, he said something about "Look at you playing with your skirt, like a
 woman" or something. It wasn't said in a vicious way, more like almost a
 fatherly thing, like don't play with your skirts because people will think you're
 10 a "poof."

Mosse (1996) noted clothes have always been one of the chief signs of gender, and in this instance the association of the clothing with the female role is so strong that the unisex gown, which is used by all health care personnel and patient visitors who may come into contact with, or introduce, infection has become a "skirt" in the eyes of the patient (line 8). The "fluffing around" (line 5), presumably the normal adjustment that one makes to an unfamiliar and ill-fitting garment, was translated by the male patient into "playing with your skirts, like a woman" (lines 7-8). In Western society women wearing what are considered masculine clothes, such as trousers, has become widely accepted, but men in women's clothing is still regarded with repugnance, being identified with effeminacy and homosexuality. The preoccupation with nurses' uniforms has become a way of feminising both Warren and Dave by other men. In Warren's example, the skirt has become a symbol for homosexuality, i.e., a "poof" (line 10).

The importance of the uniform in creating the image of the nurse as female has been a potent force for the *othering* of the nurse who is male and for the exclusion of men from nursing's ranks. Martin, while he was a Charge Nurse in an orthopaedic ward, attended a meeting in which uniforms, in particular the caps, were being discussed. For him it was further reinforcement of his difference and lack of acceptance, by some colleagues, the Principal Nurse, in particular:

She was not supportive of males at all. That's what I understand. Looking back I can see how she would more likely take the opportunity to put you down in a public meeting than anything else. So if I was trying to support my staff, for example, getting rid of the paper hats ... and they were talking about it and I raised my voice and concern that we didn't need them, because [of] traction and things like that, and was told, "It had nothing to do with you, Mr Smith."

Paul's account of the role of the uniform is more subversive: "You're a woman dressed up as a man." From this perspective the uniform the man wears as a nurse is identified as appropriate masculine attire, but that the person inhabiting that uniform is a woman. Underlying both Paul's and Warren's narratives is the image of the transvestite: in Warren's narrative the man in women's clothing and in Paul's example the woman in male clothing. Both perspectives draw upon images that challenge the accepted gender order and the stereotypes that proscribe the gender roles of both women and men: the man who chooses a role traditionally perceived as female may pose a threat to the socially constructed image of masculinity.

The androgynous nurse

Men, real men, are invading woman's own profession and making good. (Painton, 1994, p. 22)²⁵

Implicit in words above is the notion that those men who were nursing up until that time were somehow not *real* men; a remark that is demeaning of the men who had previously been employed as nurses. The use of the word "invading" to describe men's entry into the profession implies that the men have to fight to overcome opposition to their entry into the profession. The analogy is apt given the barriers identified in the previous two chapters. Notwithstanding, Painton's assertion - originally expressed in 1936 - that real men were becoming nurses the perception of nursing as an occupation

²⁵ This article was originally published in the Students Yearbook of the Class of 1936, Rockland State Hospital, Orangeburg, New York.

that is associated with low masculinity has been a persistent finding in the literature. The studies to date generally seem to indicate that men who choose nursing are *different* to men who choose more traditional career paths (Alvarez, 1984; Gumley, McKenzie, Ormerod, & Keys, 1979; Hesselbart, 1977; Laroche & Livneh, 1986; Lemkau, 1984; Vaz, 1968).

Men who are nurses are described as exhibiting more feminine characteristics and tending toward the androgynous. For example, Pointin (1988) investigated the sex role characteristics of a group of male and female nurses. From his sample of 25 men and 25 women working in a school of nursing in the United Kingdom he concluded that “male nurses do exhibit a degree of androgyny with regard to sex role orientation” (p. 772) and they demonstrated roughly equal masculine and feminine scores. Interestingly, his findings also showed that the female nurses also appeared to be androgynous, although their feminine scores were greater than their masculine scores. The images of women in nursing as angels, mothers and sex object draw upon exaggerated female traits, while another image, the nurse as a battleaxe implies a woman who is more in touch with her (stereotypical) masculine side.

With respect to the masculine norm the label “androgynous” being applied to the man who is a nurse might be construed as negative and constitutive of a man who is less “manly.” It risks perpetrating the perception that men who are nurses are inferior, for as Weedon (1987) noted, feminists throughout most of the twentieth century have highlighted that difference has been primarily perceived in terms of inferiority and lack.

The authors of the various studies that support the findings of androgyny argued that nursing transcends traditional sex-role stereotyping and that the ideal nurse, whether male or female, represents the best of both genders (Holtzclaw, 1981; Minnigerode, Kayser-Jones, & Garcia, 1978; Pontin, 1988). According to Minnigerode et al. (1978):

The ideal nurse in this study was described as not typically feminine but as someone capable of displaying both feminine characteristics (i.e. warmth, understanding, gentleness, helpfulness, kindness) and characteristics considered masculine (i.e. independence, competitiveness, self-confidence, decision-making). (p. 302)

The problem with such a trait-based approach is the binary nature of the argument (masculine or feminine) that reflects the dualism of western thought. This dualism allows the straightforward identification of difference but does not explore similarities (Connell, 1987). There is also the risk of privileging one set of gender traits over another and certainly there has been a tendency in the nursing literature to value that which is perceived as female as the preferred state. For example, Keegan and Dossey (1998) asserted that, “As nurses, both male and female, understand the importance of the feminine voice, there will emerge a reawakening of spirit in clinical practice” (p. 31).

The men in this study identified that nursing is an occupation associated with women; however, none of them described themselves as somehow being less masculine. On the contrary a number of them considered that their role as a nurse allowed them the freedom to experience a wider range of behaviours. Grant explained that he considered “a real man” to be “ a guy who feels emotional feelings, [is] prepared to cry when it is appropriate and shows emotions. I always say to everyone that I think that real men cry.”

George talked about his experience in overseas project work as a nurse, where he was able to “translate between ‘medicalese’ and engineering” and remain emotionally involved as a nurse: “You know it is really appropriate to be emotionally affected by what is horrible.” He found it relatively easy to straddle the worlds of engineering and nursing, which have been considered as masculine and feminine respectively. In doing so he was able to experience a much fuller range of his potential as a person.

Mathew talked at some length about his conscious decision as a teenager to allow himself to be an “all-rounder”:

- 1 I can remember as a mid-teen, 14 years old perhaps [] I decided I was going to reject a number of the more obvious male expectations, male roles, and become an all-rounder, learn how to cook, clean, all those sorts of things.

Interviewer: It seems as though you’re saying that those caring attributes you describe as being maternal were things you had to learn. So does nursing education teach boys and young men what they need to learn in terms of becoming caring in a non-masculine way?

Mathew: Oh. Yeah. I don’t think because you are female, you are necessarily maternal. I think there are a lot of women who haven’t learned these things

10 either. You know, I think that is where you fall into a trap [] I'm using female descriptive words for those things I've learned but I mean they probably happen more with females because that is the role the mother has; does the maternal things, the caring, the advocacy, the protecting, those things are a lot more roles that are taught to girls by our society.

15 *Interviewer:* Ok, would you say then that it was a learning experience for you or allowing yourself to actually manifest some of those things that were actually inside you?

Mathew: No, no, there was definitely, there are things that are innate and I can remember those innate things, those innate desires and needs when I was
20 very young and it was about realising and guiding those tendencies, I guess, or expressing them. It is more about expressing them, allowing them to bubble up and actually be part of my personality, which tended to keep those things down a bit [as a] a male child.

Both Mathew and I demonstrated how difficult it is to avoid the trap of gender essentialism in language. For example, in lines 8-9 where I used the phrase “caring in a non-masculine way”, whether or not the notion of the masculine stereotype was implicit, it demonstrated how easily binary thinking is expressed through language. Mathew was alert to this, when he describes the “trap” of such thinking in lines 11-16. He articulated an understanding of the social construction of gender and demonstrated his resistance to such pressure from an early age.

“Are you sure you don't want to be a doctor?”

The gender division of labour and the association of nursing with the natural female role have led to the situation where, up until recent years, the majority of the medical profession were men. Just as barriers were in place to keep men out of nursing, so were women discriminated against in terms of entering medical school and in the practice of their professional careers as doctors (Pringle, 1998).

Given an ethos, prevalent still in the early 1980s, which persisted in sex-typing medicine and nursing, given societal values that evaluated men's success through the achievement of power and status, and given that I applied for entry into nursing after

having completed a postgraduate degree, it is possibly not to be wondered at that the question “Are you sure you don’t want to be a doctor?” was asked by the Chief Nurse.

Luke commented, “Society basically dictates that men have to be in very gung-ho sort of jobs” and for Warren this aspect of masculinity remains problematic:

1 *Interviewer:* Has that ever bothered you? Have you ever thought that perhaps
you should have gone into something that is more associated with being a
successful man?

Warren: Yes, it has actually [] you don’t believe in yourself and you are
5 deliberately putting yourself at a lower rung from all other men.

Warren’s discomfort, even after twenty-two years as an RN, reveals the degree of tension that can exist between the normative male role and occupational choice. In becoming a nurse, Warren implied, you are “deliberately” (line 5) choosing to step outside the boundaries of manhood, and consciously “othering” yourself. It is questionable that these men deliberately chose to do this; the realisation of being “other” may not emerge until after the decision has been taken. Mathew described his experience:

1 I mean – things have become more apparent since then as a Registered Nurse.

Interviewer: Such as?

Mathew: Oh, the inevitable first question is, “What do you do?” You say,
“Well, I’m a nurse.” Often males will then become totally disinterested in
5 [you] and not really want to pursue conversation with you any further.

Interviewer: You mean males as clients, or males you just meet in general?

Mathew: Males you just meet in general.

Interviewer: Why do you think that is?

Mathew: Because I guess there is some sort of nebulous stigma attached to
10 males being nurses. I can’t really define it, but males ... you’re not, you’re not
slotted in easily, you know, to a particular ... [] There is no firm gender
stereotype of males in the nursing role so people feel a wee bit uncomfortable
about you. “Well what have we got here?” Particularly males.

Mathew's description of disinterest from other men on hearing of his occupation (lines 4-5) could result from two factors. First, a discourse of masculinity that requires a man to be in a position of power, which sets men against one another as rivals and competitors. There are two axes of competition. Along the vertical axis intergenerational rivalry occurs, for example, between father and son, or workplace rivalry to dislodge those in more senior positions. Upon the horizontal axis men are in competition with their contemporaries to be man of the match and so forth (Buchbinder, 1998; Connell, 2000a).

Dismissed as a rival, why would the man, who is a nurse, not be someone with whom one can relax? In lines 5, 9 and 11 Mathew emphasised that males in particular have difficulty with the concept of men in nursing, i.e., they are more likely to stereotype occupations according to gender. Miller and Budd (1999) in their study of the development of occupational sex-role stereotype, occupational preferences and academic subject preferences in children report such a tendency amongst young men:

Despite positive attempts to reduce sex-stereotypes and discrimination in the workplace, it is evident that young children still do stereotype many occupations according to gender and this is especially apparent with male children. Although occupational stereotypes appear to reduce significantly with age, there remains a substantial degree of occupational sex-role stereotyping amongst adolescents as old as 16 years and, again, this is more extensive in male adolescents than in females. (p.33)

So, the second factor relates to the *discomfort* (line 12) of being around someone who transgresses against the gender rules identified earlier.

When Bruce, at 16, decided to apply for nursing school his experience was consistent with the results of Miller and Budd's (1999) study. He described the reactions of his friends at school as being "quite anti, and I don't think they could work me out in a sense." Or as Mathew said in the earlier extract, "you're not slotted in easily."

“Are you man enough to do women’s work?”

Nowhere is the nursing profession’s ambivalence to men and masculinity more evident than in the issue of recruitment. The Report of the Auditor General of the Government of Victoria Australia (2002) identified that nursing shortages exist in many developed countries, including Australia, the United Kingdom, Canada and New Zealand. In the United States a key factor in the nursing shortage has been identified as the increase in career choices available for women (Nevidjon & Erickson, 2001); a suggested solution has been the recruitment of more men into the profession. According to Dean Dolores Sands, School of Nursing, University of Texas at Austin, “Tapping men is our only hope to increase enrolments in nursing programmes. For too long we’ve ignored literally 50% of our human resources” (MedZilla.com, 2002, online). This opinion is currently being expressed in New Zealand also; for example, even a community newspaper such as the *Manukau Courier* is writing about the drive to attract more men into nursing (Patterson, 2005).

The call to recruit men is, however, not a recent phenomenon. In the US, for example, Brown (1948) wrote, “There is general agreement that men are much needed both as graduate and trained practical nurses” (p.54). This was not in response to a shortage of nurses per se, but was to free woman from having to care for male patients, she continued:

- 1 The number that could be utilised immediately in positions of all kinds on men’s wards both of psychiatric and general hospitals, as well as in the field of private duty, is large. Because so few are available, women graduate nurses and orderlies divide the nursing care of men patients. It could probably be
- 5 better performed by men graduates and trained practical nurses, besides freeing up women nurses for other duties. (p.54)

Two questions emerge: (1) Why are men better looked after by other men (line 5), which will be returned to in a subsequent chapter; and (2) What other duties – and the implication appears to be *more important* – the women could be freed up for (line 6). This extract belongs to the discourse, described in Chapter Six, which constructed men as second-class nurses. This would seem an unlikely inducement for more men to

become nurses; being asked to leave the privileges of the male-dominated workforce to become second-class employees in a female-dominated workforce.

In the UK in the late 1980s questions were being raised about whether men should feature in an advertising campaign to address the projected shortfall in nurses. It was suggested that an injection of “machismo” was needed. According to a nurse recruitment specialist interviewed by Cottingham (1987), “You need to convince men that it’s fine to be macho and caring. Ask them if they are man enough to do a caring job” (p. 28). Within the context of the normative male stereotype described in Chapter Five this requires men to resolve a contradiction, as to be male and “macho” you must eschew the exhibition of gentler traits, such as caring, which are attributed to women.

Gaze (1987) investigated the gender imbalance in British nursing and the consequences for the profession of an increase in the number of men nursing. The article itself added nothing new to the debate on the perceived advantages and disadvantages of men in the profession. What is interesting is that the two photos that accompany the article are the epitome of machismo. In the first photo a young, black man in a nurse’s uniform gazes unsmilingly at the camera, one arm crossed over his chest beneath his nurse’s watch, with the other arm raised upright holding a very large syringe. In the second photo the same man stares into the camera, both arms folded, underneath the caption *Men needed*, and the inducement *Join the professionals* beneath his folded arms. The model’s face is strong, well defined and his biceps are extremely well developed; his appearance well captures a stereotypical image of the physically powerful male. The image is hypermasculine; the man as a nurse has been reconstructed from the inferior man into the quintessential *action man* figure. The man in this picture would look completely appropriate if he were soliciting for men to join the armed forces.

What is missing, from this image, is any sense that this man is compassionate and caring; he is not shown using his enhanced masculinity in any caring capacity. Everything about the figure is the antithesis to the construction of the nurse as an angel, or as someone who is less than a *real* man. There is nothing overtly gentle and caring, and the 50mL syringe, half-filled with a solution, looks more threatening than therapeutic. Given that pain, or the fear of pain, is often associated with needles and syringes, to place a particularly large one in the hand of the male not only reinforces a stereotypical image – the punitive male figure – but also associates it with the man as a

nurse. The ideological perspective that underlies such images does nothing to enhance the image of men or nursing. An attempt to transform the man who is a nurse from an androgynous, inferior male to a hypermasculine man contributes as little to men in nursing as do the sexualised images of female nurse that appear on many “Get well” cards. The gender stereotype is perpetuated.

The choice of a black man is also interesting, while his colour is most likely a conscious appeal to minority groups it is potent in the context of the historical discourse of black masculinity. White men’s masculinities are constructed not only in relation to white women but also in relation to black men (Connell, 1995). There been a long history of fear of black men, based on a perception that not only are they are more violent, but also that they are more sexual. As well, for a considerable part of European history the black man was perceived as inferior to the white man. Arguably this continues, although less overtly. The black man was perceived as strong and fit, but this was turned against them: “Their strength was barbaric, without order or direction, displaced into an overflowing sexual energy menacing white women” (Mosse, 1996, p. 66).

It will be highlighted in a subsequent chapter that the fear of male sexuality in relation to patients is a problem for men practising as nurses. Therefore, the choice of an image that draws upon discourses of hypermasculinity and predatory sexuality suggests that nursing remains ambivalent about masculinity. It draws upon the normative stereotype rather than supporting and promoting expressions of masculinity that do not subscribe to such a restrictive form of masculinity. It can be argued that such thinking is naïve and that attempting to “butch” up nursing will not be attractive to either women or men contemplating entry into the profession.

The putative positive impact that men might have on the professional standing of nursing issues being faced by nursing underpinned the call for men to be recruited into nursing, in the UK and the US, in the 1970s (for example: Christman, 1980; Galbraith, 1991; Lynn, Vaden, & Vaden, 1975). It was suggested that the entry of men into nursing may upgrade the status of the profession (Gordon, Herrick, & Benvenuti, 1994; Lynn et al., 1975) and provide a number of positive benefits such as improved retention of staff (Faight, 1989). It was argued, for example, by Roberts (1983) that because nurses are predominantly female they are oppressed and that there is a direct correlation with problems experienced in nursing, such as lack of self-esteem and unity and that the

promotion of men into nursing would be a step to overcoming some of these problems. London (1987) summarised the arguments for the increased recruitment of men:

- Men are less likely to be intimidated by male physicians.
- Men will improve pay and conditions because they are better able to bargain collectively and are more power oriented in their coalition strategies.
- Men are less likely to accept poor pay and conditions.
- Men would bring administrative abilities.

Having outlined the arguments for the recruitment of men into nursing, London (1987) then countered these arguments and concluded, "Actively recruiting men at this time may not provide what nursing is looking for" (p. 80). To some extent it is impossible not to feel sympathy with her views. The arguments put forward on behalf of men's entry into nursing at best appear patronising and, at worst, perpetrate essentialist gender stereotypes. Once again, the chivalrous discourse appears to lurk below the surface; when the damsel is in distress the knight on the white charger will come to rescue her. Given that men, as nurses, are constructed as less real, more androgynous and exhibiting traits associated with normative femininity then perhaps these are not the very men who will fight the dragons to rescue the damsel. London, however, falls into the trap of gender essentialising in stating, "Nursing is an intrinsically female profession, based on female values and morals and a wholistic world view" (p.80). She does allow, however, that there might be a place for men if "the women in nursing will have developed enough confidence in their own expertise that they will be able to accept entering men as equals and not as superiors" (p.80).

The problem with the argument presented above is that men in nursing have not been perceived as equals; they have been constructed as inferior both as nurses and men. To suggest that men as doctors and men as nurses hold similar positions with respect to access to power and power over women as nurses is too simplistic an analysis of gender differentials in power.

One of the most interesting warnings against men's entry into nursing was put forward by Ryan and Porter (1993). They contested the belief that an increased number of men would benefit the profession arguing that women continued to provide the

clinical care while men researched their clinical practice. They highlighted the fact that men published in the nursing literature to a disproportionate extent; in the UK and Ireland the proportion of male authors in the nursing literature was five times greater than the proportion of men in the profession, and in the US the proportion was twice as great. They used the feminist argument that male control of language underpins patriarchal power and therefore men's dominance in the nursing literature was significant and a further example of men's patriarchal privilege. The irony is that Porter is a man, a nurse and an academic. He acknowledged this as his "Achilles heel" (1996) and wondered why his detractors didn't use this as an argument rather than indulging in *ad hominem* arguments in letters to the editor in response to the original article (for example: Ciesielski, 1994; Johnson, 1994; Peichoto, 1994; Tranbarger, 1994). Porter criticized men in nursing from his privileged academic position, as a sociologist, using the language of academia and then wondered why the men were not more rational in their response. Ryan and Porter's (1994) responses to their detractors, however, could not be described as exemplars of dispassionate rejoinder, employing such comments as, "We are somewhat bemused by Gregory Johnson's rather hysterical writing style" (p. 244) and "We are at a loss to make any comment upon the infantile fantasies about cowboys that he confesses to ..." (p. 247).

Perhaps, some of the rhetoric in the rejoinders to Ryan and Porter (1993) expressed the frustration of men, who as nurses, find themselves positioned between Scylla and Charybdis; in choosing nursing they move against the malestream and are then often treated suspiciously by both society and nursing and are placed in a position of justifying their career choice. As Groff (1984, January) described in his experience, "A man in this "female" profession has to battle two stereotypes-not smart enough to be a doctor, not caring enough to be a nurse" (p. 62). Ryan and Porter's (1994) response, to those who disagreed with their original article, that they should have been more objective in their arguments ignores a significant point: the men who choose to remain at the bedside are men who do not demonstrate complete adherence to the normative masculine image. Therefore, they may well be more able to express their emotions.

Levant (1998) has proposed that normative male alexithymia²⁶, or the decreased ability to communicate feelings or even the decreased ability to identify feelings, is widespread among men. He argued that owing to male role socialisation, “boys grow up to be men who are genuinely unaware of their emotions, and sometimes even their body sensations” (p. 36). Levant (1998) described the consequences of the common inability among men to recognize and articulate emotions:

It blocks men who suffer from it from utilizing the most effective means known for dealing with life’s stresses and traumas—namely, identifying, thinking about, and discussing one’s emotional responses to a stressor or trauma with a friend, family member or therapist. Consequently, it predisposes such men to deal with stress in ways that make certain forms of pathology more likely, such as substance abuse, violent behaviour, sexual compulsions, stress-related illnesses and early death. (p. 36)

It is possible that the anger is expressed in response to perceived attacks, as exemplified by Ryan and Porter (1993), could also be an expression of pain or frustration. Holtzclaw (1981) suggested that the minority status of the man who is a nurse could well be a cause of anger; she asserted, in the US context, “The man in nursing has been faced with elements of myth, conjecture and stigma for much of this country’s history” (p. 116). Brooks, Thomas and Droppleman (1996) investigated the expression of anger in a group of US men who were nurses and reported the anger to be a response to: blaming, questioning of their knowledge, unmet expectations, helplessness and being treated differently because of their gender.

“I’m the only male nurse”: Standing out

Being treated differently because of their gender was a theme that emerged strongly in the course of the interviews with the men who participated in this study. Their presence in a female-dominated profession means they will inevitably stand out; it is a significant factor in the differential treatment, both positive and negative, that they

²⁶ Levant (1998) differentiates between normative male alexithymia, which he considers a mild-to-moderate form, and severe alexithymia which he states was originally described by Sifneos (1967) and Krystal (1982) to characterise severe emotional constriction in (primarily) male patients.

receive. Edward was interviewed shortly before he was about to leave nursing after a twenty-year career:

- 1 I see females making the same mistakes, I don't want to call it that, because I think they are things that we do [] but they just seem to become not an issue, but when I do it, it becomes a mountain out of a molehill. I don't know. I don't want to project blame or project judgement or whatever because I've got to
- 5 look at it from my own, you know, what have I done towards that? And I think I've probably taken a lot of that on board, right through my nursing career.

Edward described his perception of being treated differently (lines 1-6) when it comes to performance issues; there appears to be an underlying sense of feeling victimised and in line 6 he articulates how this has been internalised. This theme was explored a little further and he was asked if what he perceived as “attacks” were actually personally directed or more gender- oriented: “I don't know and I think it is very subtle, and I think that when you're a male nurse ... it's there all the time. And I'm looking forward to not being amongst it.”

While “looking forward to not being amongst” what he perceived as discriminatory differential treatment he also expressed regret, “I don't want to leave my roots because I actually believe in nursing.”

Edward did not choose to disclose the exact nature of the “attacks” he refers to; however, Jock identified that a common negative comment about male nurses is that they are lazy. A belief he did not agree with, “I don't think they are any lazier than any other nurse.” Charles remembered his student experience when during the morning report the Charge Nurse commented, “As for Mr Smith', because I was always Mr Smith, 'You'll just wander around with your hands in your pockets' [] and I felt really hurt about that.”

The issue, from the perspective of these men, was not that they were lazier but that it only required one male to be less than satisfactory and they were all judged by that one man. As Jock continued, “It may be that they are visible because there are so few male nurses [so] that if one male is perhaps not really that diligent than perhaps they are seen as standing out.” Being constantly under watch gives a sense that your performance is always being judged and for Robert this makes the work of nursing harder:

- 1 In some ways it was more difficult, because being the only male nurse in
the hospital and as a student you were always picked out, and it's like you can
be on duty and you are the only male and [they are] always watching you
because the people are more inclined to focus on you albeit your colleagues,
5 managers, patients ... so in a way it is more difficult like if I'd done anything
bad it would be brought up and people would remember the male nurse, you
know, where if it was that female well there are two or three hundred to be
chosen from so in those terms I suppose it is a lot harder.

Robert's belief that anything bad (line 6) gets picked up because he is so easily recognisable was shared by a number of the other men; for example, Warren commented "Women always get referred to as the nurse, kind of thing, no matter which one; 'Oh, it was the male nurse, the tall one with the blond hair'." Whereas, Andrew simply stated, "I think we stood out."

The response to this perception of hypervigilance is, for some, to work harder. According to Martin:

- 1 You did stand out, whether you liked it or not, and that made you in some
ways work harder or be-now how was I going to term this? Be right all the
time [in] how you did things, so you followed procedures or you followed
what was taught, so you didn't do anything wrong, because you would be the
5 one that would be picked up.

Martin describes a need to be "right all the time" (line 2) in order not to be singled out, yet arguably this need also unconsciously traps him in the male stereotype which requires service to the Protestant work ethic as described in Chapter Five. According to Bruce, "There was no slackening off. There was a lot riding on this both for yourself-I mean we were pretty driven people anyway - yeah, it was sort of like men can do this as well."

Bruce suggested that not only was the need to work hard personally important but that it was also important to not let other male colleagues down. Allan reiterated this, considering that he had "a responsibility for men who are nurses to do the best that I

can.” Being thought of as a “lazy male nurse” is a label that he was not keen to have placed upon him:

There was a male colleague I worked with for a number of years that I thought was sloppy in his physical manifestations and mannerisms and also in his approach to his work. I didn't like how that reflected on men who are nurses as a group. If there were incidents that involved him, which was the case a couple of times, people may have thought that it was me that was involved in those situations within the hospital, like there weren't many men who worked in City Hospital so the chance was probably that someone might have thought it was me rather than him.

Both Allan and Robert preferred to work with women in order to avoid being associated with *lazy* men; however, to what extent does this reflect internalisation of the negative message? Hearing the message often enough one might well come to believe it, whether or not it is true. According to Robert:

- 1 I just always have worked with females because I've nursed for a long time. I just like their ethic of work []they get on and do jobs and men are probably more inclined to procrastinate, [and] talk about [it]... my experience of working with other males it that they are probably more likely to talk about
- 5 the theory of why they are doing it so, yeah, I would prefer to work with females.

Robert placed value upon the doing of nursing's tasks (lines 2 and 3) and dismissed men because they want to talk about what they do. Two discourses intersect here. First, the traditional New Zealand male stereotype that was strongly anti-intellectual. According to Phillips (1987):

If the traditional male stereotype ostracised homosexuals, it also raised questions about the masculinity of artists and intellectuals. At the heart of the stereotype was a belief in the primacy of physical abilities and the all-round skills of the pioneer. The colonial was perceived to be a man of common sense, a jack-of-all-trades, compared with the specialised training and book-learning of the metropolitan man. (p. 282)

The second discourse is a culture in some parts of nursing that has been, and arguably continues to be, anti-intellectual. Robert's comments are congruent with this ethos. For example, the move of nursing education to Polytechnical Institutes in the early 1970s was criticised by many nurses who trained under the apprenticeship model; now the criticism is being echoed in the comments made about graduates who are baccalaureate prepared for entry onto the nursing register. For example, in my role as a nursing tutor in clinical practice I have heard nurses describe the students coming out from a university for clinical experience as "talking heads": the implication being they were not practically focused. As well, working alongside the students in clinical practice I have been greeted by nursing staff with comments such as "Oh, so you've come to do some real work."

This discourse has been labelled, in nursing, as the *theory-practice gap*. According to Storch (1986):

Nursing theory is frequently greeted with scepticism by practising nurses, primarily because the value of theoretical knowledge is not always apparent. There is, in fact, a tendency to relegate nursing theory to the realm of academe, to regard it as simply an academic exercise. (p. 16)

The theory-practice gap was a theme that attracted a lot of attention in the nursing literature during the 1980s and into the early 1990s (for example: Bassett, 1993; Cook, 1991; Hewison & Wildman, 1996; Mayberry, 1991; Nolan & Grant, 1992; Speedy, 1989). According to Higginson (2004) it continues into the present day and research-based evidence continues to be dismissed as irrelevant by clinical staff (Ousey, 2000).

The ward "crane"

In the workplace, male nurses have often been appreciated more for their brawn than their brains. (Brooks, Thomas and Droppleman 1996, p.5)

The man who is a nurse – constructed as emotionally androgynous, more in-touch with the so-called feminine side – becomes something other from the normative world of men. Ironically, however, his physical strength, that element of normative masculinity that creates the potential for aggressive and violent behaviour, has been valued in the

psychiatric field with respect to controlling the aggressive patient and also in general nursing for lifting patients and heavy equipment:

Personnel in psychiatric wards wonder how they ever got along without them ... Men nurses are especially well-equipped for positions in mines, construction jobs, heavy industry, and prison work. (Jamieson, Sewall, & Suhrie, 1966, p. 364)

For Ian, in his early nursing career, there was a sense that his strength and relieving female nurses from “difficult male problems” was the extent of his value:

Interviewer: You said you were also required to go and help with the lifting?

Ian: Oh, yes, yes, yes. Particularly the females, and that was one of the interesting factors even from our colleagues in the early days was when people said, “We’ve got a male nurse coming on duty.” “Oh great! Help with the lifting.” We were seen, I think, by a lot of people as not equals, I don’t know that we really were, quite probably.

Being used as the “ward crane”, as Charles termed it, was a common experience for the men and one that generated a degree of resentment. As Bruce explained:

You were always given the heavy clients-the clients that had dense CVAs-if anyone needed a lift, you had to do it. They didn’t have piped oxygen, they had oxygen cylinders and you were expected to go around and bring the trolley with the oxygen cylinders. You were the one to push the beds around, and do all the transferring, all those sorts of things. It got a bit annoying really.

What emerges from these extracts, and the preceding chapters, is that men have been discriminated against within nursing. The overt exclusionary policies “designed to reaffirm gender boundaries” (Williams, 1989, p.88), have been translated into differential treatment based on gender; for example, such as the dealing with the difficult patients and male issues such as shaves and catheterisations. Ian described the situation of being expected to do all the male shaves in the hospital as part of the preoperative preparation and the pressure that created in terms of his workload:

We seemed to be expected to shave all the male genitalia for theatre the next day. If you were unfortunate enough to be on afternoon duty you would be called in by the

supervisor to go and shave all the men and they were full shaves ... It seemed that it was our role in those early days, “Oh, there is a male nurse on, go and get him to come and do the shave” [] I was so fed up in the end because I felt we were letting our colleagues down; they were bed patients , there were not many people up and about. You were away from the ward [] and you were doing two or three shaves of people’s genitalia for the next day, you were letting your team down, they didn’t send someone to replace you.

There was also the expectation that the nurse will be available physically to help with other nurses’ heavy or aggressive patients. Bart recalled how, “Sometimes men would get called on, if one of the female patients was particularly violent and strong, and hard to deal with, some of the blokes would be called in to assist with the restraint.”

Maurice Carlyle who commenced nursing in the 1950s recalled the restrictions that were placed on him with respect to caring for women and children, except “the only time I was asked to help with a female patient was when the female nurses had a heavy patient to lift in the geriatric wards” (Brown, 1994, p. 129).

This differential treatment reveals an ambivalent attitude within the profession to men and their role as nurses. On the one hand, their physical strength is valued to assist with heavy and difficult patients; on the other hand they have historically been perceived as someone who should be kept away from female patients except on the behest of a female nurse. Paul described this as being “used and abused.” While recognising that his physical strength can be of assistance it is the way in which the request is broached that creates frustration for him:

- 1 I really object to learned helplessness. If people want me to help with something they need to ask, but oblique comments like, “This is really heavy” just cause reactions that are far larger than they deserve to be from that person’s point of view. They may have said it quite innocently, but need to
- 5 think about what they are saying. And that is a particular issue for men, because we are used, and certainly as a crane, to look after heavy patients.

Paul’s comment in line 5 that being used as a crane is “a particular issue for men” is not confined to men in nursing in New Zealand. There is evidence from the United

Kingdom, Australia and the United States that men are uncomfortable with their professional identity being associated with their physical strength. For example, as Pete, one of the respondents in Isaacs and Poole's (1996) Australian study commented, "Sometimes you are treated as lifting machines" (p. 44). In the UK, Jones (1990) described his experience of resisting the profession's ambivalence to the man as a nurse, but asked:

But what of other young men who embark on a nursing career and allow themselves to be manipulated into being a spare pair of hands on the ward, useful for recording observations and lifting people on and off bed pans, and nothing much else? (p. 7).

It can be argued, in this instance, that there is little to differentiate them from all the other men, orderlies, attendants and so forth, who have provided their physical strength at the service of female nurses.

Standing out: a two-edged sword

While standing out and the sense of being constantly watched and judged is a stressor, the men in this study also identified that visibility has positive benefits as well. As Robert stated, "You probably get more adulation than a female." Many of the men observed that patients and, sometimes other staff, were quick to praise them for their work. They acknowledged, however, that this praise might derive from the fact that they were standing out against type. This makes what they do, bad and good, visible against a background of the normative expectation that nurses, as female, will naturally behave in a caring and compassionate way. The men are praised for being *unnatural* to their gender. Robert attempted to place this within a historical discourse that expects such behaviour from women:

1 *Interviewer:* What are you getting the adulation for?

Robert: Because, because you're a male and lots of time women's behaviour has always been through history [that] women always protect men and they serve for men and it's probably like the way they've treated their husbands

- 5 basically because [they provide] a lot of support and good things to a male, where if a female colleague of mine was doing exactly the same job as me they wouldn't get the same praise as I would and yeah it's very obvious.

Robert's comment (lines 3-5) about women's role having been historically one of supporting men is echoed in the nursing literature where it is argued that women in nursing consciously or subconsciously foster men's career development (Evans, 1997; Kauppinen-Toropainen & Lammi, 1993; Williams, 1989, 1992; Williams, 1995a). Thus, men have to tread a fine line between accepting that praise may be awarded undeservedly and at the same time accepting that sometimes perhaps their performance, as individuals, is a little better. Charles commented about the praise he received from patients, "Sometimes I think it is genuine, that it's fair enough what comes back, and sometimes I think, "No everyone else has done just what I've done, but I've got the praise for it".

The question was put to Jock about the extent to which this praise was earned or was consequent upon men's minority status and hence their heightened visibility:

Oh, yes I guess that's the case ... yes, certainly because you are only one of a few then yeah, it is probably easier for the patient to remember you than if you were, for example, a female amongst a whole lot of other. Yeah, I think that is probably a fair enough comment, yeah.

While the positive feedback from patients, relatives and other staff is a reward it is can also be a source of discomfort and embarrassment. Allan disliked being singled out as a student by a tutor when he was doing the obstetric part of the programme:

I was the youngest in my family and I had fourteen nephews and nieces and I was used to children, so I had no problem holding a baby or bathing and this tutor thought that I was really wonderful and I got the highest grade in the year for that section. Even though I thought I was good, there were people that were a lot better. That was really embarrassing.

The normative template that was being placed upon Allan in fact had no relationship to his reality. He recognised that being male in nursing creates a higher

profile, but one that he accepted reluctantly, “I had not the ability to have anything but a greater profile [] I wasn’t always too happy about that position.” Even so he recognized that he “used it to positive ends when it suited.” While, there have been times that he has used his “high profile”, as he described it, in this instance he attempted to discuss the issue with the tutor:

Interviewer: Did you ever discuss that with her?

Allan: To a degree; although I probably wasn’t very confident about challenging her about it. I was probably more embarrassed in front of some of my female friends and colleagues that were in fact probably better than me in that field.

Paradoxically, being singled out for praise can be a negative experience as Grant found it could lead to some resentment from female colleagues

I think one of the problems is that I’m the only male nurse. Everyone remembers the male nurse and one of the negatives about being a male nurse in the area I’m in [is] if you are the only male people remember you more than they do lots of females and therefore you get the comment, quite often at our place, “Oh, Grant got a mention, but we didn’t.”

Andrew noted a similar response from female colleagues to his receiving praise, “They’d bring it up every now and then in a pseudo sort of bitchy way.” He described this as “wonderful”, denoting his enjoyment of what he saw as playful interchange. For Grant, however, the comments can lead to anger because he feels put down and that it becomes tiring when praise from one person may bring a negative reaction from many:

I get quite angry sometimes, but ... I had a discussion with Amelia, my daughter, one night and she said, “Well, maybe the people are right, maybe you are a little bit better than they are, and maybe the people do like you better, dad.”

The men are trapped by a visibility that can lead to them being both patted and slapped. The added visibility can also be an increased source of stress because of vulnerability to accusations of professional misconduct. This is an issue of which Robert is well aware, “As a male nurse you are always being viewed – so my standards always have to be a lot higher than my colleagues.” The presumption here is that he refers to

female colleagues. Warren wondered if being visible might actually lead to discrimination when it comes to disciplinary proceedings:

Warren: I guess you just have to look at the uhh what's that –

Interviewer: Kai Tiaki?

Robert: Yeah, and the number of men disproportionately who get struck off and I just don't think it is anything to do with being men – maybe there is hidden stuff – but men get noticed. Like when I was at County Hospital²⁷ an awful lot of those women there were diabolical with the kids. You know there was one woman there feeding one kid phenobarb every time he started getting a bit irritable. He had never, ever in his life been charted phenobarbitone ... there was another woman here who was slapping the kids, but that didn't get reported, you know? But had I laid a hand on them, or had I given them phenobarb ...

Robert was not the only person to express such a thought; Edward believed that his “mistakes” were judged more harshly and Charles also thought that it was easier for a man to be identified and disciplined:

Much easier to knock you on the head if you make a mistake-they know who you are. Sometimes a female nurse will get away with making a bit of a boo-boo. “Who was that?” and they can't remember but they've only got to go, “It was the boy” and you've had it.

An interesting feature of this theme is that the perception of men's visibility as a factor leading to greater potential for disciplinary action is divided along occupational lines. It was the general nurses who put forward this belief, while both Mathew and Bart, who were psychiatric nurses, described situations in which appalling misconduct did not result in disciplinary action.

It could be conjectured that the higher proportion of men working in psychiatric nursing has created a masculine ethos in which physical misconduct is more tolerated. Equally, it could be asserted that the feminine ethos of general nursing has led to forms of non-professional behaviour that are subtler and less liable to result in disciplinary

²⁷ A psychopaedic hospital.

action. The belief that they are more liable, as general nurses, to be treated unfairly when it comes to professional issues is anecdotal; however, such a belief can lead to degree of strain and has certainly been a factor in Edward's decision to leave nursing.

Conclusion

This chapter has highlighted that men are positioned ambivalently within nursing. On the one hand there is a discourse that constructs them as androgynous and therefore inferior, while the stereotypical masculine traits are desired on the one hand, as a man can be a source of muscle power, and not wanted on the other hand because it is suspected that there are masculine characteristics which will be used to perpetrate patriarchal oppression of women who are nurses. Their enhanced visibility leads to them being both the recipients of praise and, in the perception of some men who are nurses, unwarranted criticism. For some this has led to frustration and even anger at times.

The next chapter will continue this discussion of the reaction to men in nursing with a focus on the paradox between nursing as a caring profession and the horizontal violence experienced by many nurses and patients.

Chapter Nine: The paradox of care and horizontal violence

This chapter will continue the discussion that was begun in the previous chapter of the reaction to men in nursing. It begins with the identification of a further paradox: that of nursing's espousal of the "primacy of caring" (Benner & Wrubel, 1989) and the violence that nurses wreak upon one another and their patients. This chapter will commence with a consideration of that phenomenon and will draw upon the narratives of the men in this study and other literature to try to understand the impact that this has upon the lives of men who are nurses. Generational "snapshots" are provided which historically trace male experiences of horizontal violence in nursing.

A major theme that surfaces in this chapter is the male belief that, in their professional role, they are constantly being watched and judged and that they need to prove themselves as competent nurses through constant hard work. There is also a discussion with respect to the positive feedback that many men in nursing receive and whether this is an artefact of their enhanced visibility or is, in fact, deserved. This chapter also argues that nursing education makes inadequate provision to address the needs of both male patients and men in the nursing workforce.

Nursing: No place for a man?

Zussman (1992) observed that compared to medicine there had been little interest from sociologists and historians in nursing. Those substantial studies that had emerged, including Zussman's, continued to reinforce the belief that "nursing is, and always has been, a woman's occupation" (p. 63). It is rare to find more than a cursory mention of men as nurses. Not only have men been rendered invisible, or at best marginalized, in nursing's documented history, but also there is evidence, both from the nursing literature and from the narratives of the men in this study, that there are those in nursing who question the value of men's involvement in nursing.

At one extreme the questions raised include the arguments of those who have been hesitant to encourage men's involvement in contemporary nursing (for example: London, 1987; Ryan and Porter, 1993). Once again another contradiction becomes evident: the contrast between calls for men to "get in touch with their feminine side" and wariness of men's increased entry into nursing for fear of a male takeover. Bullough (1997), for

example, cites the words of a male graduate nurse who described his experience at the beginning of his graduate work:

There was a cohort of vehement feminists in the program. It became rapidly apparent to me that not only did these women have strong opinions about traditional science, but that also felt that men had no place in nursing. (p. 592)

When Ian began his nursing training in the early 1960s the impression he received from some of the nursing hierarchy he described as hatred. He remembered one Matron in particular, “I think she hated us quite frankly [] She was very anti us. It became obvious from her, down into certain of her underlings down the line.” He recalled that some time later he heard that the Matron (or Lady Superintendent as she was then called) had been opposed to the Hospital Board opening up the School of Nursing to men, “She didn’t want it, so we were unwanted from day one”:

So there was this reluctance, it mellowed over the years, but it took some years and I must admit even after I registered [for] some time there was still that animosity with certain of the individuals, who were still around the place, and we were nearly their equals in those days and they still had that sort of wary look. I don’t think it was being threatened for their positions. I just don’t think they wanted men around.

As more men have entered into the nursing profession and with the changes in society that are occurring in gender relations following the second wave of feminism the animosity may well have “mellowed”, as Ian suggested; however, the following section will reveal that it continues to be part of the experience of nursing for some men.

“Why don’t you just leave nursing?”: Men’s experience of horizontal violence

This belief, on the part of some female colleagues, that men have no place in nursing was discussed by a number of the men in this study. Ian was in the first cohort of men to be trained at City hospital and he described how difficult it had been to find a tutor prepared to “take the males on” and that it was virtually at the last moment that a female tutor stepped forward. He also thought there were deliberate efforts made by some female nurses to get rid of the men, although he clarified that generally the women in his peer group were supportive:

The nursing hierarchy were the problem, [they] were in fact quite vindictive. They were deliberately vindictive, they were out to trap, I think, the male staff into mistakes and errors so that they could chastise them or probably get rid of them. It was quite noticeable.

A decade later, in the early 1970s, Martin found himself contemplating giving up after being victimised by one of the Charge Nurses:

To give you an example, I would come on duty in the morning. I would be second nurse, so I was in my second year, probably going on into my third in that era. She would be there six in the morning till six at night, one of those old Charge Nurses. She would sit and listen to the morning report, and it would be we had x number of admissions coming in today, "They're all going into second nurse's side and none of you are to help", and that was blatantly said.

Another time he found himself being challenged by one of the female nursing supervisors, "I don't know why you are here, why don't you just leave nursing."

In the early 1980s, during his nursing education, Robert went to introduce himself to the Charge Nurse of the first ward he would work in. He introduced himself and was met by the response, "Well, I don't want you working here on my ward because I don't think men should be nurses." He described the emotional impact that had on him:

I felt devastated. I didn't know what to do. I was quite young and to be confronted by this woman who was overpowering and very uncompassionate and I walked back to the Tutor Sister and told her what happened and they rectified the situation, but I still went there in my first clinical placement to work under this Charge Nurse. So yeah, yeah she wasn't at all receptive to me.

Given the initial hostile reception, to place Robert back into that same environment it is questionable to what extent that "rectified the situation." To place a vulnerable individual who was at the beginning of his nursing career into such a compromising situation does not support the student either pedagogically or emotionally.

In the mid 1980s Warren had a similar experience when working in obstetrics as part of his nursing education. His initial impression of the environment was positive, but this

soon changed as he met hostility very quickly from the midwife he was assigned to work with:

- 1 I remember going to get my roster down in delivery suite and seeing this woman there, this midwife who walked past me, joking with people and seemed quite fun to work with and I remember thinking, “Wow, I hope I get to work with her” and I did. I got to work with her and she was like the bitch
5 from Hell, she was HORRIBLE to me. She was nasty to me, she would yell at me, make me do really menial tasks, that sort of thing. And each midwife had two students to look after and the other student who had that particular midwife had said, like took me aside one day and said, “You know our midwife has been talking about you really badly, that you don’t do this and you
10 don’t do that. I just want to tell you that.”

Interviewer: Was the student male or female?

- Warren:* Female, and I felt really awful about it, but I guess in a kind of way it just confirmed the impression that I’d been getting from this woman, so actually when I was alone in the room with her I brought it up. “Look it feels to
15 me like we’ve got some barrier here; we’re not getting along very well.” She turned to me and said, “Don’t take this personally, but I don’t think there is a place in midwifery for men.” It was like “Screw all of this.” I didn’t actually say that to her, I just said, “Look, I’m really sorry, but I don’t want to be a midwife, I don’t want to do obstetrics, but this course says I have to do obstetrics, and
20 I enjoy the work and stuff but I don’t want to do midwifery, I don’t want to be an obstetric nurse”, and from that point on she took me under her wing, it was amazing.

This particular midwife’s different treatment of female and male students was so marked that a fellow (female) student felt impelled to comment about it. Students are in a position of relative powerlessness with respect to registered staff; therefore, it suggests that the situation must have been particularly unpleasant if the female student considered that Warren needed the opportunity to confront it. It was interesting that once Warren reassured the midwife that he was not interested in working in her field of employment

her behaviour changed markedly. The irony is that by taking him “under her wing” (line 21) she could equally have made the clinical experience so enriching that he might well have decided to pursue it further. Equally, of course, by being more receptive to Warren after he confronted her she may have become more open to men in the role.

It is dangerous to ascribe motivation to people’s actions but given the anti-male discourse to which some subscribed, it can be interpreted that such behaviour was directed at making the environment so unpleasant that men, such as Warren, Robert and Martin, would indeed “just leave nursing.”

It might be argued that Robert’s and Warren’s experiences were manifestations of old-fashioned attitudes that have largely disappeared from nursing; however, that has not been Charles’s nor Grant’s experience. Charles graduated two years prior to the interview being conducted, and stated that he had experienced “an attitude of we don’t want you here” from female nurses:

One of the comments somebody said to me once, and it wasn’t very long ago, was that she became a nurse so she wouldn’t have to work with other men [] It’s just this real attitude. You’ll get the occasional nurse who has a really negative attitude to male nurses.

Charles was asked to describe how such attitudes are manifested in the workplace, he replied, “Just different body language, different ways of speaking ... less pleasant, sometimes quite condescending.” He allowed, however, “It is the older nurses generally who are like that.” Martin, too, commented that the hostility he met was from the hierarchy and that his peer group was very supportive of him.

Hostility from the nursing hierarchy emerged commonly in these narratives. Grant, who graduated in the 1990s, observed “I’ve got a couple of Charge Nurses I’ve worked with; I’m not sure whether they treat the male nurses with the same positiveness as they treat their female nurses.”

In the previous chapter Paul talked about the Charge Nurse he first worked with after graduation, a woman he described as having “the battle-axe” personality. He also commented with respect to his professional relationship with her, “Well, she never reduced me to tears.” The implication is that others were reduced to tears; therefore, the support Ian and Martin received in the face of hostility from the female nursing hierarchy

might well have been natural sympathy; a bond that emerges from a shared experience, as many female nurses have also experienced horizontal violence, i.e., nurse on nurse aggression. Nurses have shared their stories of such experiences with one another for generations and as Taylor (2001) commented, "Nursing has a long tradition of hierarchical power-structure in which the young and less experienced are the targets of victimisation" (p.408).

There is now an increasing amount of attention being given to this problem within the profession (for example: Cummings, 1995; Farrell, 2001; McKenna, Smith, Poole & Coverdale, 2002; Roberts, 1983; Taylor, 2001) and herein lies a paradox: the contrast between caring as the central focus of nursing, the standpoint that women are naturally better able to do it and the interpersonal violence that occurs between nurses. As Gallop (1997) observed:

If I say that nurses (i.e. women) have acquired a capacity for connection more finally attuned than the capacity I find in many men, how do I reconcile this with my observation that many nurses seem not to care or listen, perhaps for reasons of individual history, systematic oppression or benign neglect? (p. 30)

Oppression in nursing

In the latter portion of the above quote Gallop identified one of the main reasons put forward for horizontal violence within the profession: oppression theory. Roberts (1983) contended that such violence in nursing is a result of their oppressed professional status, and that this leads to self-hatred and dislike for fellow nurses. Feminist analysis takes this concept further and focuses on the fact that nursing being a largely female occupation it is prey to sex role stereotyping by dominant males (Cummings, 1995). From this perspective it can be argued that nurses are dually oppressed through the oppression of gender and the oppression of dominance from that medical profession (Farrell, 2001). According to feminist theory, the corollary is, "Oppressed groups do not have the opportunity to develop their own consciousness, their own ethos, but rather have the ways of the oppressor imposed upon them" (Lumby, 1991, p. 12). To argue, however, that the entire profession of nursing is subject to oppression risks devaluing the profession and the individuals who are part of it. As Kane and Thomas (2000) pointed out such labelling dismisses the women who have been able to overcome the obstacles to be autonomous and

independent within the profession. Such positioning also ignores the very real power that was, and is, wielded by members of the nursing hierarchy; power which they exercised over large numbers of more junior female nurses, patients, families and those men who were employed in ancillary roles, such as porters, orderlies and attendants.

It can be questioned whether oppression theory and feminist perspectives provide the full analysis required to understand this phenomenon in nursing. Farrell (2001) suggested that as well as this macrolevel analysis there also needs to be mesolevel analysis, examining the organizational structures and workplace practices, many of which are controlled by nurses, and a microlevel analysis to consider the interactional nature of interpersonal conflict.

It is not the intention of this study to provide a fine-detailed analysis of the causes of horizontal violence; however, Farrell's viewpoint suggests that horizontal violence in nursing is a complex phenomenon. As a corollary space needs to be opened for consideration of the proposition that not only are men actively involved in oppression but also that many men – at both the micro and meso levels – are the victims of oppression. If oppression theory can provide a partial explanation for violence among nurses then it can also be called upon to provide some perspective on men's violence to women and other men.

"Greg", a respondent in Brooks' et al. (1996) study of anger in men who are nurses, commented, "You feel the type of anger that minorities feel" (p.8). This comment is significant, not just because a man is able to name and talk about his anger, but because of his identification with minority groups: men in this instance are members of a minority group.

This work is not an attempt to reframe men as victims, indeed the men in this study told stories that implicated both women and men, including themselves, as being complicit in acts of oppression. Ian, for example, talked about how scared he had been of one of the nursing supervisors when he was a young nurse, but in a telling moment when he held a similar position some years later he realised that he had a similar effect on younger nurses:

Interviewer: When you held a similar position, do you think people were scared of you?

Ian: I didn't think they were until I did see a student nurse, years later, absolutely terrified, sitting at the table in the dining room at night. There were only a few of us, I said, "Come and sit here" and she looked absolutely petrified and I thought "Oh, God I used to look like that."

Interviewer: Did it bother you?

Ian: It did really. It made me realise how detached we were to these people. I was fairly renowned for being approachable, I think. But then I was also quite strict, I mean in the sense that if the hospital had rules then they had to be adhered to. I wasn't very flexible on that, they had been ingrained, you see. They were often trivial stuff when I look back. I'm sure others were equally as intimidated.

What is contended, in this work, is that a simple essentialist analysis of power and gender that ascribes power to men and a position of powerlessness to women is unable to adequately describe the complex relationship between caring and gender. Such analysis does both women and men disservice. This is a position that women of colour and lesbians have deconstructed with respect to early feminist work, for example, hooks (1984) was critical of white upper-class women for presenting a "one-dimensional perspective on women's reality ... white women who dominate feminist discourse today rarely question whether or not their perspective on women's reality is true to their lived experiences of women as a collective group" (p. 3). Ignoring the effect of race, colour, religion, sexuality or education with respect to the impact of oppression also ignores that for men, as well, the access to power and the impact of the power of other men (and women) is differential.

"The heat is on you": Being watched

In Chapters Seven and Eight there was discussion with respect to oppressive comments and reactions that many of the men in the study were subject to when they revealed either their intention to become nurses or that they were indeed nurses. As well, the men in this study readily provided many examples of oppressive behaviour from other nurses that had impacted upon them. It was evident that to be able to finally voice these stories also provided a source of relief, as they had learned to be silent because there was either little support or belittlement when they did endeavour to articulate what they were experiencing and feeling.

The following extract reveals how Edward learned to not share his feelings with nursing colleagues. He recalled when he first started working in an intensive care units (ICU) a senior male colleague said to him, “Boy, I’m glad that you’ve come along, because the heat is off me and is on you.”

1 *Interviewer:* And by the “heat” he was meaning?

Edward: I only had to put [a foot wrong], even though I was new on the block, working with fundamentally quite senior staff, I was always being judged, I was always being held accountable for anything that I did wrong.

It is not the notion of being “accountable” (line 4) that provides the tension in this passage, but rather it is the connection between being “held accountable”, “new on the block” (line 2) and “working with [] senior staff” (line 3). Edward believed he was not allowed the degree of leeway that staff, when new, could expect as they adjust to the complexity of the ICU environment; the senior staff expected him to show the same degree of competence as they themselves had achieved through longer experience in the area. He considers that he was “always being judged” (line 4) and that the judgement was that he was not competent. This feeling was reinforced by a later event: an incident in which the lack of support he received led to his decision to never again share his feelings with other staff. He described the experience of being involved with the traumatic cardiac arrest of a patient he had nursed previously. The patient had been admitted acutely following an overdose of tricyclic antidepressants, twice went into cardiac arrest and was unable to be resuscitated on the second arrest. It was a harrowing experience:

1 He put the laryngoscope blade in and up came a fountain of pulmonary oedema
that went about eight inches, fountained off her face, literally eight inches []
She arrested again a few hours later and the parents blamed the husband, and
the husband blamed the parents, and there was sexual abuse and it was really
5 messy; not only was it death, but it was a messy family situation. There was
nobody else in the unit [patients] and so we got to about 9 o’clock and I said to
my colleague, female colleague, “If another one comes through the door, I’d
prefer not to have it” and she hadn’t had anything during the duty. Well, I got
hauled into the Charge Nurse’s office, it was about two or three days later, who
10 said, “You’re not coping” and I thought it was pretty unfair because I actually

made a comment, even though it wasn't my turn to have a client, it was turned [around to] that I wasn't coping. So I made a pact with myself that I would never share an emotional thing with my colleagues after that moment.

Reading Edward's description of this incident, it can be inferred that he had unmet expectations with respect to the aftermath of this difficult experience. Zussman (1992) argued that intensive care holds terrors for both the patients and the staff. Particularly threatening for staff is the fear that they will not be able to perform competently in moments of acute medical crisis. In this instance Edward's colleagues did not immediately acknowledge the horrific nature of the incident (lines 1–5) and the significant role he played in its management. He provided an opportunity for support to be given with his comment that he would prefer not to have another patient that shift (lines 7-8). The response to this was not supportive, neither a question about how he was feeling, nor an opportunity to debrief, but a report given to the Charge Nurse who then "hauled" him into the office to tell him he was not coping. In using the word "haul" Edward is clearly describing an action on the part of the Charge Nurse that can be interpreted as punitive, as in being "hauled over the coals." Whether or not this was the intention of the Charge Nurse the experience was an unhappy one for Edward that had consequences that continued for a number of years.

To understand the consequences for Edward the notion of "mateship", which was introduced in Chapter Five, provides useful insight. Prior to becoming a nurse Edward had worked in the building industry and on a farm, spending a season in the shearing shed. The ethos of mateship, with its tacit expectation of not letting the team down, is a trait that has traditionally been valued by the New Zealand male. It is an attribute that is expected in predominantly male environments such as the shearing shed, where there is reliance on teamwork. Edward's nursing colleagues did not demonstrate mateship with him. He felt that he was "always being judged", which led to feelings of being an outsider; not only did they not provide practical support at a difficult moment, but they "dobbed" him in, i.e., reported him to a superior. Consequently, they were no longer to be trusted with his feelings and this mistrust was applied to all his nursing colleagues subsequently. Edward did not consider that he was singled out personally because of any lack of competence, but

that the treatment he received was gender-based as “this is what my other male colleague used to get before I came.”

Edward’s experience was situated in what Paul described as being a culture where:

If you asked for help you were not perceived to be adequate and so you had to work very hard to make sure [you were]. So that was a balancing act between ensuring patient safety, your own safety and a fine line between.

Being judged.

A common theme that emerged from the transcripts was the belief that they were always under scrutiny at work and that, both as individuals and as a group, they were often being judged harshly. This emerged as the least satisfying aspect of being a nurse: a feeling of constantly being scrutinized and judged, not just for themselves but also as being representative of all men who were nurses.

A consequence of this ever-present observation of them in the work place was a belief that their professional standards had to be higher than those of their female colleagues. Edward became hypervigilant with respect to avoiding any mistake:

1 I was always judged and so if you slipped up anywhere you would know about it – and the whole ward would know about it. So you actually had to do more work around the ward. You had to have a higher standard in many ways.

He used the term “slipped up” in line 1, and this expression is not one that denotes a major error of judgement that threatens the safety of a patient. When juxtaposed against the noun phrase “work around the ward” (line 3) it evokes a matter of small omissions, or moments of forgetfulness that can occur in a busy work environment. For Bruce this was an important issue, because it came at the cost of never being able to relax. This is an interesting point, because as will be discussed in the following section, one of the key criticisms of men in nursing is that they are lazy:

1 It seemed to me that the bar was always higher for the guys to achieve. We always ... yeah, we always had to do it, there was no slackening off. There was a lot riding on this both for yourself – I mean we were pretty driven people anyway – yeah it was sort of like men can do this as well.

Bruce's use of the word "driven" in line four of the above extract is meaningful within the context of masculinity and nursing. Bruce, and the other men whom he referred to (line 2), were driven by one of the stereotypical agentic masculine traits, ambition, in order to succeed within a non-stereotypical profession.

The men in this study argued that the obstacles placed in their way fostered this behaviour. Bruce elaborated that by being "driven" he was striving to prove "it was a legitimate profession for men to be in." Jock shared this view and stated, "I've really worked hard to prove myself as a male nurse." Edward described this as "walking a tightrope", Luke talked about "the pressure on you" and Warren considered he was always "on the back foot and having to prove myself all the time, and never quite matching up to anybody else." Robert used the expression "picked out" and in his words a picture emerges of an environment that "was a lot harder" than for female colleagues:

You can be on duty and there are six females and you are the only male and umm [they are] always watching you, because people are more inclined to focus on you: your colleagues, managers, patients ... so in a way it is more difficult. Like if I'd done anything bad it would be brought up and people would remember the male nurse, you know? Where if it was that female, well there are two or three hundred to be chosen from so in those terms I suppose it was a lot harder.

Robert stated that although it was hard, "I wasn't going to let it beat me." Jock suggested that it did beat some men: "It's probably quite difficult for some men to either ... they just tolerate it or they actually end up leaving or they actually never get through it in the first place." Ian also considered this to be a factor in male colleagues not completing their training:

I think individually we had to comply, conform, prove that we were worth having [] Five finished the course; we started with ten. Those that had gone had gone by the end of their second year, and those that got to the third year survived. One missed finals, but sat again six months later and is still nursing now. So it was a fifty percent drop out in that first class. I think some would have been very good material, to be quite honest, as nurses. I think a lot couldn't stand the domination or the unfairness of some of the criticisms.

After twenty years in nursing Edward has also decided that he cannot continue struggling against what he perceives as continual attacks; and at the time of the interview was about to depart nursing. He said, “I think that when you have been a male nurse, you ... it’s there all the time. And I’m looking forward to not being amongst it.” He talked about the self-analysis, and the self-doubt that the constant judging behaviour brought about:

I couldn’t work out whether that was a gender-based thing or whether that was me, the perception of me, whether I was judged at two levels [] I, all the time, try to weigh up is this about my performance or is it about me as a male?

For Edward the struggle between his ideals, “I want to be a damn good nurse” and the feeling of being found wanting has become too great. Edward leaves nursing feeling not just frustrated but describes the treatment he has received as “harassment to my way of thinking: sexual harassment.” Edward’s words are a serious indictment upon the profession, and one that will be explored in the following chapter. All these men related stories which portrayed their chosen career being located in a challenging and sometimes hostile environment in which these men in order to cope, in Paul’s words, “had to work very hard” to be accepted as competent nurses.

Proving oneself through work.

A respondent in Brooks et al’s (1996) study used the phrase “working like a Trojan” to describe the manner in which he has “always had to validate my worth” (p. 8). This pattern of behaviour in a hostile work place, whether real or perceived, emerged strongly from these men’s stories. To cope with perceived attacks upon their ability to nurse being judged more harshly because of their gender they overcompensated work-wise. To return, once again, to Edward’s experience:

- 1 You know males were judged as not doing the work, you know, the linen closet and the sluice and the whatever. They were judged as just getting in there and doing the glory stuff. Well, I know that I went out of my way right throughout my career to ensure that I did more than my fair share of that sort
- 5 of stuff. But I was continually maligned for not doing it and I would be continually maligned for spending too much time talking to patients, and so

they would perceive that sort of – those things as not doing the ward stuff when I know that I did more than my fair share.

Edward remarked, that “males were judged as not doing the work” (line 1), i.e., the domestic tasks of nursing; with this remark he identifies the stereotype of the man who is a nurse as lazy. Warren remembered a Charge Nurse who commented, “And as for Mr. Smith [] you’ll just wander around with your hands in your pockets.” The inference in that comment being that Warren was lazy. I, too, recall a comment made to me during my student days along the lines of “No doubt, you’ll be just like the other male nurses, just wanting to sit and talk with the patients.” The irony of such a comment and that of Edward’s above (lines 6-7) about being maligned for talking to patients, is that men are accused of being less likely to make relationships with patients, but they are also accused of being more likely to want to just talk to the patients, an activity which is presumably the foundation upon which relationships are created.

It is, of course, likely that there will be some men (and it is to be expected some women) who are not as diligent as their colleagues; however, the generalization of laziness that creates another obstacle to men’s acceptance as nurses requires unpacking. A number of factors are involved.

The first is that some men may use their *difference* or token status in order to avoid the less congenial aspects of the job, a technique that Allan thought he had seen being used:

Some of the other men I’ve worked with I haven’t thought so highly of, and I’ve thought that they’ve used their difference to get away with some things, to be a bit lazy and that often other women may mother or cover for them.

It is argued that the small numbers of men in the female-dominated profession are afforded a special and privileged minority status, which they use to their advantage (Evans, 1997; Ryan and Porter, 1993; Villeneuve, 1994). It is also asserted that female nurses collude with these men, i.e., ‘mother or cover for them’ because of nursing’s caring ideology which emphasises the putative feminine values of nurturing and supporting others (Evans, 1997; Kauppinen-Toropainen & Lammi, 1993; Villeneuve, 1994).

In line 1 of the above extract Allan says that he does not think so highly of such men, and this was reiterated by a number of the other men who contributed to this study. They pointed out that they went to considerable effort to ensure that they were not identified as such; however, in their silence with respect to challenging their male colleagues about their performance they are also complicit. It could be interpreted that this complicity is a result of the masculine ideal of mateship; however, given the disparagement with which men were spoken of and the need to be identified as quite distinct from them, it appeared that these men felt more professional kinship with female colleagues whom they considered harder working. Their silence more likely arises from socialisation into that part of the nursing culture that has tended to not professionally challenge performance that is of less than acceptable standard.

The second factor that contributes to the stereotype of the “lazy male nurse” is the notion that men who are nurses are “mothered” by their female colleagues. This idea is bound up the strong association between nursing, women and domesticity. Therefore, a perception has been created that; (i) men will be unwilling to undertake the domestic aspects of the nursing role, and (ii) that even if they do they will not be as competent. According to Gilloran (1995) female nurses believe themselves better at providing better nursing care, that “they saw themselves as more organized, more tidy and giving more attention to detail, for example with regard to patients’ appearance” (p.655). A female respondent in Gilloran’s (1995) study commented, for example, that a female nurse would “change a patient’s cardigan or jumper if something got spilled on it. A male would just wipe it” (p. 655). Another female in the same study also thought that women were more tidy and more likely to pay attention to detail, “Woman are naturally more organized and tidy in their work. That doesn’t necessarily mean you’re a good nurse, it just looks good” (p.655). The word *natural* once again is associated with womanhood this time with respect to tidiness. Tidiness is a trait, however, that is more likely related to personality than it is to gender. Phillip suggested that there are perhaps things that women do not necessarily see, but that a man does, especially with respect to caring for other men:

- 1 I picked up his razor to give him a shave, it was a battery razor, and the blade would only just go round because there was that much hair in it and it had never been cleaned, and I took it away and cleaned it and he was quite pleased that I’d done that sort of thing and I suppose when it comes to doing that sort of

- 5 thing I just see that it has to be done, and I don't know a woman – obviously not. It was so chocka, yeah it was unbelievable, I thought “how could anybody?” Because you know it comes out the blade and I thought “How can somebody not clean it?”

In line 5 Phillip suggests that women apparently have not been able to see the need to clean the razor, or else they couldn't be bothered. Equally, it could have been nurses of either gender who had not cleaned the razor. Phillip did notice it, and it is likely that other men notice and attend to other details, and it is possible that this is not seen because of the pervasive belief of the lazy male nurse. Interestingly, Bruce also highlighted razors in particular stating that as a student the males always got to look after the men, “You always had to do the shaves. You always had to clean the razors – no one else knew how to do that.”

With respect to the belief that men are likely to be less competent at domestic skills, Allan described being aware of an expectation that he would not be as able as his female peers. On page 160 he described the reaction of his tutor during the obstetric component of his training, “She obviously had the perception that since I was a male I should really not know what I was doing and I'd be less useful”.

Such assumptions based on gender are not only limiting for men such as Allan, but also raises questions about the reaction of the tutor to a female student who did not have Allan's experience, confidence or enjoyment when working with infants. Would this lead to the young woman being labelled as unnatural or uncaring?

The third factor with respect to men's alleged laziness is that men's heightened visibility leads to those who are identified as such are held to be representative of all men in nursing. Such labelling is as divisive and unjust as is, for example, “women are bad drivers.” Edward observed with respect to this visibility that, “You're bad and it takes half-a-dozen good ones to outweigh the bad one.”

As noted in the previous chapter nursing has traditionally been a profession that has valued *doing*. This may be a further factor in men being stereotyped as lazy: the notion they are less “task-oriented.” Robert subscribed to this view, “I find a lot of women are probably a bit more task oriented than men are and that they get on and do jobs and men are probably more inclined to procrastinate, [and] talk about [it].”

Finally, economic constraints may also play a factor in nurses, of both genders, being unable to live up to the expectations of others. Robert's analysis of this factor provides evidence that this is an important issue for nursing:

Health care providers today are so money oriented and the acuity of people, the illnesses of people, is so much higher and nurses have to work so hard and often with such a high acuity of patients.

Interviewer: So are you saying that in the present environment nurses are not able to provide the care they are trained to give?

Robert: I think particularly with new graduate nurses who are coming through in the hospital setting, they haven't got the skills to actually provide the care and they shouldn't necessarily. They come into the hospital to learn, but because there is a lack nowadays of senior staff who are actually skilled in areas, that new graduate nurses take a long time to pick up skills and it is difficult to provide the care for patients properly.

For Robert, the corollary is that this creates an environment in which "people don't enjoy what they are doing-so they leave."

In another study "Ron" described his helplessness because he couldn't complete all his work in the allocated time: "It's hard to answer all the call lights, do the bedpans, pick up the trays, and do everything without any help. There is never enough time" (Brooks et al., 1996, p. 9).

This statement illustrates a double bind for nurses. Ron's complaint is one that many nurses would recognise, and agree with, as justified; yet the inability to complete the "tasks" is also used as a criticism of nurse colleagues and is part of the environment of horizontal violence in nursing.

The issue of men's putative laziness as nurses is multifactorial, but the belief is strong. So strong, that even the men in this study identify with it and work hard to avoid having that label applied to them. Jock summarised this aspect of the experience of the man who is a nurse:

They work harder to make sure they are - well, for me anyway I may not be the typical male nurse, but I've worked really hard to make sure that I'm not letting

myself down and men down who are nursing, really. And I've worked really hard to prove myself as a male nurse.

Being praised

Another interesting contradiction emerges in contrast to the discourse of the lazy male nurse and that is the praise and positive feedback that many of these men said they received from patients. The Chief Executive of a Hospital Board, because of the number of letters that have been written expressing gratitude for the standard of care he has provided, has twice singled out Robert. A number of the others had also been the recipients of thankful letters and cards; for example, a letter that had been written to his educational provider gratified Phillip:

I got a letter from the old man that I looked after in the rest home whose wife wrote a letter to 'Tech' congratulating 'Tech' on having a high standard, congratulating me because she's never let a student look after him before and he was really pleased with the way I looked after him and so they were just writing to 'Tech' to say that.

While men's heightened visibility may well contribute to the recognition they receive it also becomes easy to dismiss the contribution they make as nothing more than an artefact of that visibility. These men did not suggest that they were generally better nurses than women, but they did believe they earned the positive feedback they received. Luke spoke about how he earned the praise:

1 I personally think that I'm good with people and that I actually give quite a lot
and I know that initially when I was a staff nurse in intensive care area I used
to get a lot of feedback from relatives, whether that be immediate or later
when they would send me cards and thank me in particular. I did get a high
5 percentage of cards being written thanking me and a lot of women did think
that was because I was male and I was more visible. But I personally refute
that and think that it was because I probably put a lot more into those people
in those scenarios than my colleagues did and that used to make me quite
angry because I didn't think there was that acknowledgement from them of
10 the work and the hard work and that extra mile that I put into these people.

So I felt that acknowledgement that was being given was quite genuine and quite warranted and this it wasn't just because I had a higher visibility.

In line 1 Luke described himself as “good with people” and thought that the reason for this stemmed from an internal ethic of care and the additional expertise acquired from his previous education and work as a psychiatric nurse before he undertook general nursing training:

But I think that some degree that is intrinsically in you or not. Not everybody who's had that same exposure would have that same encompassing [ethic] but certainly I think that my psychiatric background did allow me to develop that area and see the need to encompass relatives and relatives' issues as well as the patient and the patient's issues more fully than people who had just gone through the general training.

These men believed that they worked hard in order to establish good relationships with their patients and to overcome any negative stereotyping associated with men who are nurses. The lack of recognition from their colleagues, or the dismissal of it as nothing more than the result of heightened visibility because of their minority status, can be a source of frustration. On page 161 Grant talked about the anger he felt at times when he met resentment from colleagues when he was thanked in writing by patients; for him this was “one of the negatives about being a male nurse.” He was asked to reflect on whether he could possibly be a better nurse than his colleagues:

I think I'm a good clinician, yeah, and I think I have a good rapport with patients and I think I get on pretty well with people.

Interviewer: But do you think you are better?

Grant: Clinician? Not better than everyone, but better than some.

Grant's comment summarised well the reflections these men made about their work performance in relation to their colleagues. They considered themselves to be good nurses: sometimes better than and sometimes no better than or perhaps not as good as female colleagues. In general, however they do not see women or men as being better at

the role but this is qualified however in that they believe they are better at providing for male patient's intimate physical care.

A failure in education

It was noted earlier two of the men commented about the lack of care given to men's razors such that it would be difficult to adequately shave a man using them, and that shaving as part of a man's personal grooming is not done well. Phillip observed, "to shave somebody is a lot easier when you shave yourself, even with a blade." He also outlined how he had observed the procedure being done in such a way as to cause discomfort for the patient, "Because I've seen one, she just walked in, slapped on the shaving cream and started shaving – cringe." This lack of attention to detail also extends to the male genitalia. Once again this was something that bothered Phillip:

[G]oing back to the man I was looking after, I don't think he had been getting his foreskin washed because he was like a Billy goat and –

Interviewer: You mean the smell?

Phillip: Yeah, and it took two or three days of me washing him [before] the smell had gone out of his room. It was not nice, but yeah, so yeah. It doesn't get done, it doesn't get done at all.

Paul was also clear that men's personal hygiene was not something that women generally care for well:

There are times when I've said to female nurses that I will do something because I've seen that they are useless at it, because they are not male: shaving would be one, cleaning a man's penis would be another. Ninety percent of women wouldn't have a clue how to clean it and to make sure to retract the foreskin.

While these men were certainly critical of the hygiene provided by nurses who were women for the men in their care they were not blaming of the women themselves but of an education system that often did not address such matters well. Paul commented:

So there are those aspects of it which I think are a problem because they are not taught properly because they are taught from a female perspective from people who

don't know how to do it properly in the first place, because they are not the right gender.

In this extract he suggests that the female perspective may not focus adequately on the needs of the male patient, a point which Harding (2003) also made when writing about men's health needs in general:

Why should women – and as a consequence nurses, given the gendered nature of the profession-be interested in men's health? [] Why shouldn't those nurses who are women be more interested in issues pertaining to the health of their own gender and to understanding and overcoming the societal forces that have undervalued women and their work? (p. 2)

While such opinions risk being perceived as devaluing the work that women and nurses do on behalf of men's well-being, the intention is to highlight a possibility that men's health needs have come to be seen as relatively less important than those of women. In New Zealand since the 1980s, particularly in the aftermath of the inquiry into the treatment of cervical cancer at National Women's Hospital Hospital in 1987-1988, there has been a shift in attitude towards women's health. As Coney (1988) noted, "There were positive outcomes. We heard frequent reports of doctors taking much more care over informing their [female] patients about treatment possibilities and that women themselves were exhibiting a new awareness" (pp. 7-8). It is possible that affirmative action in women's health has shadowed men's health issues and that this is reflected in nursing education. This was an issue for Jock during his nursing education and he wondered whether this was also one of the reasons why only 50% of the men who were in his class at the beginning actually completed the course:

The causes? ... Maybe it wasn't so much the cause; maybe it was the general attitude of some of the tutors. I felt that they did nothing to promote men's health particularly. They did a lot to promote women's health, but they never went that extra step to encourage even the men in the course or the women, to learn about men when half their patients would be male patients. I think there was almost negativity to men full stop.

Interviewer: Do you think it was actually overt?

Jock: I don't think it was overt, but just the fact that I know on one or two occasions in some of the classes I would say, "What about doing something that was to do with men's health?" And it was never covered in the curriculum and it was always said, "Oh, well if we've got time we'll cover that", but we never did cover that because there was never the time and I guess it could be seen to be fairly overt in that respect.

Jock considered that the lack of formal education on men's health might mean that it is more difficult for the female to initiate necessary discussion that will allow a male patient to express his anxieties. In that respect the male patient may feel more comfortable in initiating the conversation with another man:

I would have patients who would sort of call me over quietly and say, "Oh, Jock I've got this problem, but I don't really want to talk about it with my nurse"-female nurse. And I think that a lot of men's issues women-female nurses-don't understand so they disregard them and they perhaps feel uncomfortable about them.

This was also a point made by Charles, who commented, "I find that male patients respond really well to having a nurse who is male." He provided an example where his female colleagues felt uncomfortable with exploring an explicit matter relating to sexuality:

We had a man in-not so very old-and we had to give him a permanent catheter. Now somebody had to ask him whether he was sexually active or not and I got the job. And in the process of finding that out I discovered that he was impotent and that was partly why he was depressed.

Charles highlighted the problem that nursing faces with respect to sexuality: a discourse prevails in many cultures that has constructed the genitalia as taboo. It is not surprising, therefore, that a man might be more comfortable talking to another man. For Jock this was equally applicable to either gender:

1 I know as a male nurse there are some women's issues that I don't want to deal with and I prefer to pass them on to a female colleague.

Interviewer: What sort of issue for example?

Jock: I guess sexual issues or perhaps gynaecological issues for women. For
5 men anything to do with the male anatomy - a lot of women don't want to go
there.

Interviewer: When you say you pass it on, is it because you personally feel
uncomfortable or because you think it is better approached by a member of
one's own sex?

10 *Jock:* I think there's an element of both really. I think that some patients feel
more comfortable having it dealt with by a member of the same sex and there
are some issues, which I just feel uncomfortable about as well and I think
that's seen in nursing all over the place.

An important point emerges in line 2 where Jock talked about passing such matters on to a female colleague: he ensured that the patient is not compromised by his reluctance or inability to assist. What then happens for the male patient when there is no man among the nursing staff to have information passed onto or to approach when embarrassed? Given the power differential between the doctor and the patient it cannot be assumed that a male patient will feel comfortable about approaching a male member of the medical staff just because he is also male.

With respect to the provision of intimate care Paul admitted, "By the same token, you know, I would be more than happy to acknowledge that I don't do some things well either in reverse." He was also highlighting that the lack of formal instruction applied to matters pertaining to female hygiene. Phillip, who was about to enter his final year of his nursing education at the time of the interview, described the lack of education he received with respect to the care of female and male genitalia:

I sort of think we don't get taught those things that you need to get taught, but it is a bit hard having sixty people around a bed watching a bed bath, nobody is going to want that, but even if they could video it or tell you, yeah, something like that [..]

In the couple of practice days that we bed bathed a dummy at tech ... we never got told how to wash a penis or vagina, it was just "you have to wash it, you have to wash that part of him." It was not explained how you do it and I suppose some

women would never have even seen a foreskin before so how are they going to know what you're to do with it?

Allan also thought his training was lacking with respect to education about genitalia but for him the concern was lack of focus on the female reproductive system, which he described as being “flashed over in a very short period of time.” He continued, “It was basically a sit outside in the sun under a tree day and have chats and I suppose it was presumed that the young women knew and understood.”

Allan was, at the time, a young gay man who had to ask one of his peers for help in order to gain the knowledge he believed he needed to adequately assist female patients meet their hygiene needs: “I remember saying to her, ‘I really have no idea about any of this and I need your help. Like I’ll look at this stuff and umm I’ll read and things and probably ask you some embarrassing questions.’”

For Allan such questions were “embarrassing”, given a discourse that has constructed sexuality and the genital area as taboo, a source of shame and embarrassment, this is not surprising. It must also be understood that nursing education reflects the prevailing norms and values of the society within which it is located. Thus, even in the context of nursing education the genitalia become a source of embarrassment or something that may be quickly “flashed over.”

The difficulties students may encounter in learning about the hygiene needs of the male and female genitourinary systems are part of a wider discourse in nursing that is challenged by issues relating to sexuality and sexual health. White (2000) identified that one of the factors that will affect the effective teaching and incorporation into practice of such matters is “whether or not the discussion of such matters evokes embarrassment for the nurse” (p. 51). She cited a nursing text book published in 1907 to illustrate her argument; a text which contained no explicit mention of the genitalia, nurses being instructed on personal hygiene for patients were directed to wash “the surfaces between the thighs” (White, 2000, p. 52). While nursing textbooks are much more explicit and matter-of-fact in their descriptions of such matters now, the difficulties identified by these men suggest that practical discussion and education can still be problematic.

Conclusion

This chapter has highlighted the paradox in nursing between being a care-centred profession and the problem of horizontal violence. The experience of horizontal violence has not been confined solely to female members of the profession; men are also victims (and perpetrators).

Oppression theory has been offered as a reason for this phenomenon occurring among the female members of the profession, it is unsustainable to argue that men, as a gender, are oppressed; however, the men in this study described the oppressiveness of the constant vigilance to which they are exposed and the negative judgements that are made about their abilities to engage in the work of nursing. They argued that they responded to the feeling of being constantly observed by working harder to ensure that they are seen to participate in the domestic aspects of the role.

They noted that they often receive positive feedback from patients for their care, but refuted the argument that is reflective of their token status as men and the fact that they stand out. They believe that as individuals they provide good care, sometimes better and sometimes not than other nurses, but they do not believe that the ability to provide good care is gender-based.

With respect to the provision of intimate care they argue that education does not prepare them well for dealing with the barriers their gender construct. The following chapter progresses this discussion of considerations around sexuality and nursing care through critical exploration of the belief that the man in nursing is likely to be homosexual. It explores the barrier this creates and widens the reaction to the gay man who is a nurse into consideration of men's experience of being sexually harassed in the performance of their nursing work.

CHAPTER TEN: The problem of men, sexuality and nursing

The previous chapter described the reaction to the man in nursing. This chapter continues that discussion, focussing in particular on what can be termed the *problematization* of men's sexuality. It is contended that the construction of a discourse that allocates roles based upon considerations of gender appropriateness means that the man who becomes a nurse is perceived as aberrant. In order to rationalise such behaviour he is attributed with dubious motivation. In particular, this rationalisation takes the form of assumptions about the man's sexuality; he is constructed as homosexual or, whether homosexual or heterosexual, as sexual predator.

This chapter will critically discuss the popular stereotype of men who are nurses being homosexual. The discussion will be followed by an exploration of issues pertaining to sexual harassment for men in nursing. It will also be argued that a discourse that feminises touch and problematises men's sexuality poses a potent barrier to men's engagement in the provision of nursing care.

The chapter will conclude with the argument that nursing fails its male colleagues through complicity with the discourse of problematization rather than challenging the heterosexist and discriminatory gender bias that continues to construct nursing as "women's work."

Constructing the man in nursing as homosexual

"You better watch out for them, you know what they're like!"

The comment above is one that Bruce recalled from his student days and one that still resonates for him as "horrible." He described the context:

A guy who had broken one of his legs needed a urinal, a bottle, and he rang the bell [] and I remember a visitor, a guy walked past and he said to him, when he saw me with the bottle as I started to pull the curtains, "You better watch out for them, you know what they're like."

Bruce believed that the comment was intended to imply that as a man who was nursing he was likely to be homosexual. In fact, the comment illustrates two popular beliefs. First, men in nursing are homosexual; Martin described the prevailing stereotype

about men in nursing when he entered the field in 1969, “You were queer,²⁸ I think the word is, alcoholic or religious.” Second, homosexual men are sexual predators; the implication of the comment “You know what they’re like” is that homosexual men are always intent on either seducing or sexually assaulting young men. It was the second of these two implications that disturbed the most:

I just found it abhorrent that he actually thought that would be something someone in a role like that, irrespective of sexuality really, would use a situation involving the client in such a perverse way. I just find that appalling.

With respect to terminology Sedgwick (1990) argued that there was no satisfactory rule for choosing between the words “homosexual” and “gay”. In her analysis of homo/heterosexual definition she contended that homosexual and gay “seem more and more to be terms applicable to distinct, non overlapping periods in the history of a phenomenon for which there then remains no overarching label” (p. 17). She used the terms more appropriately to provide historical delineation. While agreeing with her taxonomy, I think that unless the reader of this work is well versed in queer history it risks confusion. Therefore, I have adopted the following distinction between gay and homosexual as defined by Thompson (1987):

The word *gay* should not be confused with *homosexual*, as by definition they mean quite different things. Gay implies a social identity and consciousness actively chosen, while homosexual refers to a specific form of sexuality. A person may be homosexual, but that does not necessarily imply that he or she would be gay. (p. xi)

The stereotype of the man who is a nurse being homosexual is one that is widely reported in the nursing literature (Boughn, 1994; Meadus, 2000; Salvage, 1985; Williams, 1993, 1995b). According to Williams (1993):

1 The man who crosses over into a female-dominated occupation upsets the gender assumptions embedded in the work. Almost immediately, he is suspected of not being a “real man”: There must be something wrong with

²⁸ Queer was originally a pejorative epithet, however, it is now adopted by some of those who identify as gay, lesbian, bi-sexual or transgender to negate previous homophobic power, to evoke political mobilization and academic scrutiny (Krane, 2001).

him (“Is he gay? Effeminate? Lazy?) for him to be interested in this work.
(p. 3)

In the above extract the image of a “real man” (line 3) can be inferred as the antithesis of the adjectives provided in line 4 (“gay”, “effeminate”, “lazy”). Thus, the real man is heterosexual, manly and hardworking and *not* a nurse. Effeminacy and homosexuality are often linked in the public imagination and the use of the word “wrong” in connection to “gay” in lines 3-4 perpetuates a discourse of pathology with respect to the homosexual.

The work of Foucault (1978, 1990) allowed a view of sexuality as a flexible, socially constructed discourse, whereas the constitution of homosexuality as other and aberrant exemplifies the way in which discourses are constructed as a means of regulation (Foucault, 1972). Ian revealed a commonly employed mechanism of regulation: the expectation that “they keep to themselves” and display no overt characteristics that denote their sexuality:

I know that during the three years of my training there were some staff who were obviously that way inclined. I personally didn’t see it as a problem; if they kept themselves to themselves that’s fine, and [if] there was nothing flamboyant on duty.

No doubt Ian, and many other people, who employ similar statements to “I personally didn’t see it as a problem” (line 2) would not perceive themselves as homophobic; nonetheless, the attitudes that can be inferred from the above extract are homophobic, albeit less extreme than other forms of homophobia such as taunting and physical assault. Ian’s not seeing “it as a problem” if “there was nothing flamboyant” reveals an expectation that homosexual colleagues are to behave in a manner that others determine as appropriate. The phrase he employed, “If they kept themselves to themselves” (line 3), is salient. It can be inferred that there is a requirement, or at least a belief that it is preferable, that homosexuals should isolate themselves from heterosexual society or at least be silent. Gray et al. (1996) described this phenomenon in their discussion about heterosexism in nursing education:

People often say to non-heterosexuals, “Why can’t you just keep your sex life private?” This communicates a view that lesbian and gay existence is only about

sex, that (homosexual) sex is an unacceptable topic and practice, and that if one is engaging in such practices, one should have the decency to keep it quiet. The message is clear-keep quiet and remain invisible. (p. 208)

Being “other”.

The perception that men in nursing are gay is one which all the respondents in this study talked about, and often at some length, which suggests that a discourse that *others* homosexuals still impacts upon men’s lives. As was argued in Chapter Two, the predilection of Western culture to categorize through the use of contrasting binaries creates asymmetrical power relations. Gray et al. (1996) asserted, “heterosexuals occupy the position of privilege, and non-heterosexuals are considered ‘other’” (p. 205). A position that Hartsock (1990) describes as one of “lacking”: “the other is always seen as “not”, as a lack, a void, as lacking the valued qualities in society, whatever those qualities might be” (p. 160). Thus, to be the homosexual “other” in the heterosexual/homosexual binary positions one as a less valued member of society and limits access to the privileges of the dominant group.

This is a challenging position for heterosexual men, as members of the dominant gender group, to occupy. All men who become nurses are immediately devalued in terms of men’s work/women’s work and the relative value placed upon each. This is also accompanied by the suspicion of homosexuality. As Phillip stated, “I’ve heard the stereotypical comments that, yeah, you must be gay if you want to be a nurse.” Consequently there is the imposition of an inferior subject position that is accompanied by both heterosexism and homophobia.

Homophobia and nursing

The International Council of Nurses’ *Code of Ethics* (2000) requires nurses to promote “an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected” (p.2). Unfortunately, the reality for men who are suspected of being homosexual – either as nurse and patient – is often quite different. According to Gray et al. (1996), “nursing reflects the larger culture of which it is part” (p. 204). It is to be expected therefore that nursing reflects the predominant value of heterosexism, i.e., the belief that “the only right, natural, normal,

god-given, and therefore privileged way of relating to each other is heterosexually” (ibid, p. 205). Heterosexism is one of the forms of oppression that operates in present-day society and underpins manifestations of homophobia.

The term homophobia was coined by Weinberg (1972) to define the fear felt by heterosexuals when in proximity to homosexuals. Richmond and McKenna (1998) questioned whether classifying the feelings toward homosexuals as a phobia is accurate. It implies an irrational fear and the autonomic responses associated with phobias, such as tachycardia, blushing, sweating and nausea are generally not found in the literature describing homophobia. They suggested it is more appropriate to present a more complex view of homophobia based on the psychology of negative attitudes: in this instance, the negative attitudes to homosexuals inherent in a heterosexist culture. However the negative feelings that exist in society are labeled they are not without impact. Two of the men who participated in this study identified that internalized homophobia, the self-hatred some homosexuals experience because of their homosexuality, had been problematic for them. Warren described the personal impact:

- 1 There I was hiding my sexuality and in hiding my sexuality I picked up ideas of not being as good as anybody else and other people are much better than me and all this kind of stuff, and not being proud of who I was because underneath it all I had these ideas I was squashing. Whether it’s just a
- 5 personal thing for me because I was hiding my sexuality and so underneath it all I knew I was. Where do you pin it all? Being gay must be evil and bad and all the rest of it and “Oh, my God, I think I’m gay!” So I focused my energy on being straight but underneath it all I know I’m bad and evil and all the rest of it.

His choice of the present tense in line 9, “I know” rather than using the past tense form, “knew”, could indicate that internalized homophobia continues to influence his feelings of self-worth. Warren raised issues of moral judgment; in line 7 Warren equates being gay with being “evil” and “bad” and reiterated these words in line 9 describing himself as “bad and evil” because he was gay. The use of the word “evil” can also have religious connotations and I recall a classmate, as we made beds together, one morning

saying, “You’re a sinner, you know”. Warren and I were caught in the complex node where homophobia, religious beliefs and moral values intersect.

Hoffman (1984) explained the relationship between religion, morality and homosexuality by comparing polytheistic cosmology to monotheistic cosmology and argued that in monotheism ambiguous categories are abhorred and “one is to act as one’s kind according to one’s class” (p.38). Consequently, a discourse of sexuality is constituted which, in this case, is intended to regulate intercourse as only appropriate between husband and wife. People who subscribe to the monotheistic cosmology of Christianity as their moral foundation cite Leviticus Ch 18 v22 “Thou shalt not lie with mankind as with womankind: it is abomination” (*The New Polyglott Bible*, 1850) to defend homophobic attitudes. Orthodox Christian beliefs allow the justification of aversion toward homosexuals by the argument that it is God who condemns homosexuals (Richmond & McKenna, 1998; Schlub, 1999). Given the strong links that have existed, and presumably continue, between religion and nursing there are implications for the profession with respect to addressing issues of diversity, particularly with respect to sexuality.

Returning to Warren’s narrative extract, in line 5 Warren talked about “hiding” his sexuality. This was explored further in the interview; he expressed “the fear of being outed”, or having his sexuality being commonly known. He was concerned about the reaction of some of the patients:

I always felt awkward around younger men, like in orthopaedics. I haven’t worked in orthopaedics except for short periods since I came out, but I wonder if the phobia, almost, of working with young men is that they might call me gay and that would be too confronting.

Warren’s “awkwardness” resulted from his awareness of his otherness and the concomitant feelings of shame, or as he said in the previous extract “not being proud of who I was” (line 3). Warren was able to hide his sexuality beneath the presumption of heterosexuality that exists in a heterosexist society, but the fear of not being able to hide created considerable tension for him.

Allan, too, took some pains to keep his homosexuality hidden. At the time he applied for nursing he was beginning to tell his friends that he was gay, but “I wasn’t

ready to disclose it to my family yet.” The association of men, nursing and homosexuality was so strong in his mind that he did not tell his parents that he had applied for and been accepted for nursing training: “My being a nurse was not about my sexuality but I thought that people would think that it was. That it would be identifiable that I was gay through that decision.” The reaction of patients to his sexuality was also a source of tension for Andrew:

A seven-bedded room with young male footballers all in traction was my worst nightmare, if you wanted to make me feel ill at work, all you had to do was just allocate me to them because I just felt vulnerable that I stood out. And I hated it and despised it.

Whether these men would have actually been met by the response they feared in these situations is unknown, but their fear is grounded in their experience of growing up gay in a heterosexist society. The presumption of heterosexuality means exposure to homophobic comments and actions. This can often be accompanied by a feeling of being compelled to participate in such activities oneself in order not to be “outed” and a considerable amount of time being spent in monitoring themselves to ensure that one cannot be suspected of being gay (Hoffman & Bakken, 2001). Subsequently, a hypervigilance to the possibility of being the object of homophobia is developed. According to Warren “There is the fear of being outed or [] being sensitive to it.”

A number of theories have been put forward to explain the origins of homophobia; one of which is the notion that it is a defense mechanism, which helps the individual cope with some inner conflict by transferring it on to homosexuals (Herek, 1984). For some it may be a manifestation of the conflict between their own homosexuality and the internalized shame and hatred owing to the negative reactions of heterosexist society. Ian’s comments illustrated this phenomenon:

1 There may be one or two [gay men] who were quite flamboyant in their behaviour, but some of my colleagues were quite critical, the more assertive ones, the more masculine ones maybe, they were very critical of these people and yeah ... they never really completed their training.

5 *Interviewer:* So the other men were quite critical.

Ian: Yes, if they were seen to be that way inclined. I mean, I know for a fact, in recent years some of those who may have been critical were probably gay themselves.

The fact that those who may have been “critical were probably gay themselves” (lines 7-8) are illustrative of what Buchbinder (1998) described as a dual dynamic: “*The fascination of the possibility of same-sex attraction and, simultaneously, its prohibition and persecution*” (p. 126). Once again the language used underscores the otherness of the gay man: “these people” (line 3) and “that way inclined” (line 6). Even more significant is the implication in lines 4-5 that colleagues who were homosexual were victimized to the extent that they withdrew from nursing rather than continue in a hostile environment.

Within a hegemonic discourse of heterosexual masculinity the fear that homosexuality can prove a barrier to career progression has arisen. Thus, to gain access to positions of cultural authority some gay males remain silent about their sexuality (King, 1999). Allan’s early difficulties with coming out as a gay man have been described earlier, subsequently when he did come out he was advised that his openness about his sexuality would hinder his career progression:

There was time when I was a staff nurse in my younger days when I was interested in a Charge Nurse position and I sought advice and direction from another senior colleague in the hospital who had some abilities in coaching and practice at interviewing and such things. Her advice to me at that time um she pointed out to me that she believed the fact people were aware that I was gay was going to be something that went against me in that process.

Allan was not appointed into the Charge Nurse position; however, on reflection he does not think that the decision was owing to his sexuality, but in fact the better candidate was appointed. It is possible that the advice Allan received may have been an expression of the lesbian colleague’s own internalized homophobia; however, it could also be well-founded in her own experience and that of others. For example, Gray et al. (1996) relate the experiences of some lesbians in nursing education who have

experienced lesbian phobia from colleagues, prejudicial behaviour with respect to access to research funds and decision-making processes related to their doctoral dissertations.

The experiences described above contradict the comments of those who propose that nursing is a profession within which gay men will feel more comfortable being open about their sexuality; for example, Salvage (1985) commented:

- 1 It might be that male nurses, having decided to enter a predominantly female occupation, feel more able to be open about their sexual preferences. Perhaps more gay men are attracted to nursing because they expect to meet other gays and find the support and friendship they need. Or perhaps they are attracted
- 5 to it because it does not seem to demand the macho attributes of masculine stereotyping. (p. 24)

A number of Salvage's assumptions require challenging. In lines 1-2 there is the implication that women are more likely to be accepting of gay men. Both Robert and Charles, who identify as gay, related having comments such as "You are a waste" directed at them from female colleagues because they were not sexually available. Such comments, even though they may be said in a friendly manner, do not denote acceptance. They perpetrate the discourse that anything other than subscription to hegemonic heterosexuality is a "lack". Rather than directly challenging the inherent heterosexism in such comments they both make light of such remarks. Charles responds to his colleagues, "It's not wasted", while Robert ignores the remarks, "It doesn't bother me. That sort of stuff makes me aware of their lack of understanding and insight into how they treat other people."

George's experience belies the expectation that coming out to heterosexual men will be difficult. He described the reaction he got from friends in the army:

When I came out I started with what I considered my roughest mates, you know, very hard people, working infantry, have done some incredible things. I started the hardest and worked back. The first said, "That's cool, my brother's gay" and the second one whom I thought would be a real hard nut to crack, he threatened to beat up any straights that were picking on me that I couldn't deal with.

George's use of the word "straights" is meaningful. In the gay vernacular "straight" is used to describe heterosexuals. Buchbinder (1998) suggested, however, that it denotes not only heterosexuality but also normality. Therefore, in its use homosexuals may be subscribing to the discourse of non-normative sexuality that surrounds homosexuality. To be "straight acting" is highly valued in the gay community, as evidenced in personal advertisements in the gay press in which men describe themselves as straight acting or seeking straight-acting respondents. Then the use of the word and the desirability of the behaviour are suggestive of internalised homophobia being a collective response within the gay community. Presumably, demonstrating stereotypically male behaviour constitutes "straightness" which then allows the presumption of heterosexuality, as homosexuality is associated with male effeminacy. Thus, many homosexuals, although denied membership in the heterosexual brotherhood, continue to demonstrate allegiance to its prescribed code of behaviour.

In the previous quotation from Salvage (1985) she wrote about "sexual preference" rather than sexuality *per se* (line 2). This equates homosexuality with no more than a physical act. The use of the term "sexual preference" implies that sexuality is a choice rather than recognising the ontology of homosexuality. The reduction of a core part of identity to a mere sexual act is a heterosexist act of oppression. To suggest (lines 3- 4), becoming a nurse is a way to "meet other gays and find the support and friendship they need" is at best patronising, but at worst pathologizes gay men as solitary and friendless. In line 5 Salvage proposed that gay men are attracted to nursing because they will not need to be "macho." From here it is an easy leap for the reader to equate this with effeminacy, a link that seemed to be implied in from Williams' (1993) comment on page 191. The totality of gay male experience is not to be found within a discourse of soft masculinity that stereotypes gay men as nurses, hairdressers, florists and flight attendants. Andrew commented about the inaccuracy of such stereotypes, "Well, every male hairdresser is meant to be gay. You know, I'm hard pressed to find one in Smithville!" Salvage (1985) reflected some of the common misconceptions about gay men that are prevalent in a heterosexist society and in doing so she is guilty of what Culley (1996) described as the overlapping of the social construction of "others" with homogenisation, stereotyping and cultural essentialism.

It might be argued that the views expressed by Salvage (1985) and Williams (1993) are no longer valid in the contemporary context; however, in New Zealand the polarised response during the introduction to the Civil Union Bill (2005), which provides legal recognition for *all* couples, regardless of gender, who wish to register their partnership suggests that disquiet at the presence of homosexuals persists.

Webb (1993) voiced doubt about the appropriateness of men researching women. Sandra Harding (1987) defined feminist research as that done for women and from the perspective of their experience. She required that “the enquirer her/himself must be placed in the same critical plane as the overt subject matter, thereby recovering the entire research process for scrutiny” (p. 9). From Harding’s perspective if this condition is fulfilled then men can also engage in feminist research; however, according to Webb (1993) “most contributors to the debate dissent strongly from this perspective.” (p.417). Similarly, queer standpoint theory requires the use of a queer perspective to provide a legitimate voice (King, 1999). So equally doubts can be expressed about the validity of a woman, as in the example of Salvage, (1985) presuming to write about the homosexual male experience.

There is ample evidence, in the both the literature and from the men who contributed to this study, to dispute any claim that nursing provides a safe environment within which to disclose one’s homosexuality. In fact, Richmond and McKenna (1998) asserted, “The prevalence of homophobia amongst the nursing profession gives cause for concern” (p. 367). According to Platzer (1993), homosexual patients are often subjected to bias and prejudice from nurses and as a result, can be marginalized within health care. There are studies which bear evidence to Platzer’s assertion (for example: Cole & Slocumb, 1993; J. A. Kelly, Lawrence, Hood, Smith, & Cook, 1988; Kemppainen, Dubbert, & McWilliams, 1996; Mackereth, 1995; I. Taylor & Robertson, 1994). The majority of the studies that emerged on this theme were published during the early years of the HIV pandemic when its full extent was being revealed and these studies reflected the ignorance and fear that was prevalent, especially the perception of HIV as a *gay* disease. Hayter (1996) argued, however, that the advent of HIV provided a vehicle for the legitimisation of nurses’ homophobia rather than being constructive of such attitudes. Apart from Platzer’s (1993) work in the UK all the studies cited in this work were conducted in the US, consequently these findings must be used with some caution

in other contexts. In New Zealand, however, Bruce provided an egregious example of homophobia directed at a patient on the part of female RNs:

We had a guy in the coronary care unit who identified as gay, and he needed an arteriogram and needed a through pubes shave. Anyone else could have done it but they saved it for me. So I ended up by giving him a shave and he got sexually aroused [] and the whole time all my colleagues, who were female, were outside the cubicle laughing. I can still hear [them] and I thought that was so unfair [] It got worse, though, because that guy's partner came in and when he was getting out of bed his partner would help dress him; something a partner would do. But because it was two guys the staff were laughing, giggling and commenting. It's not ok.

Challenging the stereotype of the homosexual male nurse

The putative link between men who are nurses and homosexuality cannot be argued as fact. Salvage (1985) argued against the automatic stereotyping of men in nursing as gay; however, she added, "Interestingly, there does appear to be a higher proportion of gay men in nursing than in the male population at large, though of course there are no figures to prove it" (p.24).

Given that there is no statistical evidence to prove any statements with respect to there being a higher proportion of gay men in nursing any such claim can only be conjecture. All the men in this study stated that in their experience the majority of men in nursing are heterosexual. According to Allan, "It has definitely been my experience that most male nurses are not gay, but I think public perception is still that most male nurses are gay."

All the other respondents echoed this sentiment; yet it remains a common and erroneous construction of the sexuality of men in nursing. Grant described it as "interesting" that such beliefs exist and need to be commented on, as when he announced his decision to become a nurse:

Well, I think at that stage lots of people still had this image of male nurses being homosexuals. My doctor actually passed a comment when I told him. He was quite excited about it; "It'll be nice to have some heterosexual males in the workforce." I find it quite interesting really that comment.

Interviewer: You found it interesting: in what way?

Grant: That he perceived male nurses as being homosexual.

He added that it was not an issue for him that people might assume he was gay himself; however, he did not articulate an understanding of the inherent homophobia in the comment nor of the reasoning that might lead to such a perception. It is possible that Grant's doctor had met some nurses who are homosexual and, as has been alluded to earlier, subsequently categorised virtually all men in nursing as gay in order to understand why men would choose nursing (women's work) rather than medicine (men's work). Bruce was aware of this mechanism:

Do you think it's true that most male nurses are gay?

Bruce: In my experience-well I think that whenever people are confronted with difference in order to understand the difference they try and put people into boxes, let's put it that way. And, of course, a nurse is traditionally thought of as female, so when you see a guy nursing that is a very clear point of difference. So in order to understand, "I wonder why this person is nursing?" I think that is one of the main questions that people ask, in my opinion.

It is generally inferred if a man is married or has a partner of the opposite sex that he is heterosexual. It is an erroneous assumption. Edward suggested that "society is a lot more tolerant", but then allowed that it might be his own personal growth that allows him to be "comfortable" with gay men. His use of the word "tolerant" does not necessarily equate with acceptance as equal. Although some of the synonyms for tolerant such as liberal, open-minded and broad-minded can be interpreted as denoting a sense of acceptance other suggested synonyms, such as forbearing, charitable and lenient, cannot. For some men the internalised fear of being homosexual, or of being labelled homosexual, leads them into marriage or *de facto* relationship. They are either not accepting of themselves or they do not perceive society as tolerant. Thus, Edward made the assertion that society is more tolerant from the privileged position of heterosexuality and not from the position of the homosexual who lives in the nexus between avowals of tolerance and the manifestations of homophobia.

Warren hid his homosexuality within marriage for a number of years and Phillip wondered if perhaps one of his peers was hiding his homosexuality through hypermasculine behaviour: “He gives the impression that he has to be real macho so people don’t think he’s gay. Whether or not that’s true, I don’t really know. I’ve never asked him.”

It is possible that the young man Phillip described is hiding his sexuality or it may be that he is indeed heterosexual and his “macho” or hypermasculine behaviour is a coping mechanism to rebut any suspicions that he might be gay. It has been suggested that some heterosexual men in nursing use similar strategies (Isaacs and Poole, 1996; Williams, 1989). Two of the (presumed) heterosexual men in this study, Edward and Bruce, described the need to emphasise their heterosexuality:

Edward: I say it to my shame [that] in my early years as nurse before I started to become relaxed with who I was, there were times when I would overtly state the more masculine things that I did.

Interviewer: So you actually wanted people to know –

Edward: I was a man. I used to play senior rugby, and I did mountain climbing and I was a farmer.

For Edward the issue was complex. He acknowledged that being a rugby player and a farmer was not a protection as “there are gay[s] everywhere”, but he found it difficult to be thought of as homosexual because of his strong Christian beliefs:

It is not until I have become confident about who I am that it then doesn’t worry me what other people want to judge, but before that it did [] It’s not straightforward, and to simplify it hooks back into my fundamentalist Christian [beliefs] and to unravel that stuff becomes particularly convoluted.

Edward occupied an uncomfortable and contradictory position with respect to homosexuality. On one hand he identified himself as “tolerant” and considered society to be more so, yet also identified as having fundamentalist Christian beliefs; beliefs which are generally not compatible with acceptance, or even tolerance, of homosexuality. Bruce also owned strong Christian beliefs; however, they were not part of a need to be identified as heterosexual. For him the issue was about the avoidance of harassment:

I deliberately wore a wedding ring – deliberately – particularly in coronary care.

Interviewer: Why?

Bruce: Because I got sick of all the comments from my colleagues.

Interviewer: What sort of comments?

Bruce: Just the comments, the looks, the snide remarks-always questioning. I mean I had a number of people say to me, “You’re married now, that’s great!” I deliberately did that because I got to the point where, “Oh, look I don’t have to put up with this!”

Interviewer: What were they making these comments about?

Bruce: Issues of sexuality.

Interviewer: Ok, so they were implying that because you were a nurse and a man you were –

Bruce: Gay! Absolutely! It wasn’t just from the nursing staff; there were some doctors who would do that as well.

It is also questionable whether Ian emphasised any stereotypical male attributes. Earlier, the manner in which he distanced himself from gay colleagues by categorising them as “those people” and requiring them to “keep themselves to themselves”, was described. It cannot be assumed that he did not also adopt some form of overt behaviour to further distinguish himself from his homosexual colleagues.

None of the other respondents, who did not identify as gay, provided any evidence that they were at all uncomfortable with either working alongside gay men or being possibly thought of as such. For example, Paul in response to the question, “Did it bother you, the fact that people might have questioned your sexuality?” replied, “No, it didn’t bother me at all. There was no need for it to. I’ve got nothing against gays, so I don’t perceive it as being a value judgement on me whether people think I’m gay or not.”

What is interesting from this study is that the men who had the most difficulty in accepting homosexuality, at least based on their verbal responses, were those who identified as gay. This reflects the insidious nature of homophobia and the difficulty that gay men face in overcoming the conditioning to internalise homophobia. Holyoake (2001) voiced suspicion of heterosexual men in nursing who espoused attitudes such as the one expressed by Paul above:

As expected, this type of response typifies the caring and understanding nature we have all become more accustomed to during the past twenty years. Yet the sniggers and laughs about “being a shirt lifter” or “not turning your back” remain the common phrases offered by males who retained their sense of sexual identity and attempt to protect it as the dominant discourse. (p. 89)

Holyoake (2001) studied men in psychiatric nursing. Traditionally men have been valued in this role because of the stereotypical masculine attribution of physical strength. It can be argued therefore that psychiatric nursing has been constructed as *normal* for men, whereas general nursing was constructed as feminine and *abnormal*. Consequently, the man in the environment of psychiatric nursing would be less likely to behave in a way that could be perceived as non-masculine. According to Holyoake: “Male nurses are conditioned by a (re)productive dread to conceal and suppress elements that might betray them to others as being insufficiently manly” (p. 91).

From this standpoint, men who are psychiatric nurses, in order to reaffirm their membership of the dominant patriarchal and heterosexist culture, subscribe to the belief that men in general nursing are gay. As Luke said about his early career in psychiatric nursing, “I guess one of my perceptions of men in the general system in the early days was that most men who went into the general system were gay. That was fairly accepted.”

This stereotypical belief is also being used to blame gay men for the lack of men in nursing. For example, a report in the *Australian Nursing Journal* (“Where are all the male nurses?” 2001) stated, “The main reason men were not entering nursing was not because of poor pay, shift work or a lack of career advancement but because they fear being branded as effeminate or gay by their peers and families” (p.35).

In the US Williams (1989) reported that some men who are nurses are actually antagonistic toward gay men for perpetuating the stereotype and hold them responsible for keeping more men out of nursing. Presumably, by *men* one is to infer heterosexual, that is to say, *real* men. The irony is that gay men, who are the recipients of heterosexist oppression, are being held to account for the sexism inherent in the dominant heterosexist, patriarchal society which discriminates against them.

“We don’t want more of that sort here”: The sexual harassment of men who are nurses

During Andrew’s career he has had cause to file a complaint against a female staff member for sexual harassment, who in front of witnesses commented, “We don’t want more of that sort here” with respect to his homosexuality. Andrew was not alone in describing incidences in which these men, on later reflection, identified that they had been the victims of sexual harassment.

The role of men as perpetrators of sexual violence, particularly against women, has been extensively researched and documented; however, the experience of men as the recipients of unwelcome sexual attention has not been extensively explored. Robbins, Bender and Finnis (1997) identified that, up until that time, there were no studies addressing sexual harassment and men in nursing. Interestingly, even though citing their review of the literature, White (2000) asserted that “sexual harassment is predominantly a problem faced by women in the workplace” (p.58). In drawing attention to the contradiction inherent in White’s position I am not arguing that she is incorrect; however, until research with respect to the sexual harassment of men is actually undertaken such assertions cannot be accepted unequivocally. While recognising the culpability of many men in such behaviour, the section that follows focuses on sexual harassment as experienced by men who are nurses. It is contended that, based on the experience of these men, it is a problem commonly encountered by men in nursing.

From a review of the literature pertaining to sexual harassment in the work place undertaken by Bronner, Perez and Ehrenfeld (2003) the following characteristics of sexual harassment can be identified:

1. Any unwelcome, offensive and undesirable sexual conduct that interferes with an employee’s ability to perform their job.
2. Behaviour which is sexual in nature and directly or indirectly adversely affects or threatens a person’s job security, prospects of promotion or earning, working conditions, or opportunity to secure a job.
3. Behaviour that causes humiliation or embarrassment.

They also identified a range of behaviours that can be categorised as sexual harassment; these can either verbal or nonverbal and physical. The range of verbal and nonverbal harassment can include: offensive sexual remarks, unwanted verbal attention,

requests for unwanted dates, sexual propositions, exposure of body parts and sexually suggestive expressions. Physical sexual harassment can include unwanted physical contact and physical assault. The perpetrators of sexual abuse can be either staff or patients.

Acts of homophobia can be located within the framework of the characteristics of sexual harassment described above. It can also be argued that the unwanted attention that is drawn to the gender of men who are nurses and suggestions that they are less capable of caring behaviour, or their gender being used to exclude them from nursing or from particular areas of nursing is also a form of sexual harassment.

Bart excepted, all of the men interviewed for this study identified that they had encountered sexual harassment in the workplace. Although Bart has not been the victim of sexual harassment himself he stated that he was “definitely” aware of its occurrence ranging “from outright harassment through to sexual impropriety.” By “outright harassment” he was referring to verbal harassment, which a number of the men have experienced. Robert, who is gay, has fielded unwanted telephone calls from female colleagues asking him out on dates and had a particularly unpleasant experience in which: “A staff member had this really sick sort of idea about us and our relationship and I was confronted by her husband one day at work-and she was just a colleague.” He did not elaborate upon this experience; however, the situation appears to exhibit the hallmarks of the type of fantasising that leads some people on to stalking. Paul talked about “people who won’t leave you alone or are particularly attracted to you.” He dismissed this, however, stating “but you get that anyway.” He highlighted one of the problems with defining sexual harassment. Some forms of behaviour are quite clearly inappropriate and can be easily categorised as harassment; however, while being asked out or having someone display a particular interest in one may be unwelcome, at what point does it become harassment?

Edward related two examples of what can be interpreted as sexual impropriety. The first example, he considered, was a combination of both sexual harassment and making fun of his strong Christian beliefs:

When I left an ICU I’d worked at for a number of years they wanted to get a female stripper ... and instead they got a belly dancer because they thought it might be a little much on hospital property and hospital time to have a stripper.

He described it as “having a bit of fun in one sense, but was also having a go in another.” He was very clear that he considered it sexual harassment. He also wondered what would have happened if the gender roles had been reversed and whether such behaviour would have been tolerated. Along with Bart, he was of the opinion that “political correctness” was more likely to be applied to regulate men’s behaviour toward women than it would be to protect men from sexual innuendo and unwanted sexual advances.

Edward’s second experience was one in which he thought the double standard with respect to political correctness occurred. He remembered his first day, as a student, on a clinical placement out in a rest home:

I was with a tutor and we just went into the linen closet and we all started changing, and she just treated it as normal, and went down to her bra and undies, but I did a double take, but didn’t do anything and just carried on and got changed. And I think it probably didn’t do any harm coming from a family of five sisters, uh and normalising that process, but ... intriguing [] I think in those days my sense of boundaries were not overly clear. I think the fact that sticks in my mind, and I can still the look on her face, and it’s almost provocative. I don’t know if it’s in a sexual sense, or it’s provocative as a in a challenge, as in “What are you going to do?”

In retrospect Edward now sees the tutor’s actions as inappropriate and as indicative of a double standard that operates with respect to sexual harassment. As he stated: “If a male [tutor was] with another female student in the linen closet getting changed, no matter what happened, you would have just opened yourself up wide to ... [censure]

Charles described having had a patient make suggestive comment to him about his body, comments which were accompanied by physical gestures, “she walks past and touches my bum.” An experience that Grant has also suffered, more than once:

Nurses pat you on the bottom as you pass, that sort of stuff.

Interviewer: That’s really overt.

Grant: I know it is. I told a nurse to stop. I said, “No, that’s silly.” But I didn’t take it to anyone else. Had I been a young man I would probably have got all confused. A nurse at polytech, she was 19, was making advances to me and I told her, “Listen, I’m 46; I’m old enough to be your father. Don’t be silly. Go away.”

It is argued that abuse of power is central to issues of harassment (Clare, Jackson, & Walker, 2001; I. White, 2000) and, according to Robbins et al. (1997) in order for it to succeed there needs to be collusion by the organisation with respect to lack of recognition and/or inaction and a “conspiracy of silence with the victim” (p. 166). It is contended that both nurses and patients are placed at risk because nurses are unwilling to report such incidents due to embarrassment, guilt or rationalisation that the patient “couldn’t help it” (*ibid*). According to Bronner et al. (2003) the most common reaction is the use of passive coping strategies, usually ignoring the behaviour, as some of these men do, or getting away from the perpetrator. This study was undertaken in Israel and they concluded that Israeli women were capable of detecting harassment more easily than men and so could respond accordingly. In an extraordinary claim they suggest that one of the reasons that men who are nurses do not complain is because they “yearned for female attempts to touch intimately or for offers to have sex with them” (p.643).

Bronner et al’s (2003) study is part of a discourse that also sexualises the heterosexual male such that from their “yearnings for sex” it is an easy step to constructing them as sexual predators. This was strikingly brought to my attention when I saw the Spanish film *Hable con ella* (*Talk to her*). In this film the writer and director Pedro Almodavar (2002) explored the obsession a man who is a nurse has for his comatose female patient. His obsession eventually leads him to raping her and she becomes pregnant. This movie disturbed with its depiction of obsessive and unrestrained male sexuality associated with a nurse. It insinuated that a man who is a nurse cannot be left alone, especially at night, with a vulnerable patient without the risk of sexual impropriety.

From the interviews conducted in this study it would appear that men do not complain either because they do not recognise the behaviour as sexual harassment or because they generally dismiss it as too trivial to bother about. Returning to Paul’s words “but you get that anyway”, it is as though such behaviour was to be expected when working with large numbers of women and that it is just part of the friendly relationships between male and female colleagues. Therefore, they tend to ignore or trivialise the behaviour. Bart identified this process:

I'm aware that I've done a lot of anger management and stop violence groups and there are a lot of men who tend to dismiss their anger and aggression, to trivialise it, pass it off and, I dare say, the same thing can happen with sexual harassment, overture, comments. Men would pass it off, trivialise it, women would perceive it quite differently. But then again that's too simplistic, too. You get into a different environment and groups of women are quite capable of sexualising and trivialising men in everything from their fantasies to their interactions too.

Conclusion

This chapter has revealed that a complex and challenging area for men in nursing is created by discourses that have normalised female touch and sexualized men's touch. These discourses have created potent barriers with respect to men providing care while at the same time making them particularly vulnerable to accusations of sexual impropriety.

The latter discourse which problematises men's sexuality as threatening is accompanied by one which ascribes homosexuality to the man in nursing as a mechanism to explain his deviance from accepted heterosexual male roles. The men in this study carry out their nursing roles, therefore, in an environment that is often hostile to them with respect to their sexuality. This hostility is often manifested in sexual harassment. It has been argued that nursing has largely ignored the issue of the sexual harassment of its men and the need for strategies to assist both the men and the patients in normalising the provision of care by men and the provision of safety for both parties. Because of their gender men are victims of discrimination in the performance of their chosen profession. The challenge, therefore, for nursing is to work for the acceptance of both men and women in the profession.

CHAPTER ELEVEN: Career development

In the mid 1990s I was appointed to the position of Clinical Nurse Consultant, one of a number of new senior nursing positions that had been recently created at City Hospital. Part of the role was to liaise with nursing staff in the intensive care unit (ICU) to determine whether patients were ready for transfer to the surgical floor. I recall going to the ICU and encountering a female colleague I had not seen since we worked alongside one another, as RNs, in an ICU in an Australian hospital a number of years previously. Naturally, a conversation ensued that involved catching up on the direction our professional lives had taken. When I told her about my appointment into this newly created position her response was to call out to the staff working around her, “See! See what happens when you’re a man!”

Nowhere do men in nursing come into more criticism than with respect to their career progression. It is alleged that women, especially those who move into those occupations that are stereotyped as masculine, have to contend with a “glass ceiling” that limits their career progression. In contrast men in nursing are reported to be able to glide up a “glass escalator” (Williams, 1992) and quickly move into either influential administrative positions or into speciality nursing (Evans, 1997; Hunt, 1991; Porter, 1992; Ryan & Porter, 1993; Williams, 1989, 1992; Williams, 1995a).

This chapter turns to the consideration of men’s career progression in nursing. It discusses men’s overrepresentation in the so-called speciality areas of general nursing (critical care²⁹ and the emergency department) and in administration. The creation of what Egeland and Brown (1988) term “islands of masculinity” (p. 265) will be explored and alternative readings to those commonly found in the literature will be proposed.

²⁹ In this study the term “critical care” includes: Intensive Care (ICU), Coronary Care (CCU), Paediatric ICU and Neonatal ICU.

Men in psychiatric nursing

I recall my first three-month preliminary training (prelim) block, in 1973, at a large psychiatric institution in Auckland. It was our first day and no one really knew what to expect. About 30 of us were seated in a smallish room. I remember thinking there seemed to be a lot of men in the group—men with long plaited hair and wild beards ... This group contrasted markedly with the general nurses I had sat with two years earlier when starting my training at a small city hospital—they were all female, wore smart white uniforms and hats to class and were predominantly young, white and middle-class. (Walsh, 2002, p. 28)

Walsh's (2002) recollection of psychiatric nursing introduces a paradox for men and nursing: the prevalence, and acceptance, of men as psychiatric nurses. As Bart, who commenced his psychiatric nurse education in the late 1970s, commented: "Certainly, nobody in those days looked at us, either within or outside the field and said, "You're a nurse, that's a girl's job"".

The barriers to men's involvement in general nursing, through its identification as women's work, have not been evident in psychiatric nursing. Mericle (1983) noted, "rarely has the right of men to care for psychiatric patients been challenged" (p. 29). In New Zealand, the report of the Nursing Manpower Committee identified that men composed a higher proportion of the nursing workforce in psychiatric and psychopaedic nursing programmes, 32% and 18% respectively, and that 51.6% of men employed in nursing were to be found in those services (Department of Health, 1985). There is, perhaps, some irony in this more politically correct era to read of nursing *manpower* in a profession which was, and remains, 94% female.

The reason for the higher proportion of men in psychiatric nursing cannot be attributed to one sole factor, but lies in the intersection of the masculine stereotype, the nature of psychiatric care in its early days, public reaction to the person with a psychiatric illness, the barriers that lay in the way of a man seeking education as a general nurse and the fact that psychiatric nurses in New Zealand earned more than their counterparts who were general nurses.

Aggression and violence.

The association of masculinity with strength and violence has led to a perception that men, as nurses, are better suited to dealing with the aggressive patient. A cultural myth existed which permitted Knepper (1989) to write, "The presence of male nurses makes a difference on psychiatric wards. Male patients tend to take notice of male voices, and female nurses feel reassured by the proximity of male strength" (p. 138).

The suggestion that female nurses will be "reassured" by male strength diminishes the contribution of men to psychiatric nursing and devalues the experience and ability of female nurses. It was argued earlier that beliefs about chivalry have played a role in the construction of modern masculinity and certainly from the above quotation the inference can be taken that there is an assumption that men protect women from acts of physical aggression and that masculinity requires the manifestation of physical prowess. Mosse (1996) described this as an important element in the construction of masculine identity. Wiegers (1998) asserted that bodywork is a site for the pursuit of normative masculinity; it is a norm that not all men in nursing, psychiatric or otherwise, meet. Bart, for example, described himself as a "skinny Pakeha", while Luke when talking about potentially violent situations said, "I'm not, as you know, [of] an incredibly masculine sort of frame or composure so I would never put myself in that situation". Bart's use of the racial label "Pakeha" suggests subscription to a discourse of masculinity that constructs the non-Pakeha, i.e., Maori and Pasifika men, as physically more powerful and more likely to participate in situations in which there is a display of physical strength and aggression.

Returning to the extract from Knepper (1989), the notion that "male patients tend to take notice of male voices" (p. 138) implies the existence of a masculine hierarchy in which the voice of the *authoritative father* will be heard and obeyed, even during an episode of mental illness. This supposition is debateable and as George explained, both with respect to a man's perceived heroic qualities and the need for a female nurse to be protected by a male:

You would get the acute presentations and you had to do something with them before you commit them – and certainly as a bloke I got to do the escorts – and why they didn't realise bloke equals wimp, I don't know, because I would be the worst possible person in a confrontational situation, and of the confrontation situations I

witnessed it has always been the petite women who have taken control of that and have been much more successful.

James, a respondent, in Holyoake's (2001) study of men in psychiatric nursing in the United Kingdom also agreed on the ability of female colleagues to defuse a potentially violent situation: "We're all the same, male nurses just hang around the edges of any incident and let the females try and talk them down. It's only if things start to get out of hand we act" (p. 83). While valuing the abilities of female colleagues, the suggestion that the man must be prepared to act "when things get out of hand" continues to draw upon the image of the chivalrous male. Peplau (1982), in her reflections on earlier days in psychiatric nursing, also described an expectation that men will protect female staff. More saliently it draws upon a binary discourse of gender that perceives women as more relational and men as more physical in orientation. However, as will be shown in the next section, with reference to Bart's narrative, males can also use language rather than force to create a safe environment for the patient.

Abstaining from aggression.

It can be argued that the expectation that men will react with strength can create an aggressive environment that precipitates a violent response from patients. Luke recalled: Certainly in the acute assessment area there were men who went into that area because they saw themselves with that prowess. Even today that is one thing I quite like [about] not being in that environment is the edge of aggression it has and that show of strength that I think is sometimes expected from the people working there. Even if I had been working in that area I would probably be more likely to gravitate away from areas that demanded that.

Bart also challenged the need for an aggressive response to the patient. When asked about what was most dissatisfying in terms of providing nursing care as part of a nursing team, he replied:

Things that could have worked or could have run but have been stymied through people's lack of vision or by lack of resourcing or by outright aggressive responses from people who believed that the way to deal with things was by aggression, not to

get me wrong there are times when the only thing you can do is put a headlock on someone and have as many people there to grab as much as possible and get them down on the floor. There is no need to act with people in ways that are conducive of aggression.

He provided several examples of how a non-aggressive response to patients provided opportunities to learn that the way you use language has an important role in the nurse-patient relationship. He continued:

1 I always remember we were sitting in the admission ward one day when a
 young bloke came in for admission. We put him through our normal
 admission procedures. In those days you had a bath and went to bed—middle
 of the day, morning or what[ever], you went to bed. We put him through the
 5 admission process and we chatted away and it was discovered after a while
 that he had come to the wrong place that he actually should have gone to a
 locked ward because he had the reputation of being a violent bugger. So me
 and my mate looked at each other and said, “Well, you are here, it’s ok if you
 stay here, if you bloody behave yourself”. It was fine, so the way we came
 10 across to him didn’t bring about any aggression on his part. Why not? You
 get from people what you project yourself.

The interesting aspect of this extract is not only the situation he related, but also the language he used to describe it. The use of the words “bloke”, “bugger”, “mate” and “bloody” in lines 2, 7, 8 and 9 respectively is vernacular that is more likely to be associated with a stereotypical *hard* man image, yet he is able to incorporate such words as he “chatted” (line 5) in such a way that the intent of the words was not perceived by either the interviewer or the patient as aggressive.

In another example, he described how he was able to use language to prevent a potentially violent situation from occurring:

The other one that really stands out again was a young fellow who – he was quite disturbed and he was charted ECT³⁰ and he fought like a tiger and we had a

³⁰ Electro-convulsive therapy

couple of sessions with him and it was really all on; grabbing and hold downs; ripped my shirt completely off one day and broke the Charge Nurse's ribs before somebody got him down, held him down. So I got sick of this after a while and went along to him one morning and said, "Hey, do you know what ECT is about?" He said, "No, I don't, I'm shit scared". Ok, so I sat down and explained to him what it was for [] and at the end of it he said, "Okay, now I understand it" He went through the procedure again that morning, walked in, went through it happily – no problem. So these were learning experiences, if you like, of how to relate to people and how not to relate to people, which always seemed to me to be pretty simple, but you could look right across the profession and see the way that people use language and the way they act themselves toward people that would get them an aggressive response back.

Holyoake (2001) argued that men working as psychiatric nurses are trapped in a discourse of machoness which requires them to be physically aggressive and that failure to act in the proscribed manner is "to fail maleness and, therefore, be the other; that is, something, which is not maleness, e.g., a female or homosexual" (p. 82). Mathew spoke about being trapped by "the unspoken expectation that you supported your male counterparts, you were in the job together". He believed that there was no expectation that women would participate in such situations, "I guess they had more of a choice in the matter".

For Mathew, being required to participate in such displays of maleness was emotionally damaging:

- 1 In the early days when I went into mental health nursing there were a lot males in that system, and they were used in a quite illegal way ... we were probably three or four times a day used purely as muscle to jump on people and force medication into them and that was incredibly damaging for me and
- 5 for the clients obviously.

Interviewer: Damaging to you in what way?

Mathew: I inevitably had to synthesize those repeated situations, somehow take them on ... I was a very non-violent person. I never had a fight in my life, as a kid, you know, I always backed away from violent situations. So suddenly

- 10 I was being forced into situations where I was regularly being violent and causing people distress and inevitably I dehumanised them. Yeah, you have to ... you can't do these things to humans, so I dehumanised them, and in the process of dehumanising them I dehumanised myself, and became this grumpy, aggressive, angry person – really unpleasant person.

In line 10 the word “forced” highlights the way in which Mathew, as a young man, felt trapped by a hypermasculine, or macho, discourse. What makes this narrative especially poignant is the contrast with Mathew’s account of the “defining” moment that lead him into nursing which was described on page 126.

Mathew’s narrative reveals that the cost of adherence to the scripts of normative masculinity can be high. Recent research, and better understanding of masculinities and gender practices, has revealed that contemporary masculinity has a range of toxic effects on men’s lives and those around them. These effects range from the emotional devastation described by Mathew, to men’s shorter average life expectancy, higher rates of injury from accidents, higher rates of alcohol abuse and men and boy’s higher suicide rates (Connell, 2000a; Harding, 1998a; 1998b; Huggins, 1996; McKee & Shkolnikov, 2001; Raeburn & Sidaway, 1995; Schofeld, Connell, Walker, Wood & Butland, 2000).

Othering the mentally ill.

In colonial New Zealand anyone considered to be mentally ill was treated as a criminal. The first asylums were established in 1844, one was attached to Auckland Hospital and the other was attached to Wellington Jail. The care provided in these early asylums was essentially custodial and strictly authoritarian in nature (Ernst, 1991). The attendants were, in the early days, men. By 1890, although some of the asylums had appointed trained matrons and commenced on-the-job training for attendants, formal training for psychiatric nurses, or “Mental Deficiency Nurses”, as they were called did not commence until 1905. Although passing of the Final Examination set by the Department of Health entitled them to the remuneration and status of a trained nurse, they were not registered, in the same way that the general nurses were, until the Nurses and Midwives Amendment Act 1944 (Papps & Kilpatrick, 2002).

The history of psychiatric care is one in which the mentally ill were nursed in isolated areas. Foucault (1965, 1988b) described how this situation evolved over a period of 300 years, from the end of the Middle Ages through to the 17th century: the mentally ill, pathologized as a threat to society, began to be isolated in asylums. Thus, society was able to ignore the plight of those suffering from mental illness. Until the 20th century there were no forms of chemical restraint available; barbiturates were not used clinically until 1903 and major tranquillizers such as *librium* did not emerge until the early 1960s. At times, the only option available for attendants, as the men employed in this field were generally known, for the control of aggressive behaviour was physical restraint (Mericle,1983). Bart describes what he termed “aggressive crap” and the staff who responded aggressively, thus:

A lot of those people worked during the days before major tranquillisers, imagine a place like that with hundreds of people in it, who were totally unmedicated, the violence that you would be dealing with day-by-day would have been horrendous. That’s where a lot of those people came from; it was their legacy, if you like.

Mericle (1983) contended that the efforts of the men who worked in such difficult and isolated environments were often criticised and belittled. He cited the words of Dr. Campbell Clark, when speaking to the Medico-Psychological Association (now the American Psychiatric Association) in 1883:

Undoubtedly the status of an attendant is at present an inferior one in the industrial scale. Some common notions are, that the rougher and stronger the material, the better is the attendant, that it leads to nothing reliable or desirable (for men or women) as an occupation and that as life’s work, it is not sufficiently respectable to satisfy an average ambition. (p. 11)

The belittling of the work of the men as asylum attendants was not confined to the United States. In 1895, in the United Kingdom there was uproar in the Royal British Nursing Association (RBNA) at the suggestion that there should be registration within the Association of mental nurses. According to Mrs Bedford Fenwick, the former president of the RBNA in an editorial in the *Nursing Record*:

Everyone will agree that no person can be considered trained who has only worked in hospitals and asylums for the insane. The scheme also proposes to open the register of trained nurses to men as well as to women, and, considering the present class of persons known as male Attendants, one can hardly believe that their admission will tend to raise the status of the association. (cited Adams, 1969, p. 12)

While today we may recoil at the descriptions of the violent and aggressive behaviour of men working in psychiatric institutions, it was this very element of the male stereotype that made men welcome in this world: the association of men with aggression and the restraint of aggressive behaviour.

Men and “speciality” nursing

A prominent theme in the nursing literature with respect to men and their nursing careers is that they “are attracted to the more high-status and prestigious aspects of nursing, such as emergency department (ED) and critical care areas” (Clare et al., 2001, p. 173). No discussion is provided to explain why they consider ED and critical care to be “high-status” work places; however, by labelling these environments as “high-status” and “prestigious” they are constructed as elite and, as a corollary, other areas of nursing are devalued. Such work environments are frequently labelled “specialities” in the literature, which further adds to the notion of a more elite status. Normally, it would be expected that higher status is also equated with higher salaries, but in New Zealand the financial rewards are no greater for nurses who work in such areas. It is evident, however, from recruitment advertisements that more money can be earned from working in critical care in some overseas countries, especially if the nurse has an appropriate postgraduate qualification. Evans (1997) argued that the men who choose to work in the “high-status” areas are demonstrating “the use of strategies by male nurses to separate themselves and their masculine sex role identity from their female colleagues and the feminine image of nursing itself” (p. 226).

The flaw in such an argument is that while men may well be disproportionately represented in speciality areas in relation to their total numbers in nursing, the majority of the nurses in such areas are women. Therefore, if a man wishes to *separate* himself from his female colleagues in order to protect his “masculine sex role identity” there is

no area in nursing where that can happen. Jock expressed the opinion that if his male colleagues do have problems with being in a female-dominated environment they either “put up with it, or they actually end up leaving.” When Jock was asked whether he thought having a woman as a supervisor was a problem for men, he reiterated that if it were, they left:

I think that most of the men I’ve worked with don’t seem to mind having female Charge Nurses. They wouldn’t have got through their training or got to where they are in their nursing careers if they really felt that way, I think.

“Petticoat rules.”

This viewpoint is congruent with that expressed by Ian; he was of the opinion that if men “weren’t prepared to work under what we used to call petticoat rules” then they left. Ian identified himself as being one who could “put up with” working alongside and under women, “It didn’t really worry me, because as I say most of my life [I] had been surrounded by females anyhow.” More important than his ability to tolerate working with women constantly was his acknowledgement that gender did not equate with ability, as he said, “Even now I don’t mind if somebody is better at a job. I don’t mind learning from them.”

Ian’s use of the term “petticoat rules” can be interpreted as dismissive of women, but it was a not uncommon expression at one time and was used to describe too much emphasis on matters of little importance. He provided a number of examples, such as meal time segregation, to illustrate what he meant: “For the whole three years of our training, and those that followed on, we were never allowed to sit with our [female] colleagues at meals.” He provided an even more telling example of excessive adherence to petty rules when he wondered “whether if in some bizarre sort of way [they were] trying to get rid of us, another ploy.” He described the situation:

We had to live in our own quarters, we weren’t in the Nurses Home, there was the male nurses’ quarters at County Hospital and as there were no male nurses’ quarters at City Hospital and we had to do half our training legally at City Hospital. we had to travel each duty from County Hospital at ungodly hours of the morning. It was a quarter to six start on duty in those days, six days a week and they had rickety old bus things. Sometimes a taxi had to be used, but we had to be ready at a

quarter past five to get in this bus [] Another interesting aspect-the girls had capes. I mean they didn't have to travel into City Hospital, but they had capes to huddle in. We had nothing [] and because the etiquette was so strict we were not allowed to wear a jacket or anything and all our uniforms were short-sleeved. So we travelled in an unheated minibus type thing, they were really bizarre old things to City Hospital at a quarter past five in the winter months with our uniform on, no top cover at all.

Such treatment was discriminatory and it was this that bothered Ian, not working alongside women but being treated differently and "the unfairness of some of the criticisms, that's what it was."

Gender appropriate nursing

Williams (1995a) proposed that both men and women in nursing are "tracked" into specialities that are considered more appropriate to their gender. She did not describe exactly what was meant by "tracking" although she also used the word "channelled" synonymously; however, the reader is able to infer how this mechanism works through some of the examples she provided. The experience of "Bill", who worked in a neonatal intensive care unit, was provided to support her argument. Most of Bill's colleagues are men, so it could be contended - even given men's alleged focus on the technical aspects of intensive care work - that choosing to work with neonates is counter to the argument of what is gender appropriate. It is here that the mechanism of tracking can be perceived; Bill actually wanted to work in obstetrics and gynaecology, but was prevented from participating in the relevant rotation in nursing school. It can be argued, in this instance, that tracking or channelling is also synonymous with discrimination. It would appear that if Bill (and his male colleagues) wanted to work with the neonate then it was only the neonatal intensive care environment that was perceived as appropriate.

George encountered a similar experience as a student when he was not going to be allowed to spend time in the gynaecological ward as part of his training. He challenged the decision:

I sat on the District Health Board for the City Hospital Board's Education Committee which oversaw the activities of the school and pointed out that I had an

employment relationship with them in a Nursing Council approved curriculum and ... that they were denying me access to gynaecological training. They said they would give me more orthopaedics to compensate.

The exclusion of men during their nursing training from gynaecology was a common practice in nursing education and likely remains so today when it comes to the allocation of students' clinical placements.

Two discourses intersect to create this discrimination between men and women in relation to providing intimate bodily care for women. The first is a belief that not only will women prefer a member of their own gender as care provider, but that they have the right to this. The second is a discourse that problematises male sexuality and perceives it as threatening to women. With respect to the first discourse it is argued that women are entitled to make choices with respect to the gender of their nurse whereas men are expected to be comfortable with a nurse of either gender. Finch (1990), for example, argued against the recruitment of men as carers on the basis of women's choice, "partly because one would want to defend the right of women who need care to be cared for by another woman, not by men" (p. 54).

Luke talked about the care he took in ensuring the privacy needs of female patients were met, but was of the opinion that:

[W]omen have tended to be very complacent in the way that they have approached people and patients and that came across to me, I think, when I was working in ICU more so. Women would just basically go in and not think about those areas of their management of their patients ...

In this extract Luke is describing the "taken-as-given" described earlier in this work that can lead to both nurse (who is female) and patient not questioning the manner in which the relationship is enacted.

The second discourse emerges from the potential sexual threat that men present to women and is illustrated by Lodge, Mallet, Blake and Fryatt's (1997) study to ascertain gynaecological patients' perceived levels of embarrassment with physical and psychological care given by nurses of both genders. Men who are involved in caring for women may be met with suspicion about their motives, as is illustrated by the comment from one of their female respondents:

1 I can't help wondering what would make a male nurse undertake duties
 involving intimate care of females – i.e., curiosity? Males obviously lack
 understanding because of their gender. Probably very sick people may well
 not feel embarrassed, being helped by anyone is appreciated in those
 5 circumstances. However, human nature being what it is – I feel careful vetting
 would be needed to prevent perverted personnel being recruited – by that I
 mean people who seek gratification from certain aspects of their work. I
 believe we should be broad minded, and over the years embarrassment will
 ease, but at the moment-I still wonder what attracts men to the intimate side
 10 of nursing females. (p. 900)

In the above extract the comment (lines 2-3) about men's lack of experience and understanding because of their gender is salient. If this comment is set against the fact that there are men working as obstetricians and gynaecologists, childless women working as midwives and acceptance that it is normal for a man, who may be undergoing prostate surgery with all the attendant physical and emotional consequences, to be cared for by women, then it would appear that men as nurses are subject to an extra layer of discrimination. A 90-year-old woman in the same study was able to articulate this anomaly:

At the moment I am only used to female nurses looking after me so think I would prefer this, but this might not be the case. I've nearly always had male GPs and a lot of doctors in hospital are male and this does not cause any embarrassment. A lot would depend on attitude and training of male nurses. Male patients are frequently attended to by female nurses after all. (Lodge et al., 1997, p. 899)

The question of the right to demand a particular type of caregiver is problematic. On one hand a patient refusing to be cared for by a particular nurse because of her or his colour would be considered an act of discrimination and is unlikely to be acceded to. On the other hand, common sense would suggest that the preference for intimate care from a member of one's own sex is reasonable within a societal discourse that has constructed genitalia to be shameful and taboo, and in which a good deal of vulnerability is centred. Consequently, it would seem appropriate for Mathieson (1991) to ask: "Does this patient

feel uncomfortable with his nurse on the grounds of gender?” and “How can we ensure such feelings are respected?” (p. 32).

Mathieson’s use of the word “his” is curious, taken out of context it would be read as though she argued for the right of a male patient to be comfortable with the gender of his nurse, whereas in fact her article discussed the appropriateness of men providing nursing care for psychiatric patients who are female. It is only at the end as she concluded that she reverted to the use of the masculine third person; a gendered use of language which while once considered correct usage now appears incongruent in an article that discussed the rights of women as patients.

Men who are nurses are caught between these two discourses: the threat posed by their sexuality and considerations of the appropriateness of their provision of intimate care for women. Subsequently they can face discrimination based upon their gender, not upon their ability to provide competent care. For men, their gender is a potent barrier for them in their role as caregivers.

It has been asserted that tracking into gender-appropriate specialities not only enhances men’s prestige but also their pay (Williams, 1989; 1985a; 1995b). Evans (1997) describes this as one of the “hidden” advantages for men in nursing; however, all nurses who choose to work in those areas share the enhanced pay: a group that is still predominantly female. Enhanced pay may well be an inducement for many men’s career decisions, especially in the context of the bread winner ideology; however this also needs to be understood in light of the fact that they still earn less than their male colleagues in “men’s work” (England & Herbert, 1993). These arguments are based on research conducted in the U.S. so the conclusions, particularly with respect to the financial rewards, are not necessarily applicable in the New Zealand context. Here one of the most lucrative specialities is that of Independent Midwife; while midwifery education no longer requires a nursing background many midwives do come from a nursing background. Mathew works in the field of community mental health and psychogeriatrics. He took the opportunity to be a full-time father for four years, as his wife was able to earn more money in her role as a midwife. He described the transition as being “both extraordinarily difficult and obviously rewarding [] I was extremely isolated ... I never felt like I fit into the mum’s morning teas, so I felt as though I was on my own”. He talked about the issue of money and being a man in nursing:

- 1 If you get into nursing you really choose to become a manager to advance and
earn more money or else you specialise and, yeah; it seems that a lot of people
do nursing and then go on to do psychology or something like that so they can
advance and earn more money [] and I've just been fortunate in that Jean
5 has been often the main wage earner and so we've been able to have a family
and both work which is lucky. I couldn't have continued in nursing really if I
was the main wage earner.

Interviewer: So that is a disadvantage for a man?

- Mathew:* Yeah. Well in a lot of roles you can earn a lot of money, but that's
10 working unsocial shifts in mental health, so if you want to work in the
community you're going to limit how much you earn significantly. That's the
main drawback.

Interviewer: So for you as a man, there's never, ever been a problem in Jean
earning more money than you?

- 15 *Mathew:* Absolutely not! Jean is a dominant personality. She's brilliant and
she's very, very clever; whatever she does, she does well and it's great that she
earns more money than me.

A number of issues emerge from the above extract. First, in order to earn a reasonable income a nurse must choose to go either into management (line 1), specialise (line 2) or obtain qualifications in a better-paid occupation (lines 3-4). If you wish to earn a reasonable wage without choosing any of those options then you must be prepared to work "unsocial shifts" (line 10). Thus, the nurse working such hours will be less available to family and friends in the evenings, nights or throughout the weekends. Second, in lines 6-7 of the above extract Mathew stated, "I couldn't have continued in nursing really if I was the main wage earner."

The notion that some nursing roles may be gender-typed is one that was explored by Muldoon and Reilly (2003). They questioned 384 nursing students, using a 7-point Likert-type scale, about the gender appropriateness of 19 nursing specialisms. Participants rated jobs as more appropriate for men as 1 and those as more appropriate for women as 7. The majority of nursing careers were considered by the respondents to be more appropriate for women; therefore, they used the 25th and 75th percentiles of the data to characterise

nursing specialisms as either gender neutral, female sex-typed and highly-female sex-typed. A summary of the results is presented in Table 11.1.

No area was rated as being male sex-typed, so it is to be inferred that the specialisms considered most appropriate for men are those ranked as gender-neutral. The results appear counter-intuitive as both critical care and nurse teacher are defined in this study as female sex-typed.

This study was conducted in the United Kingdom whereas many of the other authors, such as Williams (1995a; 1995b), are writing from a US perspective and this possibly reflects differences in the critical care environment between the two countries. In the United States the nursing staff in critical care is more likely to work in the capacity of junior Registrar directing unlicensed caregivers to provide the personal care and family support, whereas in the United Kingdom (and New Zealand) it is a more family-based nursing environment with a major interpersonal component to the work and the nursing staff are generally working 1:1 with patients providing holistic care, support and treatment management.

Predictably those careers viewed as most appropriate for men are those that have traditionally had larger numbers of male nurses, such as mental health and learning disabilities, areas that at the time of Muldoon and Reilly's (2003) study had the most severe nurse shortages in the UK. They suggested that women not considering these areas as career options exacerbate recruitment problems in those areas. They did not explore the reasons for this. Two possible inferences can be made; (i) that the women do not choose these areas because of the predominance of men, but more likely, (ii) the nature of the work and work environment itself is not attractive to women.

With respect to the present study the second of these two inferences is worthy of further consideration. The nature of psychiatric nursing and reasons for men being valued in that field have been put forward in a previous chapter, and there is probably a very similar explanation to be found in the field of learning disability. The form of learning disability that some children and young adults experience may make them liable to physically aggressive impulses; therefore, men's physical strength may be valued in situations requiring calming and restraint.

Table 11.1

Perceived gender appropriateness of nurse specialisms

Specialisms rated as highly female sex typed	Specialisms rated as female sex typed	Specialisms rated as gender neutral
Midwifery	Palliative care	Nurse manager
School nurse	Oncology	General surgical
District nurse	Critical care	Nurse consultant
Health visitor	Nurse teacher	Theatre
Paediatrics	Elder care	Learning disability
Practice nurse	General medical	Accident and emergency
		Mental health

Adapted from Muldoon and Reilly (2003), p. 95

Once again a paradox seems evident. It is not considered appropriate for men as nurses to work with children in what might be considered a “normal” environment, such as a school, a GP’s practice or a paediatric ward, presumably because of the value placed on mothering in such environments and also because of issues surrounding suspicion of the men’s sexual motives. Yet, children who are possibly at greater risk from sexual predation because of mental disability are considered appropriate to be placed in men’s care. The corollary of a construction that creates men as sexually threatening is that the child with a learning disability is constructed as less valued if men are then deemed suitable to be their caregivers. If women are also less likely to choose to work in such areas then it must also suggest that the putative feminine ethics of care does not operate equally across all areas of nursing.

Another interesting feature of men working in both psychiatric nursing and with people with disability is that it also contradicts the notion that an important aspect of men’s career path in nursing is the protection of their masculine status (Evans, 1997; Williams, 1989; Williams, 1995a, 1995b). This ignores the fact neither psychiatric nursing nor care of the chronically disabled are considered high status. As Rune Bakken commented in an interview with the Norwegian nursing journal *Sykepleien* in 2004:

[F]or det er ikke entydig at menn *fordi* de er menn streber oppover i hierarkier. Psykiatrien er lavt rangert, men der er det mange menn (Fonn, 2004, p. 15).

It is not clear that because men are men they climb up the hierarchy. Psychiatry is lowly ranked, but there are many men there.

Men working in early childcare and in nursing share a similar experience with respect to questioning of their motivation. According to Murray (1996), in child care settings “This questioning occurs most often on those occasions when men get judged negatively for engaging in the same behaviours as their caregiving counterparts who are women-when they are suspect for just doing their jobs” (p. 377).

It seems evident that men who do not conform to accepted gender roles by moving into female-dominated occupations upset the gender assumptions embedded in the work. Within the context of an ideology that has constructed gender-appropriate roles and

occupations such a career move is seen as irrational and in order to rationalise such behaviour they are attributed with dubious motivation.

The allure of critical care.

From the nursing literature it can be inferred that the underlying discourse with respect to men choosing to work in critical care is negative. The men who choose to work there are accused of focusing on the technical to avoid intimate physical and emotional contact with patients. It is also alleged that it is a mechanism that men employ to maintain masculine status while distancing themselves from their female colleagues. The need to identify and deconstruct gender advantage in career advancement is imperative from an equity perspective. Given, however, that women also choose to work in such areas it appears strange that there is little consideration of what draws them there. It is not suggested in the literature, for example, that they choose to separate themselves “from the feminine image of nursing itself” (Evans, 1997, p. 226).

Working in ED may not have the same demands for sustained intimate physical and emotional contact as occurs in the ward; however, as has been argued in a previous chapter, working in ICU demands an intimate physical relationship with the patient and often an intense emotional one with the relatives, friends and partner of the patient. Men are not able to avoid intimacy by working there. It was also pointed out in the previous section that men are not able to avoid working closely with female colleagues. As well, if the speciality areas are “higher-status” and more “prestigious” as has been alleged by Clare et al. (2001) it is not unreasonable that any nurse, either male or female, may wish to spend some time in such an area as part of their career development. With respect to this theme, however, other significant factors emerge from the transcripts.

Twelve men in this study were working as, or had worked as, general nurses and seven had worked in either critical care or ED, but of them Allan was the only one who continued to work in such an area. The two who were currently finishing their RN education, Robert and Phillip, imagined that their future career paths might include ICU or ED; however, Phillip also conceded that he could contemplate working in gerontology, “Why not geriatrics? Maybe it is somewhere I might [work].”

The issue of men’s apparent lack of involvement in care of the elderly, both formally and informally, is one that has generated some interest in the literature (for

example: Applegate & Kaye, 1993; Harris, 1993; Russell, 2004) and challenge has been mounted to earlier studies which focused solely on women as caregivers to the frail elderly which dominated the research in the 1980s. Clare et al. (2001), without citing any evidence to support their argument, contended that men are “far less represented in slower stream areas such as aged care” (p.173). This is a theme that Baines, Evans and Neysmith (1992) also addressed: “It is primarily women, as wives and daughters and as home help aides and nursing aides, who care for the frail elderly, the chronically ill, and individuals with disabilities” (p. 24).

It is significant that the authors do not include registered nurses as part of the roll call of caregivers to the elderly. Nurse educators know the truth of this assertion from the opinions expressed by students, many of whom see little value in working with the elderly as part of their education. The fact that care of the elderly is not attractive to a large number of nurses of either gender could result from the fact that often it is not as well paid as other aspects of nursing. It may also be reflective of a discourse, in the Western world, which tends to devalue the contribution of the older person to society. In the Norwegian context, Bakken (2001) highlighted the fact that health care for the elderly is less attractive by pointing out that only one out of ten nurses actually choose to work in this area post graduation.

A further contradiction that emerges from the above extract is the notion that men are less likely to be found working with people with disabilities. First, as has already been pointed out in this work a higher proportion of men are to be found working with people with mental health problems than in other fields of nursing and from Table 11.1 on page 296 it can be seen that working with people with disability is considered, by both female and male nurses, as a more gender appropriate area for men to work.

Four significant themes emerged from the transcripts of those men who have worked in, or plan to work in, the critical care environment: gaining experience, the variety of work and the challenge that entails, a more autonomous work environment, and acquiring experience that would assist in pursuing career goals.

For Edward working in critical care was part of developing himself as an expert clinician:

It was really a conscious choice; I developed my career as an expert clinician not from career progression. So for the first five years of my career I would work in a

ward till I had learned as much as I could, until the learning curve dropped off. So, I worked in older adult, infectious medical, general medical, orthopaedics, women's gynae, men's urology, general surgery. My breadth in clinical experience is probably more significant than most. And that was a conscious choice because I wanted to be an expert clinician and I wanted to work in an area where I could get those demands. I worked in ICU, CCU .

Allan left ICU because he didn't feel confident and disliked being so focused on machinery rather than attending to the emotional needs of patients and relatives. Subsequently, it was identifying a lack of experience in an emergency situation that lead him to ED; where he has remained, apart from periods working with medical and nursing teams in relief work overseas:

So I thought about leaving nursing altogether but instead of leaving I decided on a total change of speciality and loved being a prison nurse and all the dynamics that went on, but what I learned really was that my emergency clinical skills were lacking and I had an officer collapse and I found out later he died from a ruptured triple A. So I wouldn't have been able to do much but there were inmates who had heart attacks and inmates who had seizures and there were assaults and I had limited emergency knowledge so that was logically the next field for me.

Bruce described his decision to go into Coronary Care as "looking to expand my horizons", and from there he went on to work as a nurse in primary health care with a volunteer organisation abroad. In Chapter Seven, Bruce and Allan described a humanitarian impulse: the desire to be of service in countries with impoverished health care. They perceived the experience they gained in CCU, and ICU and ED respectively as developing the relevant clinical expertise that would enhance their prospects to be able to undertake such work.

Edward also saw the critical care environment as providing greater demands intellectually and clinically. He talked about the challenge of working in a unit in which there was no full-time medical cover and the responsibility that placed upon the nursing staff. He found it an environment in which he developed "the ability to give expert care

but also to be stimulated academically.” Paul talked about the “variety of work” and like Edward enjoyed “the way nurses participated, more directly, if you like, in patient care.”

Looking down through the “bed pan” ceiling³¹

Stepping onto the glass escalator.

A prominent theme in the nursing literature is that men are advantaged when it comes to moving into senior positions (Buchan, 1995; Evans, 1997; Kvande, 2002). Luke, a Charge Nurse, referred to this:

There was a feeling that men in the general system, at times, [that] if they did get a promotion it was because they were a man, but personally I didn’t ever take that on board, and even the men I saw who got a promotion I felt that they were the appropriate people for the position and that they didn’t get them because they were men. But I know a lot of women used to think that.

Nine of the men in this study have held senior nursing positions. Five of these men, Allan, Luke, Warren, George and Andrew, are still employed in senior roles in clinical environments. Luke and George both have administrative roles, whereas Allan and Warren hold clinically focused positions in which they work with patients. Andrew has a dual administrative and clinical role; Martin is about to leave nursing, Paul and Bruce are now working in education and Ian has chosen to step away from administration to work as an RN in community mental health.

Ian’s career, in particular, is a fascinating study. On page 105 he described how at the outset of his training in the early 1960s he was told, “not to have grand ideas”, i.e., to expect promotion. That comment registered with him:

- 1 I never had any expectation from day one. I accepted that I would always be a staff nurse, that’s me. It was quite a boost to know that to be given these positions up the scale by Matron, whom some people would say - in unfairness to her — “Oh, well anything that’s male, she’ll be pushing ahead.”
- 5 *Interviewer:* Do you think that is true? Do you think males were promoted unfairly?

³¹ The term the “bed pan” ceiling originated in Lane’s (2000) study of female part-time nurses in the National Health Service in the United Kingdom.

Ian: I don't think so, but I think others thought that.

A contradiction appears in the above extract between having no expectation of advantage and the suggestions that he had to do very little in order to gain promotion (lines 2-4). In his instance it was because of the intervention of the Matron of the hospital in which he worked. According to Evans (1997) women are complicit in nurturing and furthering the careers of male colleagues as a result of oppressed group behaviour. Clare et al. (2001) also argued that women's tendency to support men in the workplace and at home costs women in terms of their career progression. They contended that the domestic support provided by women to their male partners means that men are more likely to pursue higher degrees and on-going education. This assertion is supported by the findings of Marsland, Robinson and Murrell's (1996) UK study which showed that 16% of their male respondents ($n=13$) would like to take a postgraduate degree in nursing, whereas only 6% of their female respondents ($n=56$) had similar plans. While expressing intent is not necessarily followed by action this finding challenges Finlayson and Nazroo's (1998) UK findings which suggested that men are doing better than their female counterparts despite having less experience and fewer post basic qualifications. This argument is one that Bruce has found to not always be true:

When I look back and see what other people have got and some of the positions they have got, women have actually got some of those promotions with less qualifications than me. And so, I mean I don't know whether I agree with what some people have generalised that just because you're a man you get promoted.

Ian thought that the support he received from the Matron with respect to career promotion was because of the positive experience she had of working with men in the United Kingdom:

She did tell us in later years that her first experience of working with males was in the United Kingdom, as there were quite a large proportion working in the clinical field, and she felt it balanced up nursing; it gave a better balance having the men around, not necessarily in senior positions, but having men there. That's why she advocated [it], and she felt that they probably had proved their worth in her experience in the UK.

The other aspect was that Ian had acquired qualifications that enhanced his career. Along with two other men he went on to do the “bridging” programme, i.e, a two-year psychiatric nursing programme leading to registration as both RN and RPN. All three men became Nurse Supervisors, but according to Ian none of the women at senior level had done the bridging programme. Whittock, Edwards, McLaren and Robinson (2002) pointed out that childbearing and being primary caregivers to children puts women at considerable disadvantage with respect to gaining the necessary qualifications for career advancement. Meleis (1991) suggested that prior to the 1970’s, and presumably the impact of the second wave of feminism, this may well have been the norm. She postulated that up to that time nursing may have “attracted non-career-oriented individuals who were looking for an occupation that allowed them to get in and out conveniently as their families demanded” (p. 51).

It is likely that this remains the case today in nursing for many individuals and might well be one of the features that attracts some people into the profession. Until more family-friendly policies are introduced in the workplace career progression and caring for one’s children will remain dichotomised and mutually exclusive. Women’s careers continue to be most affected by a discourse that conditions women to consider a professional career as secondary to family and home. As Meleis (1991) elaborated, nursing was the ideal career for many women:

- 1 Women who entered nursing, at least until the 1970s, had identified strongly with the roles of wife and mother and either believed that nursing would prepare them for the natural roles of women or that the nursing role was a way to earn a living until a knight came along and rescued them from the drudgery
- 5 of full-time work.

It is interesting that she associated full-time work with drudgery (line 4) and that women can be “rescued.” This highlights the “taken-as-given” that men should be condemned to the “drudgery” of full-time work with little hope of rescue. It is incontrovertible that generally it is women who leave or cut-down their professional work commitments in order to care for children. It can be argued, however, that women have greater freedom to choose the role they wish to pursue and that social barriers discriminate against men having the same ease in making that choice. The flaw in this

argument, however, is that it reinforces gender polarity becoming an either/or choice rather than both genders being equally able to choose either option. The challenge is to ensure that both women and men are able to satisfy personal and professional aspirations without having to compromise either role.

Ian's promotion was in the 1960s, which was a time when many senior female nurses were single and financial support was available from the employing hospitals. It could be argued that there was therefore generally no financial disincentive to further education, such as the "bridging" programme, to gain nursing qualifications that would enhance one's chances of promotion. It would also appear that the female nursing hierarchy at this time encouraged nurses to remain single, as Ian noted with respect to the Lady Superintendent of the hospital in which he was employed: "She was Mrs. Jones, there were very few nurses trained at City Hospital, in our era, who were not single women. It was unusual to have a married woman."

This illustrated the prevailing discourse of nursing's service to mankind and the expectation that one had a duty to dedicate one's life to nursing. I recall, in 1983, talking to one of my male peers during our training, he had confided in one of the tutors about the difficulty of balancing the demands of apprenticeship-style training, studying for final exams and maintaining a life outside of nursing. Her reply was to state that there should be no life outside of nursing. This was a powerful discourse that stifled independent and critical thinking and, according to Meleis (1991) continued to leave its mark on many nurses.

Another aspect to men's success in terms of promotion may also be that because of the expectation that they will pursue the traditional vertical career trajectory they are more likely to put themselves forward. Allan was of the view that "the pressure to take senior positions is there, and I suppose I am reasonably competitive" so he put himself forward when the opportunity arose. One of Kvande's (2002) respondents stated that men, "generally dare to put themselves forward more than the ladies. Some male nurses get the idea pretty quickly that they want to get ahead in the system" (p. 21). Bruce's experience reflected this. He talked about opportunities that came his way:

I don't think I got them because I was a man. I think I got them because I showed initiative, and I was questioning. I was looking to expand my horizons and, hey, if there is an opportunity, take it; it may not come again.

It could be argued that Bruce's gender had much to do with his getting the opportunities he sought, because of socialisation processes that have constructed men as more self-confident, more willing to put themselves forward and take risk. Ian's promotion to the role of supervisor also came about because he displayed initiative:

So I heard that one of the afternoon supervisors, I was already a Charge Nurse [] was leaving. So I went to see matron and asked whether I could be considered for this job. I saw it as a way of getting an understanding of the hospital and all the wards and things [] just getting more overall awareness.

It is possible that in merely "testing the water" some men have found themselves appointed into positions that even they did not necessarily expect to achieve so soon in their careers.

Pushed onto the "glass" escalator.

Four of these men stated that the vertical career pathway held no appeal. Robert saw himself "working in health until the end of my working life to some degree. I'm not really interested in management. I can see it taking me more into patient education; I'd say that is where I'd like to go." Carl thought Charge Nurses had an unenviable position where "they are just the meat in the sandwich", while Charles didn't want to be "making decisions about who gets what because of finances and dealing with budgets." Mathew considered that he has quite actively avoided promotion:

I've got a very long [held] belief that authority is a power that is incredibly seductive and difficult and there is not a lot of people who learn to master being an authority well, and I don't think that I do it well and I've dabbled in it when I was a team leader and yeah [in a] manager's position. I found it really difficult because it changed me as a person and I didn't like the way I was changing, so I got out of it.

William's (1995a) notion of *tracking*, which was introduced on page 220 is also significant in terms of men's career development. While an expectation remains that men will be the primary earners in a family there is pressure on men to apply for jobs that provide greater financial rewards, such as administrative positions. Earlier Mathew pointed out that for him the cost of having to support a family while working as a clinician

would be unsociable hours, which would then decrease the amount of time available for the family. Carl has felt pressure from others to apply for more senior positions, although it doesn't interest him:

Yeah I've got an auntie and she would just love me to go for a Charge Nurse's job. But, "No Madge, it's not going to happen, get over it."

Interviewer: Why does she want you to do that?

Carl: Oh, I think ... it's like a status thing or something, I don't know.

Interviewer: So status doesn't worry you?

Carl: No.

The pressure to move up comes from colleagues as well because of their assimilation of what is considered normative for men's careers. Naish (1996) cites Thompson Charles who is "contentedly working as a clinical nurse":

"But lots of people have asked: "Why haven't you moved up the ladder when you are capable of doing so?" I usually hear it from the staff nurses and sisters", he says. "They have always given me the impression that I am wasting my time. I think they are comparing me with what they see as the norm for male nurses." (p 31)

Men are subject to pressure both in the work place and society to move away from clinical nursing yet, as was described in Chapter Seven, the desire to work with people is mainly responsible for their original entry into nursing. Porter-O'Grady (1995) described this as reverse discrimination: the expectation that men will ultimately choose to pursue leadership roles in nursing. He argues that the expectation is, "Reaffirmed by the notion that there is something 'wrong or suspicious' regarding the man who appreciates and resonates with rendering good patient care and ascribes to no other ambition" (p. 57). This discourse is exemplified by the film "Meet the Parents" (Glienna & Clarke, 2000). The main protagonist is a man who is a nurse, Gaylord "Greg" Focker, which allows for play on words such as "gay fucker" and which draws upon popular suspicion about male nurses' sexuality. The premise is that he is a suitor who has to convince his future in-laws of his suitability to marry their daughter. The punch line of many of the jokes is his occupation. In one scene, for example, he meets the friends and family of his fiancée — affluent professionals — who think he is joking when he tells them he is a nurse. At the end of the

movie after all the chaos caused by Focker's ineptness, the one thing that his future father-in-law cannot forgive is that he is a male nurse.

Men in nursing are placed in an invidious position. They are encouraged by patriarchal discourses to pursue a vertical career trajectory and are then subject to the criticism that they "taking over" the profession. It has been alleged that their dominance in administrative roles and espousal of "new managerialism" (Davies, 1995), which focuses on cost containment, rationalization and efficiency is inimical to women's putative more democratic style of management. On the other hand, if they choose to eschew the traditional career path and remain in a caring role their motives are questioned and they become viewed as less of a man.

Stepping onto the "down" escalator.

Earlier the example of Ian was cited, as someone who achieved promotion, because of having acquired further qualifications: in his case becoming "double trained." When he applied to enter the bridging programme he was already a supervisor. He stepped out of a powerful position in the nursing hierarchy to become a student again because he was often called upon to assist staff with "what I considered disturbed people – psychotic behaviour in the night [] I felt a bit inadequate, I didn't really understand." He wanted to be able to provide better care. Allan also stepped out of a senior role as a Charge Nurse after two years because he "was increasingly becoming a manager and I wanted to be a clinician and I didn't have the expertise I wanted." He eventually went back into a Charge Nurse position, but one that had a greater clinical focus. His belief is:

That the models I had been shown by my parents and that had [been] most appreciated in Charge Nurses, and the people I worked for, were people who were clinically competent and used that expertise as the basis for their authority. So that was my aim.

All of the men who had been in senior administrative roles within a hospital setting have at one time or another moved away from these positions. Some returned to senior positions and subsequently moved away again into different roles. Only three, Allan, Luke and Martin were in senior nursing positions at the time of the interviews and Martin was about to leave nursing after a career spanning some thirty-three years.

Martin's career choices, which have involved horizontal, vertical and downward movement, have been motivated by the two factors. First, the need for personal growth; this led him to leave his position as a Charge Nurse after four years to move to another city as a staff nurse which was more conducive for "working through a whole lot of issues personally." Second, he was motivated by the challenge of a new role:

I couldn't see myself still being a Charge Nurse, like some people stay as a level two or three for years and it is all they want. I don't think I could do that because there would be no more challenge. I always like the challenge, something to keep me going.

Stalled on the "glass" escalator.

Muldoon and Reilly (2003) claimed, "men who enter the nursing profession tend to have faster and more straightforward career progression than is the case for women" (p. 93). The evidence cited for this statement is that men are over-represented in senior positions. From this study, however, it would appear that to simply link a seeming overrepresentation of men in senior positions as being evidence of straightforward career progression may not be accurate. Of the eleven men interviewed in this study who had applied for promotion only one, Paul, has not had the experience of being turned down for a job. Bruce believed that men could also be passed over for promotion even though they may be better qualified for the role and described a personal experience of this:

I applied for a Charge Nurse position in the coronary care unit; knowing that I'd only been back in the country for about four months beforehand. But I'd worked in the coronary care unit before and had been Acting Charge Nurse before I went overseas for eighteen months. I worked as a primary health care practitioner and I had actually acquired some significant management skills, because I managed a staff of about 26 people, full rostered duties; I managed two maternity units, nine-to-five clinic, immunisation clinic, full mobile bush clinic, all that sort of stuff, and had also done two post-registration courses and a manager's course.

When I applied for the position there were three of us short-listed. One of them was an external person and had less staff nurse experience than the other person and I. Well, I had more qualifications. I had greater experience in coronary care. I had

significantly more managerial skills, significantly more skills in managing budgets and people than this person, but she got it. And to this day I still haven't got over that I didn't get the job. When I wrote a letter and asked some questions about what were the areas that I missed out on, what were the key areas I needed to work on for the future, I got a very nasty letter back saying it was sour grapes as I didn't get the job.

Edward, too, described the experience of being turned down for a job for which he believed he was more qualified:

I was better experienced. I think I was better qualified. I think what came out in the long run wasn't particularly constructive in the year or two that followed.

Interviewer: What do you mean by that?

Edward: I don't think she ever made a very successful Charge Nurse and she was gone in about two years.

It is not possible to judge the validity of claims of being unfairly passed over for promotion; there is the possibility that the successful candidates brought other expertise that was more valued. A circumstance that might also, in some cases, be applicable to some of the men who have been "unfairly" promoted. Allan described one such example:

There is one individual who comes to mind to me who historically I've heard of being promoted to move on from his existing position. The reality was they wanted him shifted, so they shifted him up where he could do less harm [] I think, now that I have more maturity and seniority, that was in fact a bit unfair and that he had in fact attributes in certain areas that he was utilising.

What is evident from both these interviews and stories published in the nursing literature is that many men do not feel that it is a *given* that because of their gender they will have unimpeded career progression in terms of promotion. Once again it remains an area that presents contradiction. There are those studies in which the men have agreed that their gender is an advantage in obtaining promotion, for example, one of the men interviewed by Kvande (2002) said:

It surely attracts notice, people remember you-since you are a man. In that sense there are other demands, I'm pretty certain that I exploited this quite consciously.

Some men actually get management positions even if they are not qualified, but getting a position because you are a male, that happens. (p. 21)

This contrasts with the experience of some of the respondents in this study and also with other published work. For example, Chung (2001) reports Eddie Herbert, a board member of the American Assembly for Men in Nursing, who said:

The fact that male nurses are not given equal opportunity to move up the ranks or are being denied equal employment opportunities is repeatedly heard during our annual conferences by our membership. (p.4)

Not being successful in a job application, while disappointing, is not normally challenged; however, in the UK in 1996 a landmark case occurred when a RAF practice nurse, Gordon Main, successfully won his claim for sexual discrimination against the Ministry of Defence (MoD). He had six years experience as a practice nurse and applied for a practice nurse position at an overseas base. He was turned down and subsequently found out the job had been given to a young woman with no experience or qualifications in general practice. Gordon Main found out that his application had not been considered because he was a man. At the tribunal the MoD's defence was that as the job involved taking cervical smears a female nurse was required. The tribunal found that where a practice nurse carries out intimate examinations, there is "no material difference between a male doctor and a male charge nurse" (Coombes, 1998, p. 15).

Creating "islands of masculinity" or being ghettoised?

Several authors (for example: Egeland & Brown, 1998; Evans, 1997; Greenberg & Levine, 1971) have suggested that men seek out and create "islands of masculinity" within the profession, and psychiatric nursing is cited as one such island. It is suggested that men do this because they choose fields of nursing with low feminine and high masculine sex role identification. There are several issues that arise out of the notion of masculine enclaves.

First, from the preceding discussion in this chapter and the previous chapter, it can be argued that men in nursing have not necessarily created masculine enclaves to support their masculinity, but that other avenues to the profession have been closed to

them. Men were denied entry into general schools of nursing and they were also not welcomed into the professional nursing organisations. Psychiatric nursing was the area in which they were wanted although not necessarily valued. In order to ensure reasonable pay and conditions of employment they were forced to align themselves with the trade union movement, in doing so they established mechanisms which have partly contributed to the differential between the average pay of men and women in nursing. Williams (1995a) described this as a “secondary benefit” from masculine specialization (enhanced prestige is the other), yet given that 50% of psychiatric nurses are women, then it would appear that some women benefit.

Second, if areas such as psychiatric nursing are masculine in their ethos then what motivates women to work in such areas? There is a paradox: men are accused of creating enclaves that benefit them, yet no one questions the motives of women who choose to work in such areas. Equally, midwifery could be seen as a female enclave that, in these days of independent practice, provides the secondary benefits of enhanced pay and prestige. Men who enter the female enclave of midwifery are likely to have their motives questioned, as was Andrew’s experience after his first day in a delivery suite:

At completion of my shift, the senior midwives all held a meeting over me and what they were going to do about me and to put forward a submission to management about how they would treat me, now this male had arrived on the staff.

Casual observation of members of society, both at work and at play, tells us that men and women, at times enjoy the company of members of their own gender. It provides the opportunity to talk about, or participate in, those interests that members of the opposite sex may not necessarily share. Thus, an important aspect of the creation of “islands of masculinity” may also be a homosocial impulse: the desire to be with other members of your own gender. A respondent in Williams (1989) study commented:

I’m around women all the time. I feel like I need to sort of escape from that a certain while and be with my male friends and do male things. You know, like go down to the garage and work on my motorcycle and get my hands dirty. Talk about motorcycles or something like that. Just to establish a bit of balance. (p. 118)

A number of men in this study considered that working predominantly with women could, at times, be difficult. For example, Luke in his first Charge Nurse position “found it very difficult working a predominantly female work-force”:

I guess I never appreciated the dynamics of being a man in charge of say 50 or 60 staff, being one man in charge of 50 or 60 women. It’s not a sexist comment because I think it would be the same if one woman were in charge of 50 or 60 men. So I don’t think it was necessarily a sexist issue. I think it was just difficult being one against a mass of other.

Charles, who was one of 10 men among some 140 students when he began his nursing career, recalled the first day and “all those women’s voices, because I had worked with men all the time [] it took some getting used to.” Grant expressed it simply as “women are different to us.” Luke thought the difference was one of approach to problems:

I think women process things differently than men and I think that it has always been acknowledged throughout life that men tend to have things out there and then; women tend to smoulder on things and small talk. I actually think that men don’t small talk enough, but think that women sometimes small talk to the point of it being destructive. You would sometimes feel that you had resolved an issue, but you would find that it just smouldered underneath and it would raise its head again a month or two months down the track.

A differing approach to resolving professional issues may cause friction between female and male nurses and lead to a sense of frustration on both sides. Choon and Skevington (1984) in a study involving 99 psychiatric nurses in the UK (28 men and 71 female) found that the women perceived the men as independent and never crying while the men considered the women to be more cautious, having unpredictable moods and crying easily. Grant talked about female colleagues’ mood swings and how a lack of understanding on the part of male colleagues can be problematic. He ascribed the mood swings to being:

[P]art of women’s physical makeup, you know, their mood levels – they’re menstruating, all those sorts of things. Some guys don’t even think about those sorts

of things so they find it quite difficult dealing with lots of women who come to work, today in a good mood and maybe tomorrow not so good, because they can't work out what the hell's wrong with so-and-so today, but it's part of life. Women are different to us and maybe some guys don't think about those things. They don't understand those sorts of things; they think they're bloody difficult to work with.

Choon and Skevington (1984) suggested that nurses subscribe to gender stereotypes in their perceptions of colleagues of the opposite gender. Extrapolating from this finding it can be theorised that this potentially creates problems in communication and resolution of work place issues. Jock thought that this was a major area of difference between the two genders in the work place:

It's a bit of a hazy thing that I've never been able to get to grips with myself. It's just that women have a different way of understanding issues to men. I think that men are probably quite clear cut, black and white, in some issues, whereas women tend to be a lot more airy fairy, I guess, as to why things should be done and to rationalise how and why they do it. Whereas men tend to like to know where they are going and to just get on and do it.

Jock's theorizing could be interpreted as exemplifying Gilligan's (1977) argument that men's subscribe to an ethic of justice whereas women are concerned with relationship and use discussion and consensus decision-making. It could also be interpreted as demonstrating the socialisation patterns reported by Belenky et al. (1986, 1997) in which women have more difficulty in asserting authority or seeing themselves as figures of authority. Jock's statement is open to multiple interpretations; however, no matter which perspective one chooses it indicates that communication between female and male nurses is potentially fraught.

Beyond the domain of professional interaction it would appear that non-work time socialization is also problematic. Floge and Merrill (1986) observed 540 hours of nurses' interactions in two small US hospitals and found that men were often absent from their female colleagues' informal socializing networks. In their study of tokenism in the hospital environment they concluded that a tendency of the dominant group is the exaggeration of

their similarities with one another and their differences with the token group. With respect to men who are nurses, they wrote:

Observations indicated that the typical conversations of female nurses revolved around “female” topics. The nurses in one unit joked about baby and bridal showers, their dates, finding a man, dirty jokes, their husbands’ sexual habits and sexual needs, and various aspects of the female menstrual cycle. Conversations in other units centred around their experiences giving birth and raising children (including breast feeding), boyfriends’ and husbands’ habits, and clothing and haircuts. Male nurses were not included in these conversations and the female nurses made no attempt to include them. Only once were two female nurses observed to change their topic of conversation when a male nurse was present. Female nurses usually directed their comments to other female nurses or women, especially if the comment was of a female nature. It was only when the female nurses were not discussing such female-oriented subjects that male nurses were included, although there were several (three) instances in which men were not even included in the gender neutral conversations. (p. 932)

Edward talked about his social relationships with female colleagues. During morning and afternoon teas he preferred to spend time talking with the patients: “I would still socialise, but I wouldn’t spend those protracted periods of time talking about family and boyfriend and all that other stuff.”

Williams (1989) also noted that the men in her study tended to withdraw from small talk with female colleagues; as one of the men said: “It’s nice to share things with men. You have a professional attitude toward both, but when it comes to small talk ... the women only want to talk about babies and periods” (p. 118). The men in her study said that they sometimes participate in this small talk; they aren’t excluded, but they don’t enjoy talking about the same things as their female colleagues all the time. She also referred to the work of Floge and Merrill (1986); however, she argued that as the men are not excluded from the informal conversations of female nurses at the workplace and that they choose not to engage therefore “men are again segregating themselves from the lot of nurses in general” (p.119). She ignored the informal process of exclusion the dominant

group exerts by not introducing conversational themes that are of mutual interest for all members of the group.

Williams (1989) represents one perspective and it can be argued equally that the expectation that men, the minority in nursing, should participate as determined by the dominant female culture does not demonstrate men segregating themselves from nursing. Another reading is that it is a reinforcement of the men's "otherness" and that the world of nursing continues to be a woman's world.

Conclusion

This chapter revealed men's career pathways to be more complex than reported elsewhere. The evidence from these narratives demonstrates that men do not necessarily pursue a vertical career structure, but also move horizontally and in a downwards direction at various times in order to construct a career pathway that provides satisfaction and stimulation.

The careers of the men in this study have not matched the vertical trajectory that is described as being expected of men (for example: Kvande, 2002; Porter-O' Grady, 1995). Jones (1994) described six career orientations: getting ahead, getting secure, getting free, getting high, getting balanced, making a difference and making a contribution. It seems that these men are generally more concerned with: getting free, or being able to obtain maximum control over work processes; getting high, which entails excitement challenge and adventure, making a difference and making a contribution. Their career moves have been a mixture of vertical and horizontal moves that have enriched their working lives while enabling them to feel that they were making a difference. In none of these narratives was there any implication, overt or otherwise, that to maintain a masculine identity required upward movement.

The predominance of men in areas of nursing such as psychiatry, critical care, care of the disabled and administration can be attributed to multiple factors including; socialisation pressures with respect to what is considered gender appropriate, a desire for challenge and control of the work environment, homosocial tendencies, the perception that multiple work experience equips them to be better nurses, better financial remuneration and that in undertaking administrative responsibilities they may also be better positioned to effect change for the betterment of patient outcomes.

This chapter highlights, once again, the contradictions that exist between the theorising and the reality for men in nursing. It continues the argument that essentialist readings of masculinity in the context of nursing are inadequate to describe and explain the complexity of men's experience in nursing.

The next chapter turns to considerations of how men, as nurses, demonstrate care; building upon this chapter it is theorised that through the intersection of the breadwinner ideology and career planning career becomes a way of "doing care."

CHAPTER TWELVE: Men, nursing and care

The preceding chapter began a discussion of caring, as this particular group of men who are nurses understands it. Their narratives were placed within a discourse of caring which has been used to create a belief in men not caring. These essentialist views of men and women in relation to caring have been adopted by some nursing theorists to promote an ethics of care based upon a perception of women being naturally predisposed to caring. Again a paradox appears in that the men in this study also describe caring in terms of those traits usually attributed to the female ethos of care: empathy, communication and “working with” to create relationships to provide the foundation for caring work.

Toward an ethic of care

The late 1970s was a period in which feminist writers were expressing doubts that “women’s issues” could be addressed in terms of traditional ethical theories. Theories that, it was argued, failed to describe the female experience because of their male bias. The development of a theoretical approach to ethics that represented the experience of women lead to the emergence of feminist ethics out of the work of critical feminists in applied ethics and in ethical theory (Card, 1990; Kuhse, 1997).

It was followed, in the 1980s, by an important conceptual development in nursing: the adoption, by some, of an ethic of care which, with reference to the early work of Gilligan (1982) and Noddings (1984), has claimed caring as essentially female. The implication for men, as Bullough (1997) pointed out, is the belief that caring is something that they are not especially qualified to do. For example, Davies (1995) asserted, “For those who would understand caring is that the public world, or at least the masculinist fiction of it, is devoid of caring. Culturally, it is built on this absence, it celebrates it” (p.24).

While such a statement lies at the extreme end of perspectives with respect to men and caring, such a belief reflects a pervasive assumption that women are somehow imbued with a deeper, more natural caring response by the very fact that they are women. For example, according to Pringle (1980), “It may well be that because only women can conceive and bear children, they have developed a greater capacity for nurturing and caring which has then been further enhanced by the traditional division of labour between

the sexes” (, p. 5). This echoes the earlier discussion of the meaning of the word nurse, in which the word that signifies caring, being associated with a biological function of which men can have no part.

Gilligan’s (1982) book *In A Different Voice* was a controversial and highly influential response to Kohlberg’s theory of a hierarchical ordering of moral reasoning. This work is not the place for a detailed discussion or critique of Kohlberg’s work, nor of Gilligan’s response; lucid explorations of these authors’ works and the debate between them have been well documented (for example: Kuhse, 1997; Nortvedt, 1996). Two points, however, are pertinent to this discussion. First, in her critique of Kohlberg’s assertion that a fully developed morality is both principle-based and impartial, Gilligan postulated that women have a “different voice”, a voice of care that has its own distinct moral value. She argued that her research reveals two different moral “languages”: one of impartiality and justice and the other of care. This “different voice”, that of care, is based in social relationships and, she maintained, is mainly associated with women. Although, she does not hold that there is an essential, or absolute, link between gender and moral approach:

The different voice I describe is characterized not by gender but theme. Its association with women is an empirical observation and it is primarily through women’s voices that I trace its development. But this association is not absolute, and the contrasts between male and female voices are presented here to highlight a distinction between two modes of thought ... rather than to represent a generalization about either sex. (p. 2)

From a social constructionist perspective Gilligan has opened space for multiple voices, narratives and accounts of development to emerge. Hekman (1995), however, challenges the social constructionist reading of Gilligan’s work, indeed in all moral discussions, because, as she asserted, moral language games are “unique in their claim to certainty” (p. 160). Be that as it may, as Tronto (1999) observed Gilligan is part of the postmodern turn that challenges thinking about the universalist and absolutist epistemology of modernity.

The second aspect of Gilligan’s work that informs this study is the significance that her work has had with respect to theorizing about care. Gilligan provided no empirical evidence to support her argument of who engages in an ethic of care (Tronto, 1993), but as

Kuhse (1997) observed there is no academic discipline, including nursing, influenced by feminist thought that does not regard Gilligan's work as of fundamental importance.

Defining care

The concept of care has been explored, discussed and written about by many nurses for some decades yet it remains a problematic and elusive notion. A number of nursing theorists have described caring as the fundamental value, or primary concern, of nursing (for example: Benner & Wrubel, 1989; Fry, 1989; Gadow, 1985; Hagell, 1989; Leininger, 1988; Watson, 1985), yet it is difficult to find agreement in the literature as to exactly what constitutes caring, or what behaviours and attitudes demonstrate it. Kuhse (1997) suggested that one of the problems is that nurses understand caring in two different ways. One involves providing for the needs of the other, a focus that she summarised as helping, enabling and seeing to needs. This understanding from the male perspective is conceptually unproblematic; although, as will be discussed in a later section of this chapter, problems arise for men when they try to operationalize this concept behaviourally. The other involves an emotional response in which there is an emphasis on relationship of depth and intimacy; for example, Watson (1985) argued for "true transpersonal caring" occurring when "The nurse is able to form a union with the other person on a level that transcends the physical ... there is a freeing of both persons from their separation and isolation" (p. 66).

Some nurses have used Gilligan's work as a starting point in the attempt to establish an ethical framework that distinguishes it from medicine and the work of Noddings (1984) has also been drawn upon to support the argument. Kuhse (1997) summarises this trend in nursing:

[W]hile Gilligan seemed to have assured nurses that the care approach was not inferior to the justice approach, Nel Noddings seemed to tell them that "caring" was all that was necessary for a nursing ethics of care. As long as nurses cared, there was no need for universal principles and rules, no need for concern with the traditional ideas of impartiality and justice. (p. 144)

Noddings' theoretical positioning has been built upon by a number of nursing theorists in an attempt to articulate the relationship between nursing and caring (for

example: Crigger, 2004; Fry, 1989; Haegert, 2004). This form of caring emphasises the values of concern, compassion and empathy. Noddings (1984) calls this for the “one-caring” (i.e., the one who is providing the care) “feeling with” (p.30). She used the word empathy in connection with this form of caring, but had difficulty with standard definitions of the term. She explained:

The Oxford University Dictionary defines *empathy* as “the power of projecting one’s personality into, and so fully understanding, the object of contemplation.” That is, perhaps, a peculiarly rational western, masculine way of looking at “feeling with.” The notion of “feeling with” that I have outlined does not involve projection but reception. I have called it “engrossment.” I do not “put myself in the other’s shoes”, so to speak ... On the contrary ... I receive the other into myself, and I see and feel with the other. I become a duality. (p. 30)

The use of the words *projection* and *reception* are interesting because they can be seen as reinforcing what Noddings perceived as a gender-based difference between caring, as these words are also metaphors with respect to the act of sexual union between women and men.

To return to Spender’s (1980) argument, from Chapter Two, that men have not only dictated what constitutes reality but have also created the structures, categories and meanings of language, Noddings is right to question accepted definitions of words. Dictionaries may well reflect a masculine dominance in language, creating a masculinist bias in the language we use to describe and construct our realities. What is open to question, however, is the manner in which she linked empathy to feminine receptivity, and used mothering as the model for an ethics of caring:

- 1 Mothers quite naturally feel with their infants. We do not project ourselves into our infants and ask, “How would I feel if I were wet to the ribs?” We do this only when the natural impulse fails. Naturally, when an infant cries, we react with the infant and feel that something is wrong. *Something is wrong.*
- 5 This is the infant’s feeling and it is ours. We receive it and share it. (p. 31)

In these two passages from Noddings’ (1984) influential work *Caring: A feminine approach to ethics and moral education* a link was asserted between empathy, caring,

mothering and it was proposed that this is a *natural* process. In line 3 she suggested that if a mother were to actually think, "What is wrong?" then this is not natural mothering. Kuhse (1997), in her critique of Noddings work, highlighted several problematic areas. First, women without children and those who chose not to have children contend that an emphasis on motherhood in constructing an ethic of care does not correspond with their moral experience; and second, Noddings position did not take into account variance between and within cultures. Other writers were also critical of Noddings' model; for example, Hoagland (1990) argued that a model based on mothering puts carers at risk for exploitation from those for whom they care because of its other-directed emphasis. She also questioned Noddings' notion of self-care as being directed at becoming a better one-caring, because then ethical identity emerges out of always being other-directed, which also risks exploitation. Noddings (1984) contended that withdrawal from a relationship involves a diminishment of the ethical ideal; however, withdrawal may actually be a way to help the other, especially with respect to dependency issues. Finally, Hoagland (1990) questions Noddings denial of judgement in the initial impulse to care arguing that even not to judge is to judge and to "pretend a stance of non-judgmentalism merely discourages awareness of one's environment and the values of the status quo" (p. 111).

While Gilligan distinguished between justice and care in her original work she acknowledged the value of both to a fully developed ethic. Noddings (1984) however rejected any universality except in the universal accessibility of the caring attitude; it is this rejection that Card (1990) questioned. She asked "Can ethic of care without justice enable us to adequately resist evil?" Noddings' model requires encounters with real people and does not encompass how we are to care for those we do not meet, and Card (1990) argued:

[R]esting all ethics on caring threatens to exclude as ethically insignificant our relationships with most people in the world, because we do not know them individually and never will. Regarding as ethically insignificant our relationships with people remote from ourselves is a constituent of racism and xenophobia. (p. 102)

Noddings' model is avowedly "feminine", although she denies that this form of caring is exclusively female. She argues that its being rooted in the "deep feminine" does not mean that all women will accept it, nor that all men will reject it:

- 1 [I]ndeed, there is no reason why men should not embrace it. It is feminine in
the deep classical sense - rooted in receptivity, relatedness, and responsiveness
... It represents an alternative to present views, one that begins with the moral
attitude or longing for goodness and not with moral reasoning. It may indeed
5 be the case that such an approach is more typical of women than of men, but
this is an empirical question I shall not attempt to answer. (p. 2)

Noddings claims not only relatedness and responsiveness as feminine in the deeply classical sense, but also the *longing for goodness* as female (line 4). In the introduction to her work she lays the blame for that which is wrong in the world at the feet of the *father*, i.e., men. In the introduction to her ethic of care she wrote: "One might say that ethics has been discussed largely in the language of the father: in principles and propositions, in terms such as justification, fairness, justice. The mother's voice has been silent." (p. 2)

While it might be difficult to accept the notion that the "cared-for" cannot expect the mother to be just and fair, Noddings as part of the justice versus care debate questioned the status afforded impartiality and universal principles in ethical thinking. In the above extract she linked the ethics of the father with "principles"; however, she then went onto link "principles", i.e., masculine ethics with the problems faced by humanity:

When we look clear-eyed at the world today, we see it wracked with fighting, killing, vandalism, and psychic pain of all sorts. One of the saddest features of this picture of violence is that the deeds are so often done in the name of principle...This approach through law and principle is not, I suggest, the approach of the mother. It is the approach of the detached one, of the father. (pp. 2-3)

This essentialist contrasting of "mothers" and "fathers", or men and women, quite clearly presented an image of women as morally superior. Such essentialist models of ethical thought are not new; male philosophers such as Aristotle, Kant, Rousseau and Schopenhauer, for example, had no doubt that the male approach to morality was superior: a position that a number of early feminists disagreed with. Elshtain (1981) cited

the example of the nineteenth century feminist Elizabeth Cady Stanton, the most significant early Suffrage theorist who vehemently espoused women's moral superiority:

The male element is a destructive force, stern, selfish, aggrandising, loving war, violence, conquest, acquisition, breeding in the material and moral world alike discord, disorder, disease and death. See what a record of blood and cruelty the pages of history reveal...The male element has held high carnival so far, it has fairly run riot from the beginning, overpowering the feminine element everywhere ... The need of this hour is not territory, gold mines, railroads ... but a new evangel of womanhood, to exalt purity, virtue, morality, true religion, to lift man up into the higher realms of thought and action. (Stanton, 1881-1891 cited Elshtain, 1981, p. 232)

As Elshtain (1981) noted the image promulgated by Stanton contended that the male element is destructive and selfish, whereas the female element is loving and virtuous and enslaved and required that the balance be tipped in favour of the feminine in order to ensure that social chaos did not prevail.

Echoes of these words resonate in the citation from Noddings' (1984) work quoted on the previous page. These essentialist beliefs have been challenged by writers such as Bohan (1997) Kuhse (1997) and, even earlier, Wollstonecraft (1792, 1999), who argued that men and women's social roles and approaches to morality are socially constructed and open to change rather than being an immutable product of gender.

It can be contended that the manner in which Gilligan's (1982) articulation of a "different voice" and, above all, Noddings' (1984) model of a feminist ethics of care have created a belief of caring as inaccessible to men; for example, according to Fry (1989), "It is not in their natural tendencies to adopt such notions" (p. 93). Notwithstanding the disclaimers of both Gilligan and Noddings that they do not exclude men, their theories have been significant in reifying the link between being female and caring.

The problem of men's touch

In some areas of nursing touch is an important part of the work and its purposes and meanings are manifold within the relationship between the patient and the nurse. As van Dongen and Elema (2001) noted, "Touch is not only utilitarian in nursing. Touch

is about cleaning, washing, medical actions or taking someone's temperature; and touching is also about emotions, care, relationships, gender, intimacy, age, and well-being" (p.150).

For men, two issues in particular arise with respect to caring and touch; namely, the feminisation of touch and the sexualization of men's touch.

The feminisation of touch.

A male student nurse in the study conducted by Paterson et al. (1996) described the feelings of confusion, resentment, fear and embarrassment that can accompany the first attempts to emulate what has been constructed as female: the act of touch in the caring encounter:

- 1 So then I put my big hand on him, the way I had seen her [a classmate] do it. There was my big hand on his [the patient's] little arm and it looked so huge and heavy. I wondered if I was hurting him. I felt so stupid. I wondered if he thought I was coming on to him. I thought about what my dad would say if he
- 5 could see me. Or some of my friends. They would think I was gay or something. But I knew that I needed to touch this man to express my caring for him. (p.33)

In the Anglo-Saxon world, at least, men have been trained to not touch each other intimately, or to demonstrate caring behaviour through touch. Thus, for men intimate touch between men may be misinterpreted as sexual (lines 4-6). Martin also described the feelings of embarrassment and the association with sexuality that can accompany having to touch another man intimately:

I mean, as a teenager, it was quite embarrassing at times; you know, you get all the comments from patients. My first thing was I had to put a suppository in an older gentleman, 60-odd, and doing the most appropriate procedural thing, you know, step-by-step-by step, which is how you were taught. And I had him screened off and done everything, laid him on his side and put the suppository in, did a great

job, and he got off the bed and said, “Hmm, I suppose this sort of thing makes you homosexual, does it?.” And I went “whoomph”!³²

The construction of nursing as a female role has been accompanied by the caring in nursing being defined by those actions which have been judged as coming more naturally to women. These include behaviours such as speaking in a soft voice, hugging and gentle touching (Evans, 2002). A respondent in Evans’s research, which was conducted in Canada, talked of the newness of touching people “because that wasn’t part of my existence to that point” (p. 443).

In Chapter Five the role of the Protestant work ethic in shaping the stereotypical image of masculinity was described. For men in the Anglo-American axis in particular, a grouping that can also be extended to include New Zealand, Australia and South Africa, a masculine image was constructed that centred upon a physicality in which discipline, hard work and the ignoring of pain were central. This image was reinforced by the emergence in nineteenth century Britain and the United States of a movement known as “muscular Christianity.” This movement—parallels to which can be seen in Baden-Powell’s Boy Scout Movement—held that muscular growth, Christian morality and masculinity were interwoven and were the antidote to the tendency for men to become weak and effeminate (Wiegers, 1998). For men, therefore, the appropriate manifestation of touch in the public domain was that of strength and bruising physicality in contact sport and in the domestic sphere gentle nurturing touch was relegated to women. Men’s differentiation from women becomes particularly apparent in the use of touch.

An unfortunate consequence for men is that not only have they been separated from the use of touch in demonstrating care but also the ability to use touch became associated with the demonstration of feeling. The term “touchy feely” is often used to describe a form of caring behaviour that involves touching and the use of empathy. This term is more likely to be used in relation to women and their caring. For example, Paterson et al. (1996) stated that “male caring was perceived by the senior students as being less ‘touchy feely’” (p. 32) and a participant in Evans’s (2002) study described the difference between women and men nurses by characterizing women’s caring as “warm

³² At this point Martin did not exactly use the word “whoomph”, but rather he made a noise that sounded like air being released from a out of a balloon.

fuzzies” and more “touchy feelie” (p. 443). The danger in linking touching and feeling in this manner is that men, who touch less, become vulnerable to the accusation that they also feel less than women. Furthermore, touching is associated with mothering, this coupled to the bread winner ideology described in Chapter Five has constructed fathers (men) as absent figures who are distant from caring and nurturing behaviour. For example, in the early childcare setting this has led to differences in the amount of physical contact that men and women have with the children. According to Cameron, Moss and Owen (1999):

One area of difference between men and women workers is the behaviour of each in their close physical contact with children. Whereas people are used to women having close physical contact with children, Tom says they are not used to men doing so. (p. 4)

For many women, it is a taken-as-given through the role ascribed to them as women, that it is normal for them to have close physical, non-sexual contact with the body of another. David (2000) stated that as a nurse she is “mother to the patients” (p. 85), in describing one of the subject positions of women as nurses. The notion of nurse as mother reinforces the non-sexual aspect of the role, given a prevailing moral discourse that constructs incest not only as taboo but generally frames it as a male issue. Incest is constituted as the perversity of the father.

As a distancing strategy for nurses who are women, the association with mothering in respect to the provision of intimate care, has had limited success. Lawler’s (1991) analysis of the problems inherent in nursing with respect to the body reveals that even though repeated, non-sexual touch is fundamental to the provision of care it has become inscribed with sexual meaning. Popular media often loads sexual meaning and innuendo to the work of nursing so that young female nurses may become associated with sexual images; they become objects of sexual desire.

Men in nursing, on the other hand, are constituted as objects of sexual threat. The masculine stereotype which excludes many men from the intimate, physical aspects of fathering and from the display of physical nurturing and caring behaviour both with children and other adults has created a discourse in which it is acceptable for women to touch female and male patients, but it is not as acceptable, or at least viewed as strange,

for men to do the same. For example, a respondent in Evan's (2002) study talked about being seen changing the diaper of a newborn boy by the father, who subsequently accused him of sexual molestation. We are conditioned from childhood to expect such behaviour from women as mothers, so the offer of such care by a man is suspect. As Phillip commented in relation to women, "It must be strange for them to have a man come up and want to give them a wash." Such othering, or non-normalization, of men's nurturing and caring touch leaves space for two forms of physical contact for the male, both of which can be problematic: the violent and the sexual. It is the latter which is most problematic for men as nurses.

The sexualization of men's touch.

For men, performing a physical procedure or providing physical comfort to patients, especially women and children, is fraught with risk. Bart voiced the concern that the man in nursing, along with men in early childcare, is especially vulnerable to accusations of sexual impropriety:

I think there is a lot of paranoia nowadays about the possibility of sexual abuse and sexual harassment; not just in nursing, but in a lot of fields as well [for instance] childcare. Every profession I've been in really, I suppose, [it] becomes more and more of an issue, more and more something that people are sometimes downright paranoid about, and I would imagine that would be a problem as well for nurses, particularly if you are getting into intimate, personal issues.

The risk associated with nursing was a significant theme that emerged from the interviews. A very real issue is that the touch might be misconstrued; this leaves the man vulnerable to accusations of sexual misconduct. The fact that much of intimate nursing care takes place behind curtains or closed doors in situations when the nurse and the patient are alone together heightens the risk. A respondent in Evans (2002) study highlighted the difficulty of defending oneself against such allegations in such situations, "It's my word against theirs" (p. 444). Phillip also identified this problem, "Being only two of you there, it would be her word against mine" and Jock, in lines 2-3, in the extract below, reiterated this:

1 I guess there are precautions I take for both male and female patients because
either way you could be seen to be – well, if you are on your own it is their
word against yours. So you maintain your professional integrity and you make
sure you don't do anything that could be construed as being sexual or putting
5 yourself at risk of being jeopardized in that sort of way [] I'm always feeling
vulnerable when I'm with a patient on my own [] It's stressful, but it's part of
your job and you are always aware of being discrete about things, being
careful, telling the patient what you are up to, talking with them as you do it,
just explaining what you are doing. I think it is all part of professional
10 integrity-maintaining your professional presence.

Interestingly, Jock identified that the provision of physical care is problematic regardless of the gender (lines 1 & 2). Caring for females leads to the risk of being accused of heterosexual sexual misconduct and caring for other men leads to the risk of being suspect of being homosexual and seeking inappropriate conduct with a member of your own gender. In line 6 he described, "feeling vulnerable" which is "stressful" but, he continued, such feelings are part of the job.

Luke was also of the opinion that men are very vulnerable when it comes to defending themselves against any accusation of sexual misconduct:

I think men have been given bad press over the last few years. When somebody complains it is very hard to refute claims often. And if it goes before any sort of authority or any disciplinary hearing the chances are that the system is going to believe the patient than, I think, they would the health professional.

The feelings of vulnerability and stress associated with providing intimate physical nursing care may be significant factors, albeit unconsciously, in the career choices made by men in nursing. The accusations that they pursue stereotypical male career trajectories within nursing to overcome masculine role stress or avoid the intimate work of nursing may be less about their masculine identity but more about protecting themselves from accusations that could harm them professionally and personally. It can be argued that choosing to work in environments such as ICU allows men to provide intimate care safely. In that environment you are often within the view of another nurse

as you perform even the most intimate of care, or else the complexity of providing intimate care for a patient who is linked to various monitors or other pieces of equipment requires assistance from another nurse, who then acts as an informal chaperone.

Nursing's collusion with the sexualization of men's touch.

Bart's comment on page 258 that there is a lot of "paranoia nowadays about the possibility of sexual abuse" is not new behaviour within nursing itself. Nursing has a long history of keeping its men well away from female colleagues and patients, and children. Bruce recalled being segregated from female colleagues in the nurses' home:

1 We were segregated in the nurses' home on the ground floor and you weren't
allowed to go upstairs or downstairs or anywhere without supervisors. It was
interesting this was in 1983. It was quite strict [] It was incredibly unfair
because the female nurses got bigger rooms, and their own hand basins in
5 their rooms. We never got those. They seemed to have a lot more freedom
than we did [] If we needed to do something different or we needed space to
socialise we had a small lounge. If we wanted to socialise elsewhere we were
asked to go to the doctor's rec[reation] lounge and socialise with the doctors.

10 *Interviewer:* So you are saying you could socialise with the doctors but not
with your female nursing colleagues?

Bruce: Yeah, unless they came down into our lounge.

Interviewer: So the women would come to your lounge.

Bruce: But we weren't allowed to go to theirs.

Even into the 1980s adult women and men, in some instances, were being kept apart in their off-duty hours by nursing administrators owing to the perceived sexual threat posed by men. In this situation, the men could perceive themselves as being discriminated against in terms of the treatment they received (lines 4-6). Their otherness in the world of nursing was reinforced and they were channelled into association with the medical staff: a group who also inhabit the world of the "other" in respect to (female) nursing.

The otherness is delineated not only by the traditional gender segregation between the two professions but also by the care/cure dichotomy which some in nursing have

adopted in order to claim a distinct separateness from medicine. This collocation of the men together with the doctors appears paradoxical when placed alongside criticism of men's socialization with doctors on the wards (Williams, 1989); a socialization which often occurs because men are not welcomed into the social space of their female colleagues. In this instance they were not allowed to inhabit the same social space.

Bruce describes being "supervised", i.e., chaperoned, if wanting to go anywhere other than the ground floor of the nurses' home. Ian recalled that being commonplace in the 1960s and 1970s. In some hospitals the wards were segregated and the men were always chaperoned whenever they were asked to assist with female patients. Several of the men suggested that a variation of this monitoring continues to exist today in the form of other (female) staff asking the (female) patient's permission for a man to look after them. This bothered Andrew and Edward; in particular, as they considered that they should have the right to interact with the female patient first. According to Edward when talking about having his services refused by a female patient:

- 1 In virtually every occasion it was another person – female-that said "Is it all right?" I felt really aggrieved because I've never had a woman turn me down that I've actually had a chance to establish a rapport with first. And to my way of thinking it's the woman introducing you that actually has the problem,
- 5 whether it be a nurse it's normally a nurse-has a problem with you as a male, and puts that on to the patient.

Andrew also commented that it was only when a female colleague introduced him that he experienced any problems:

I never had issues with women as consumers if I actually went, knocked on their door and went into their room and introduced myself. I had problems with women accepting me as a midwife if another female midwife did that on my behalf. And to this day I don't know whether they would do it apologetically, "I'm sorry we've only got a male midwife today" or how they went about it, but that was where I would get my refusals as a male.

It could be, as Edward suggested in lines 5-6, that it might be a problem for the female staff member and that is picked up by the patient, or as Andrew wondered it might

be in the way it was introduced to the patient and that the refusal is attributable to the action of the female colleague. Andrew also thought that often the male partner of the woman in labour was influential in the refusal of his care, "I think I would be seen primarily as a sexual threat to them." In these instances the construction of men as competitors and to be protective of women overrides the commonsense need for skilled attendance at the labour.

It is, however, also possible that the female patient feels more comfortable in expressing the refusal to another woman and that it is harder to say "no" to the man directly. Charles noted that sometimes the refusal seemed to upset the patient more than him: "Sometimes them saying it upsets them more than it upsets me. They catch me a bit later and say, 'I'm so very sorry.' But that's fine, that's their choice."

There are many women, however, who are able to personally refuse to have a man provide nursing care for them and they all described having had women refuse their services; some have also met refusal from male patients. Their statements during the interviews would indicate that they accept it as the patient's right as generally they denied being bothered by the rejection. Even though one can accept the rejection cognitively there can be an emotional reaction to being rejected because of your gender, not because of your professional ability. Carl described feeling "insulted." Edward thought that the very fact that someone else asks the patient for permission to him to provide care immediately creates a "totally abnormal situation." He is rejected on the basis of his gender: "because they don't know me from a bar of soap. They don't know the sensitivity and the skill that I've developed as a nurse." A paradox emerges in this discourse: the belief that patients have the "right" to refuse care based on gender, yet to refuse care based on race would be viewed as discrimination.

Nursing education fails many men also by the lack of education provided with respect to managing such difficult situations, particularly with respect to how men may safeguard themselves from unjustified accusations of sexual impropriety. For example, a male nursing student in the study conducted by Paterson et al. (1996) talked about his concerns with respect to touching patients:

I don't think it's always men who feel funny about touching and stuff. I know that some of the girls in my class weren't very comfortable with it at first. But it is mostly a male thing. And the teachers never discuss it. They just think that it is good enough

to give us a lecture on the importance of touching. There were so many questions that I had back then. Like, do you touch everyone the same way or should you touch men and women patients differently? Or how do you know if a patient might not want to be touched or get the wrong idea if you touch them. (p. 34)

Another student in the same study found himself being angry over the lack of teaching provided with respect to such an important theme:

I got mad at my teachers for not understanding how I was feeling. To them, it's such a little thing. Women touch each other all the time, even when they're just talking to one another. Men don't. (p. 33)

Whether women "touch each other all the time" is a moot point, however, this reflects the understanding that women's use of touch has been normalised. In the above extract the student describes the taken-as-given use of touch by the female teachers. Phillip, who was a student at the time of the interview, was asked about the education he received with respect to intimate touch:

Interviewer: Are you given any support or training at 'tech around how you, as a man, should approach these intimate situations?

Phillip: None at all. They should have some strategies in place ... it would be nice to have some sort of ... procedural guideline or something ... because I think it is more of a male problem.

The interview that was undertaken with Phillip was the last in the series and the question above was prompted by his response to the following question:

Have you thought about strategies you might employ to ensure that you don't get into a situation where anybody can misconstrue what you are doing?

Phillip: I make sure I put on some gloves so there is never any skin-to-skincontact, basically, when I am washing them.

This innocent response is disturbing within a discourse that problematises men's touch. The lack of insight and education into the risks and the consideration of potential strategies to minimise such risks can make the man in nursing vulnerable. The response

also created a dilemma for me as researcher, man and nurse educator. I wanted to protect the integrity of the interview while at the same time protecting my own integrity as an individual who felt responsibility to help Phillip become more aware of his vulnerability. The interview continued and after it was finished I discussed his response with him.

The area of men's touch is, as Paul identified, complex and one that is not discussed much within nursing education. For the reasons outlined below by Paul, I would argue that there is real need for nursing to address the issue by both assisting nursing students and registered staff in strategies to ensure their safety and in working toward a society in which men's touch is not sexualised:

If I think about some of the things we did, or I've done-if I look back on situations that I can picture myself having been in and think, "Was I in a vulnerable position?" Had someone decided to be particularly vindictive for whatever reason, then I would have been in an extremely vulnerable position. At the time, of course, you never think about it, but if you think about protecting yourself from potentially risky situations that may not have involved you specifically but you're in the wrong place at the wrong time. If I use the analogy about a child, for example: if you are a father, and I am, you do a whole lot of things with your children in terms of physical contact that are very easy to adopt with their friends, for example, if you know them well. Now if you do those sort of things and if you're doing them completely innocently, but if you think about some of the positions that people appear to have got themselves into about being accused of doing inappropriate things with children, you find that maybe that's the situation where I could have been accused, had the child decided this was not appropriate. Therein lies the problem. If, for example, something external to that particular situation has occurred and the child either mentions it to someone who has got it in for you or sees it as an opportunity to add leverage they might use it.

This is all supposition, but male teachers, for example, are always cautious about never touching, no matter how innocent, unless there are other people around. Now, that's fine up to a point. But as I say, you get into a situation when you're nursing where exactly that sort of thing occurs, and I can look back and think of

hundreds and hundreds of occasions where that might be the case. If I was looking objectively at a film of somebody else doing it, you would say, if you could see yourself in that film, was this person acting appropriately or were they in a vulnerable position? I would say that I've been in an incredibly vulnerable position many, many times.

The key points emerging from Paul's narrative are: (i) the fact that there is considerable potential for your seemingly blameless actions, as part of your work role, to be misconstrued either innocently or deliberately; (ii) the intimate nature of much of the work of nursing places one at risk; (iii) the risk may only become evident retrospectively; and (iv) the precautions that you may need to put into place can become an impediment in building a relationship of trust with your patient.

Keeping oneself safe.

Phillip also identified a situation in which he should have been more punctilious in asking the patient for permission to look after her: "Looking at it now I should have asked her whether it was ok, but only having been there for two shifts ... I was still feeling my way around more or less."

The asking of permission and the thorough explication of the procedures to be undertaken were the two most common strategies adopted by the men with respect to providing intimate care. These strategies, however, were not employed solely with respect to women. For example, Paul described his utilization of such strategies with patients of both gender:

I don't necessarily treat women differently than I treat men from that point of view. That is a problem and it's not a problem. I mean if I think about it that's the way I believe it should happen that I would talk to a man and say "Are you happy that I'm going to do this procedure" and I would explain to the what I'm going to do and get their implicit or explicit permission to do what it is I'm going to do.

Other strategies include asking for another nurse (female) to undertake the care or the procedure. Carl, who worked in paediatrics, employed this tactic frequently:

Paediatrics is different and depending on what's happening uh [with] teenage girls I [am] just sort of careful in what needs doing. I will sometimes get the other nurses to do it.

Interviewer: Can you give me an example?

Carl: Say a 13-year old girl needs an ECG I will get one of the other nurses to do it.

Interviewer: Why are you doing that?

Carl: ... to protect myself. As a guy I don't want to be put in any sort of position where uh I can be accused of uh misconduct or anything like that.

Sometimes they request another nurse to accompany them as a chaperone. Luke, for example, "Would never do an ECG on a woman without having a chaperone there or wash in their groin area without having a chaperone." Grant, who works with the terminally ill, asks family members to help or be present if that is possible. Asking permission is a common strategy employed but, as was discussed earlier, some patients may find it hard to say "no" directly; however, several of the men also volunteered that the seeking of permission is often accompanied by them providing the option for another nurse to provide the care. Paul discussed this at some length:

If I was going to something with a female patient, for example, [] if it was going to be something that would be considered invasive and it didn't matter if it was going to be something fairly innocuous, helping them clean their teeth or do their hair or something like that – I would always ask them if they minded or if they would prefer to have another nurse. It never worried me if they said they would prefer to have another nurse. So from that point of view, I asked their permission, or we talked about it. I really struggle to think of times where I would have ... and there probably were, and I'm sure there are, or have been occasions when I would go into a room without making sure first. But as a general rule, I wouldn't do that. Now if I was critically reflective of that, that is not a really flash way of doing it, but at the time it always worked, and I always worked hard to never take that [for granted] or make the assumption that someone would always be accepting of what I was there for and so on.

Paul's last point is a central theme that emerged: not been able to take for granted their right to be there. Luke was of the opinion that many female nurses do take their right to provide care for any patient as a given and thinks that men demonstrate more awareness in this regard:

I do think a lot of men that I have worked with have been quite considerate and thoughtful in that area. But I guess I haven't explored it enough with them to know whether it was innately in their personality or whether the reason that they are like that is because they are like myself making a calculated decision to cover their actions.

Men's different caring voice: career as a way of providing care

The role of the "provider" also encompasses nurturing, but the emphasis on the female ability to nurture through nursing the infant has been emphasised to such an extent that it repudiates what men do as caring and resists their attempts to express caring and nurturing in ways that challenge the stereotype.

In Chapter Eleven it was outlined how one of the factors pulling men away from clinical work is the pursuit of higher pay. That impetus is often fuelled by the desire to be a better provider, or to be able to take better financial *care* of one's family. Pursuing a career that allows them to financially provide for those they consider to be dependents is an important part of masculine identity. On a personal level career becomes synonymous with providing care and this can also be a compelling factor professionally. A movement into an administrative role not only provides increased income, but also decreased need to work unsociable hours which in turns means more availability to the family; as well it allows greater opportunity to effect positive change within the environment in which care occurs.

The idea of being able to provide better care was a powerful motivator for Paul when he applied to become a Charge Nurse. It was not the position in terms of personal status but the power to effect change that was the key for him:

I've never seen them as positions of authority except to the extent that it enables you to do the job better or to have a greater input into how a job is being done. It's not the promotions *per se* it is more the ability to effect change. That's really the thing I've been keen about.

Martin, after thirty years in nursing, was in a senior administrative position at the time of the interview. He was however leaving nursing and he said it was “not by choice”:

- 1 The only reason I’m contemplating it is because of the environment that it is at
this point of time. Otherwise I wouldn’t, because a couple of times I’ve been
approached and, “No, not interested.” This time I am and it’s because of what is
happening now, because also what I’ve been brought up with and worked
5 through for the last 30 years no longer exists in the organization, even with all
the changes there was a constant. That constant is no longer there-gone. It’s
destroyed and I don’t want to be a part of this new health environment any
more.

Martin originally became a nurse because “it was just the right thing to do at the time, and I have never, ever regretted the decision.” Now, however, after 33 years, nursing, or at least the environment in which it is provided, no longer feels “right.” He later described the “changes” (line 6) as a move away from a model of empowerment into one where the primary focus is on finance. Martin was struggling with what Phillips (1994) has described as a “crisis in caring.” A crisis in which, “Caregivers are rewarded for efficiency, technical skill, and measurable results, while their concern, attentiveness, and human engagement go unnoticed within their professional organizations and institutions” (p. 1). The introduction of market reforms into health care delivery has created an environment in which he no longer wishes to participate. Martin’s experience parallels Taylor’s (1994) argument that “the language of cost-effectiveness, and of much professional training negates the experience these nurses have of caring and does not express what their own life is about and what is of value in it” (p. 182).

Considering some of the career choices described in Chapter Eleven it becomes possible to theorize that for some men the vertical career path is also a way to provide care. As well, those who chose to go into critical care also saw this as providing a basis for developing skills and knowledge that would ultimately allow them to become better practitioners and, in their view, better at providing care.

To dismiss men’s career choices in areas such as critical care and administration as reflecting a need to hold onto masculine status is not a complete analysis and ignores the

caring impulse that brought them into nursing and the possibility that their decisions continue to be motivated by that original urge.

Caring versus curing.

Accompanying the endeavour to equate caring with feminist ethics, there has also been the separation of caring from curing, and the association of curing with medicine and masculinity. This can be understood in terms of nursing's attempt to remove itself from its subservience to medicine and the articulation of a distinction between the two professions. Thus, some have attempted to ascribe two different sets of ethics to provide some demarcation between the two. It has been suggested that medicine is based on principles and rules, i.e., the ethic of justice, which is perceived as male and that nursing is based on a female ethic of care, which emphasises the relationship between the nurse and the patient (Kuhse, 1997).

The healthcare setting that is most frequently cited as exemplifying the medical – masculine emphasis on cure is the intensive care unit (ICU). Williams (1995a) described ICU along with the Emergency Department as being “male-defined” areas within nursing, and as “more masculine specialities” (p. 65). It is interesting that if these areas are indeed “islands of masculinity” that there has not been a body of research generated to investigate why women would want to work in such areas. Even though men may be disproportionately represented in such areas with respect to their total numbers in the nursing profession, the reality remains that most of the nurses who work in ICU, mental health, emergency departments, administration or education are female. It has been proposed that men who are nurses choose these work settings in order to reduce the identity conflict or *role strain* associated with being a male in a female profession (Bush, 1976; Cummings, 1995; Davis-Martin, 1984; Egeland & Brown, 1988; Greenberg & Levine, 1971), or because, according to Greenberg and Levine (1971) such specialities allow men to avoid the “need to touch” (p. 421). They theorised that role strain is a result of the difficulty men encounter in reconciling the normative script, or role, of masculinity with the feminine role of the nurse. They believed “that in order to reduce this conflict in role obligations, a man nurse chooses certain areas of specialization, and that within these areas his perception of his status tends to minimize role strain” (Greenberg & Levine, 1971, p. 419). Bush (1976) argued that the man in nursing experiences a conflict in knowing

whether to present themselves as a man, i.e., strong, assertive and a leader, or to present themselves as a nurse, i.e., caring, tender and warm. The data from the interviews conducted as part of this study do not support Greenberg and Levine's (1971) nor Bush's (1976) findings. The men whose voices are heard in this study suggest that it is not that they experience role strain or confusion with respect to their masculine identities but rather it is often those around them who have difficulty in knowing how to relate to the man who is also a nurse.

Greenberg and Levine (1971) and Bush (1976) are the seminal investigations into role strain in men who are nurses and have been referred to by others in their investigations of this phenomenon. Egeland and Brown (1988), for example, were surprised that among 367 nurses who were men in Oregon, USA, they only found a mild degree of role strain. They noted, "This finding was unexpected in the light of prior literature and role theory. It is possible that the finding is an error, and a consequence of flaws in the method (p.265)."

It is possible that there was a flaw in their method; however, it must also raise the question about a hypothesis of role strain which has been based on the experience of *nine* men in Greenberg and Levine's (1971) research and of *ten* men in Bush's (1976) study. At that particular time in gender history men were experiencing role strain as the second wave of feminism questioned the role of both women and men in society; therefore, the role strain observed may not have been solely a response to the men's role as nurses but also to their role as men in the wider societal context. Be that as it may, the notion of role strain has been an influential hypothesis with respect to men in nursing and the subject of further investigation (for example: Williams, 1989, 1995b). Williams (1989) used almost pioneer imagery with respect to what she described as "immense pressure" on men leading them to "stake out a terrain within nursing to identify as masculine because the profession is so closely identified with femininity" (p. 90).

Questions raised from a postmodern reading must also open space for alternative readings to emerge as to why some men might choose to work in ICU or the other speciality areas. Alternative readings might focus on, for example, greater intellectual engagement, a perception of more autonomy or a demand for different professional skills.

It has been proposed that men chose to work in ICU because they prefer the more technical aspects rather than manifesting compassion and caring (Dassen, Nijhuis, & Philipsen, 1990). Paul worked in ICU for a number of years and admitted, "I don't have a

problem with machinery. I enjoy it from an intellectual perspective.” As he continued it became clear that the machinery was not of primary importance:

It’s an intellectual challenge to manage patients like that. You’ve got to work at it, you’ve got to be aware, you’ve got to be bit more precise about what happens, and it is a lot more evidence-based which I enjoyed - the relationship between research which shows you how to behave, rather than being task-oriented. It is much more clinically-based in terms of what you do; reflects what the patient requires, and that relationship is far, far stronger than what you find on the ward.

Some might perceive Paul as using intellectual engagement as a distancing mechanism to avoid intimacy, both physically and emotionally. However, when he elaborated on what drew him to ICU it was the depth of involvement he was able to have in patient care: “the relationship between the way the nurses participated more directly, if you like, in patient care.” What emerged in talking with Paul was the notion that in ICU nurses had more voice in the decisions around clinical management. He saw this as “relationship” and “team work”; however, for others this is seen as nurses moving away from caring to become more like doctors. For example, Zussman (1992) observed nurses and medical staff in two American ICUs and concluded that the nurses were not “patient advocates. They are not ‘angels of mercy’. Like physicians, they have become technicians” (p. 80). While a nurse interviewed by Henderson (2001) suggests that nurses (both women and men) in ICU avoid emotional engagement: “I mean you see a difference with people that would prefer ICU nursing as opposed to hands on. Or operating because you’re so detached. Some people, in ICU you’ve got to know how to work the machinery” (p. 134).

To suggest that nurses who work in ICU are not “hands on” (line 2), engaged in physical contact with their patients is not an uncommon attitude expressed by nurses who have not had experience of intensive care nursing. Luke commented:

The thing I was very aware of in ICU [was that] you were probably working a lot more intimately-I mean you work intimately in the general nursing arena with patients with bodily functions-but in ICU you tended to work a little more intimately with people.

The reality for many nurses, both men and women, working in ICU is that they have more physical contact with their patients than most other nurses, as they are at the bedside of one, perhaps two, patients and are totally responsible for “hands on” care such as providing bed baths, mouth care, eye care, cleaning of bodily secretions, passive range of motion exercises, hair combing and so on. As Robert said, it is “satisfying giving the ultimate care, one on one.” Nurses in ICU are able to give total patient care in a physical sense, as well they can be seen talking to their patients, whether or not the patient is conscious, explaining, reassuring and apologising for potentially painful procedures. Because they are “working with” the patient for their whole shift they are often emotionally engaged with the patient’s significant others as well; explaining, reassuring, coaching, listening to the fear and grief that inevitably accompanies most admissions into this environment. They often build significant relationships with the relatives and friends of the patient and learn about the meaning of that person to those who sit in anguish at the bedside. They request photos be brought in which are placed at the head of the bed so that they can “see” the patient as a real person rather than merely a dehumanised object connected to machines.

Warren worked in ICU for a number of years and when asked to articulate his understanding of care, he described an example of how he was able to demonstrate caring in that environment through working with the patient to avoid the use of machinery:

- 1 Like that guy in intensive care who I turned around from being intubated, like
for me that was a really caring kind of thing in terms of [] not being
empathetic and just feeling sorry for him. In terms of nursing it’s more working
with the person and [having] their good in mind [] like this guy was really
- 5 confused and the more hypoxic he got the more confused he got, but instead of
barking at him, you know, telling him he had to wear his mask, I worked with
him, you know, going along with his fairy tale kind of confusion and all this sort
of thing. It was more like, yeah, it was a different experience it was working
with him and I had a goal in mind and trying to-it almost sounds wrong-trying
- 10 to get him to see my goal, kind of thing. Which is not what we are meant to do,
but that was caring because I took the responsibility for his breathing, if you
like, from him because he couldn’t do it.

In lines 9-11 Warren talked about the principles that might be expected to be applied in this situation and how he ignored them; in doing so he demonstrated a form of care that was contextual.

There is no denying that the technology of the ICU environment can, at times, be the main focus of the nurse especially during situations of crisis or when the nurse is new to the environment and has not yet assimilated the required knowledge and skill as part of their professional repertoire. This is a natural learning response and nurses learning new wound management techniques, for example, or student nurses trying to practise what they have learned in the classroom setting focus on the task or the equipment rather than the patient until it becomes a familiar tool. Allan recognised this during his time in ICU but become frustrated with the length of time it took to “become competent with a ventilator”:

- 1 Maybe I’m just not very technological, but I didn’t have the confidence in my
machinery. So on my eight-hour shift I listened to every breath my ventilator
took. I know that you should be able to set your ventilator at the beginning of
your shift and you know that it will continue to go. But I just didn’t feel like
5 that. I had awareness of every breath and I found it really exhausting and I
spent so much energy on the technical components, having a patient with the
big technology was quite stressful for me. I didn’t feel very confident in caring
for my patient’s other needs and things like supporting relatives was quite out
of my realm, whereas my first ward, the respiratory medicine ward, was
10 obviously an oncology ward and a large number of my primary patients died
and I supported their families and thought that I had become, you know,
relatively skilled at that, but in ICU I was so busy concentrating on the
ventilator that I didn’t have time to worry about the relatives.

The extract above describes how, for Allan, the machinery took his focus away from what was important for him, “caring for my patient’s other needs” (line 8) and supporting relatives (lines 8-13). In the ICU setting his patient’s “other needs” would have required intimate physical contact to provide hygiene care and to ensure skin integrity, and arguably in supporting the relatives Allan must engage emotionally with them. For Allan, developing relationships is an important part of nursing and the provision of care:

Interviewer: Would you say then, that being part of a team and developing relationships with other people is really important?

Allan: Yeah, definitely.

Caring as relationship.

“Caring about” does not mean personal disclosure or over involvement but it does mean acknowledging the importance of relationships in women’s lives and of being real in the relationship. (Gallop 1997, p. 37)

Not only has nursing been gendered as female, but a similar process has also occurred with respect to caring. As exemplified in the above statement by Gallop (1997) caring has become identified with a posited female ontology that emphasizes relationship.

In the interviews with these men it was at the point where that they were asked to describe what the concept of care meant to them that there was a noticeable disintegration in fluency as some struggled to articulate a precise meaning. As Charles said in relation to this question, “...it’s a really hard one ... no, I’ll come back to it.” He wasn’t alone in groping to elucidate an understanding of the concept:

Interviewer: The word *care*, what does that mean to you?

Phillip: ... umm ... I suppose keeping somebody ... giving.... Hmmmm... [laughter] ... care? ... ummm... it depends, I suppose if you’re talking about daily types cares, giving them ... keeping them clean and stuff like that, but also keeping them safe ... umm...physically, emotionally, ummmI think it involves letting them do, push the boundaries-what they need to get better themselves rather than doing things for them ... umm ...

Perhaps, it is understandable that Phillip, who was a student nurse at the time of the interview, struggled to voice meaning to the concept, but his response is noticeably disfluent, with a number of anacolutha (grammatical constructions abandoned before completion in favour of other grammatical constructions). This contrast with greater fluency with respect to other questions posed by the interviewer was found with some of the other participants as well.

1 *Interviewer:* What does caring mean for you?

Robert: Oh ... I suppose it is maintaining health or improving people's health, it means that caring has different meanings in different situations whether you are working with someone who is terminally ill, the caring there, the palliative
 5 care and the caring for someone who is acutely ill, may be younger, caring is ...
 I've lost it....

Caring as “working with.”

While Robert also struggled to clearly articulate his understanding of the concept, he did subscribe to the notion of “working with someone” (line 4), which was also the expression used by Warren (“worked with”), on page 272. Martin thought that the key to the positive feedback he has received during his care was “the way I relate to people”, which was based in “working with patients.” Grant also used the phrase “working with” in terms of his caring role with in the hospice environment: “Because I’m there with the people, working with the people, helping them, helping to make things better for them before they die. I enjoy working with people-that’s the bottom line.”

When Grant talked about being there “with”, there is an echo of the notion of “presencing” articulated by Benner (1984) when she described the “essential importance of just *being* with a patient” (p.57). He elaborated on his notion of “working with”: “For me the important thing when looking after patients is letting them make the decisions about their care, not us forcing what we think they should have about the care.” The notion that work should be structured around the nurse and not the patient is in Grant’s opinion “diametric to our philosophy as nurses, really.”

Bart also spoke of the importance of “being there” in relation to caring and that “to be able to sit there and talk to people” was fundamental in his opinion to demonstrating respect and maintaining the patient’s dignity. Andrew described it in terms of “displaying an interest in them” and opined that it was also important to make that connection with the patient’s partner and support people. Others also talked about the necessity of extending the relationship to the significant others in the patient’s life, so that there was a sense of a community working together. For Grant it is “important for the family to be involved as much as they want to be” and for him the notion of community and “working with” was also valued in terms of his relationships with other nurses. It bothers him when nurses don’t see the value of community when making decisions:

I also think that some female nurses are inclined to make clinical judgements without consulting their peers. I think if you are going to make a decision about Joe Brown's subcut infusion, for example, I always consult with a peer, but some female nurses-not that it is a criticism-are inclined to take that power onto themselves. I have decided to do this, and I think that is wrong. I think two heads are better than one, it doesn't matter how much you know.

Grant's denial of criticism in line four aside, what is interesting about this critical comment is that given the stereotyping of men with agentic norms, such as confidence in decision-making, this would not be an unexpected comment if the gender of the protagonists were reversed. Earlier research, for example Gilloran (1995) revealed that men in nursing also expect their gender to be more confident in making independent decisions, according to a male participant in Gilloran's study male colleagues tend to "make quicker judgements and are more confident about decision-making" (p. 655).

Caring as "contextual."

Both Robert and Warren express an ethos of care that is contextual, as in Robert's words on page 275, "caring has different meanings in different situations" (line 3), or in Warren's case being prepared to break the rules because they wouldn't work in that particular situation, as he described it, on page 272, doing something "which we're not meant to do" (line 10).

Part of the difficulty for these men is that caring is such a multi-faceted concept, such that it becomes difficult to describe precisely. As Luke stated:

Care is so encompassing and that is why it is so hard when you are asking me to define it. How I would define it and how the next person would define it is quite, probably quite different-and it is so broad ...

With respect to the definitions of care these men provided that, there was a wide range of ideas; however, what emerged strongly was the role of communication and the need to create relationships. Mathew voiced the belief that men are not expected to form relationships well, and how that can work to his advantage: "Yeah, I've noticed that I can form trust relationships very quickly because people become very relieved when I am not a

classic male in the way I relate to them.” He returned to this theme later in the interview, and stated that his belief in his ability to establish relationships with the patient was based upon feedback, which he termed the “reward”: “Because I’m told that! Because I’m rewarded by clients [laughter] I know I develop very good relationships and clients tell me that.”

A sense of urgency emerged in the transcripts around the importance of communication and men’s need to do it well because of the barrier that essentialist gender beliefs create with respect to men’s care giving. Mathew also argued that the stereotype could also create a barrier for women as nurses in creating relationships. The assumption that it is right for them to be in intimate contact with a patient because of the “naturalness” of women’s caring can lead to the nurse actually not communicating with the patient about their needs:

I see a lot of, particularly female, nurses who actually have difficulty in forming relationships. They have a stereotyped idea of the type of relationship they’re going to have and it’s often that power-driven thing where they tell, they don’t actually form a, you know, client-centred relationship, for example. They don’t do it any better than men do it.

Two possibilities emerge. The first is the possibility that men as nurses have fewer taken-for-granted assumptions about the role and what they can do in that role. The second is that a man needs to take more time getting to know the patient better in order to be able to function effectively. Edward explained the need to establish a relationship of trust when physical contact is required, especially with a patient who is a woman: “We don’t take it for granted, where I think a women would feel much greater freedom and liberty.”

The importance of communication kept being reinforced; for example, George, in the space of one page of transcript material when talking about those qualities he displayed which made him a “good carer” used the word communication four times. He summarised by stating, “I think your communication skills are really important”; he linked communication to empathy and being “emotionally affected by something that is horrible.”

Robert has twice in his nursing career been publicly acknowledged by the Chief Executive Officer of the District Health Board for which he works because of the written feedback that has been received from patients. He believed it is because he has been able to put aside the rigid rules of his early training and is able to really communicate with the people he is caring for:

You wash people's backs and do their dressings and make sure they were comfortable, but I think now that was how I was trained, but over the years umm you know my, my ...how I deliver my nursing, I have gone outside the boundaries of those carings [] that comes with maturity of myself and maturity of being a nurse, as well that I'm able to communicate and get to find out about them.

It can also be interpreted here that by stepping outside boundaries the context of the nursing situation is important. Benner (1984) in her identification of the factors that denote excellence in nursing highlighted that context is an essential component of caring, which in turn depends on relationship. It can be argued that the ability to skilfully move outside the usual boundaries of nursing practice is a hallmark of the excellent practitioner.

Caring as empathy.

Empathy also emerged as a key component to caring. Edward saw it as "giving the best part of himself", but also viewed empathy as one important part of caring but not the whole essence. He also valued the role of "excellent clinical knowledge" as part of caring: "It's about having empathy and respect and bringing these along with the technological understandings together and holding that with the client that is in front of me."

Edward's eloquent description of the meaning of care for him, may not actualise Watson's (1985) notion of caring as forming a "union" or Noddings' (1984) concept of empathy as "reception", but his use of the word "holding" suggests that care is encompassing, that the nurse surrounds and supports the patient within a caring ethos. Bart, like Edward, also described care as having two facets: the affective and the practical:

A sense of being aware of someone else's state of distress and wishing to empathise with that, alleviate, assist with it in some way - that's one dimension of it. The other dimension is similar, but almost in a technical sense-there is something wrong; an

ulcer on your leg or suffering from delusions or something. This is what we can do to intervene, to bring you back to approaching normality.

In this extract two significant themes emerge. First, as already identified caring is multifaceted, and second, that it is not the actual achievement of empathy that defines caring but the intention, “the wishing to empathise.” Underlying this can be inferred the commonsense realisation that it is probably impossible to enter into an empathetic state of communion with each of our patients; however, to care in a truly human context we must have the intention to strive for such unity. Luke perceived this ultimately in terms of mutuality:

My whole philosophy right through my nursing career-that I very much treat people as I myself would like to be treated or how I would like my family treated if I were in the same situation.

It is a philosophy that he doesn't think is shared by all his colleagues. He continued: “I do think sometimes the way nurses relate to their patients ... I sometimes think I would wonder how they would feel about that if they were the ones on the receiving end of the dialogue or care.”

Luke's comment reiterates one of the most interesting paradoxes in nursing, which was explored in Chapter Nine: the contrast between nursing care and nurses' *violence* to their patients and each other.

Do men care differently?

With respect to the positive feedback these men have received from their patients during their careers it is easy to dismiss it as being nothing more than an artefact of their heightened visibility deriving from their minority status. To do so not only devalues the men themselves but risks disregarding an important possibility for nursing education: that men may provide nursing care differently and that the care they provide may be what the patient wants from a nurse.

The issue of whether men who are nurses provide care differently from their female counterparts has not been one that has received much attention from nurse researchers to date. There is a much greater focus in the literature on men's career development

Studies, which have investigated why men enter into nursing, have found that men generally become nurses because they want to care.

According to Davies (1995) caring work is defined as “Attending physically, mentally and emotionally to the needs of another and giving a commitment to the nurturance, growth and healing of that other” (p. 18). She argued that femininity stresses the acknowledgement of emotions and intimacy and of nurturing others and that these are attributes that men fear, deny and repress in order to create a masculine image that is seen as other than female. In the same paper which discusses gender and caring work she cited from the Royal College of Nursing’s (1992) account of stories which exemplify the value of nursing. Ironically, in one of the four stories she used, the nursing protagonist is male:

The enrolled nurse explained to her exactly what we were going to do and how much better she would feel. He was quite clear about how unpleasant the tube could be when it was going over the back of her throat [] After all the preparation, he proceeded to put the tube up to her nose, and lifted her two hands and wrapped them round his. “At any time when you want, you can stop this”, he said. So she did, three seconds later. The second time, he was just as patient, Eventually, with tears pouring down her face, she pushed at his hand to “help” the tube going right down her throat. After she was all tidied up and settled, and some of the bile had been drained off, we all held hands for a second, and he made her laugh by inviting her to help with the intubation of any other patient who might need it. (p. 21)

The key points from this extract are the man in this nursing situation provided honest information and, more importantly, gave the patient control of the situation. It was described earlier in this chapter that the men in this study use communication as the foundation for their caring. The importance of communication was also highlighted by Milligan (2001) in his study of the concept of care among eight men who were nurses. He has constructed a conceptual model in which the meeting of needs, effective communication and information giving were central to the practice of the nurses in his study.

As has already been argued, men have to spend more time in communicating with the patient and her relatives in order to establish the caring relationship. In doing so

they are less likely to immediately commit themselves to physical activity, but to spend more time establishing what exactly the patient needs help with. Phillip described this as “knowing when to actually offer help with doing things as opposed to just stepping in and doing it more.” Charles was also clear about the importance of the patient having control:

[I]t is about getting them back to doing it themselves, and taking care of themselves.

Interviewer: Do you think that other nurses apply a similar philosophy?

Charles: Not always no. I think it is sometimes about getting the job done and getting onto the next on.

The time that the men need to invest in communicating and developing a relationship with the patient can possibly explain the following comment from Carl: “I remember patients making comments about the men, you know, we’re sort of better uh more sensitive to their needs.” The time spent talking with their patients about what they need from their nurse, including at times for some patients finding a nurse of the same gender to care for them, may make them more aware of their patient’s needs or provide a basis for patients to think that.

Arguably, that which the patient values in being cared for is the most important aspect of the patient-nurse relationship, which is not the focus of this present study. There is an aspect from the literature about nursing care that is germane to this study, namely the argument that nurses may over-emphasize the importance of emotional care (given the gendered nature of the profession it must follow that this largely means women) (Phillips, 1993; von Essen & Sjoden, 1991, 1995). According to von Essen and Sjødén (1991), “Patients perceive behaviour such as giving honest and clear information and showing competent clinical expertise as most important, whereas nursing staff ranked expressive/affective behaviour as most important” (p. 1363).

Wilde Larsson, Larsson and Starrins’ (1999) study provided similar results. They found that both male and female patients tended to evaluate care similarly, placing higher value on medical-technical competence and physical-technical conditions than they did on an identity-oriented approach and socio-cultural atmosphere. The studies by von Essen and Sjødén (1991; 1995) and Wilde Larsson et al. (1999) were all conducted in

Sweden so to generalize into another cultural context is problematic. They are provocative, however, in that they suggest that what has been described as the “masculine” approach in the literature on caring may in fact have greater value to patients. This highlights the danger of essentialising about both gender and care and trying to link a particular model of care to one or other gender; it is likely that the best nurses of either gender are able to combine numerous performative aspects of caring to create an approach that creates safety for the client on numerous levels.

It would not be to nursing’s advantage to associate a particular mode of caring to one or other of the genders and to then argue that this proves that either men or women are better at providing care. What this work suggests is that men are as capable as women at providing care and that there may be some differences in the way that this is delivered. The challenge for nursing and nurses is to ensure that the way care is taught and provided is relevant to the needs of the patient and not constrained by the demands of a particular ideological standpoint.

It is possible that men care differently and some of the men interviewed in this study thought that they did; none however were actually able to articulate exactly how that is manifested. Jock accurately summarised what is the most important aspect when considering men and caring: “I couldn’t put my finger on how they care differently, but I certainly think they care for their patients.”

Conclusion

It has been contended that not only does women’s caring flow naturally from being a woman, but that it is also invisible: unrecognised and unacknowledged (Henderson, 2001). Equally from a male perspective it could be argued that men’s caring has been rendered invisible and unacknowledged. I suggest that the focus on caring as based in “mothering” has provided us with models that are limited in their scope and application. As Gilligan argued with respect to woman’s different moral voice, it can be argued for space to allow that men “care”, but that the way in which they demonstrate that care is different from many women and that it is a function of history and social process.

This chapter revealed that a caring impulse was the primary motivating factor in these men’s choice of nursing as a career. A critical discussion of the emergence of the ethic of care and its association with the female was provided. The notion that men are

more concerned with the ethic of justice was contrasted with these men's identification that relationship based in communication formed the foundation of their caring behaviours. They described three essential aspects to the care they provide: it is contextual; it involves empathy and requires them to 'work' with the patient.

CHAPTER THIRTEEN: Conclusions and recommendations

The aim of this work has been to provide a social constructionist lens through which to view the experiences of men who are nurses in New Zealand. In particular it has focussed on the interplay of socio-political factors that have created particular images of men and nurses. The discussion that has emerged in the preceding chapters has shown that previously constructed images of men in nursing are rich with paradox and contradiction; they are inadequate to account for the complexity of men's lives and work as nurses.

This, the final chapter, will first address issues of rigour. It will then synthesize the understandings that have emerged from the work. The limitations of this study are discussed, along with comment on its contribution to nursing and, finally, it will propose suggestions for further research.

Ensuring rigour in qualitative inquiry

“Without rigour, research is worthless, becomes fiction, and loses its utility”
(Morse, Barrett, Mayan, Olson, & Spiers, 2002, p. 2).

Central to assessing the rigor or quality of quantitative research are the criteria of reliability and validity; however, there has been much debate among qualitative researchers since the 1980s with respect to the relevance of such concepts for establishing rigour within the naturalistic paradigm (Brydon-Miller & Tolman, 2001; Carpenter & Hammell, 2000; Gaskell & Bauer, 2000; Morse et al., 2002; Tobin & Begley, 2004). A number of frameworks have been put forward (and debated) in qualitative inquiry literature; however, a widely adopted set of criteria has been that proposed by Lincoln and Guba (1985). They have replaced the concepts of reliability and validity with that of *trustworthiness*. Rather than criteria of *internal validity*, *external validity*, *reliability* and *objectivity* which are typically used to establish trustworthiness within a quantitative research paradigm, they originally proposed that research using qualitative methods, such as this study, should consider the criteria of *credibility*, *transferability*, *dependability* and *confirmability*. In response to their critics they later expanded these criteria to include that of *authenticity* (Guba & Lincoln, 1989; Lincoln & Guba, 2000) .

With respect to discourse analysis Potter and Wetherell (1987) proposed four validity criteria: *coherence, participant's orientation, new problems* and *fruitfulness*. By 1996, however, Potter had revised his view on the appropriate criteria and while retaining the criterion of coherence had replace the latter three criteria by *deviant case analysis, participant's understandings and reader's evaluations*.

Trustworthiness

According to Lincoln and Guba (1985) with respect to trustworthiness the basic issue is simple:

How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, that would be persuasive on this issue? (p. 290)

Using the criteria outlined by Lincoln and Guba (1985; 1989) and Potter (1996) the following discussion will establish the trustworthiness (or rigour) of the study by auditing the events and influences on the research process and my reactions to these. Koch (1994) noted that although the readers may not share the interpretation presented by the researcher they should be able to follow the way in which it was derived. This is a result of the fact that each of us brings to the analysis our own preconceptions that influence the dialogue between researcher and text or the reader and the interpretation. My own prejudices and preconceptions were outlined in Chapter One (p. 5) and as will be discussed below, during the period of this study these initial beliefs were challenged and rescripted; a process that continues as part of the constant dialogue that sustains and creates knowledge.

Credibility.

Lincoln and Guba (1985) suggested a number of techniques that make it more likely that credible findings and interpretations will be produced: activities in the field that increase the probability of high credibility, peer debriefing, negative case analysis, referential adequacy and member checks. Of these techniques, four were adopted during this study: activities in the field, peer debriefing, member checks and negative case

analysis. The latter criterion has been considered as synonymous to with Potter's (1996) concept of deviant-case analysis.

Activities in the field

With respect to activities in the field that increase the probability of high credibility Lincoln and Guba (1985) suggested three techniques: prolonged engagement, persistent observation and triangulation.

Twenty three years of engagement with nursing and eight years of studying, teaching and writing about masculinity and nursing would suggest that I am not a "stranger in a strange land". Of course, such prolonged engagement risks the introduction of "distortions based on *a priori* values and constructions" (Lincoln & Guba, 1985, p. 302). In an attempt to minimise this problem notes were written and kept for referral as new ideas and challenges emerged. These challenged my *a priori* beliefs such that they came to be perceived as too simplistic in light of the complexity of the issues being explored.

It is, no doubt, the nature of preconceptions to be simplistic; however, there is danger in adhering to simple tenets in the face of complex and dynamic interacting factors as it may lead to ignoring the change processes that may be occurring and maintaining unwarranted commitment to ethnocentric beliefs. I look back upon those early declarations and now perceive them as both right and wrong; each one could be (re)viewed through a different lens leading to agreement or disagreement. It permits an understanding, and it is to be hoped a degree of sympathy, with respect to the contrary views that are expressed in the literature; however, I now hold that one of the points at which I diverge is that they are cultural "snapshots" whose relevance can now be disputed in a contemporary analysis of nursing and gender.

The analysis that I have produced is, therefore, only one of many interpretations that could emerge from a study of men and nursing and I accept that others may disagree with particular aspects of this interpretation. Prolonged engagement has allowed me to be open to the multiple factors that impact upon the phenomena being investigated and has provided the scope to the study, whereas persistent observation has provided depth to the study. Persistent observation and reflection over a number of years allowed the in-depth focus on the themes that appear in this study; thus, as the work progressed those themes

that were initially perceived as the most salient were reshaped and reprioritised by detailed exploration of the literature and through the interview process.

The exploration of the literature and the use of interviews were a form of triangulation: that of the use of different sources of data. The themes that emerged from the exploration of the literature and the opinions being expressed were either confirmed or challenged through discussion with the co-researchers.

Peer debriefing

This involves exposing the work to a disinterested peer in order to illuminate aspects of the research that might otherwise remain implicit. Lincoln and Guba (1985) argued that this should not be undertaken by those in authority to the doctoral researcher such as members of the research committee. I would argue, however, that in this instance my supervisors were part of that process. They constantly spoke of me as the “expert” in this subject and their probing was for elucidation rather than dictates about what should and should not be included. Ultimately, the decision-making was mine; however, perhaps, my nursing experience, role as a lecturer in a nursing degree programme and involvement in men’s issues over the last two decades enabled the development of a peer relationship beyond that usually inherent in the supervisor-student relationship.

Peer debriefing was also ongoing through the use of a peer who has substantive knowledge about nursing and its history. She read the entire work as it progressed and provided written feedback, which provided an opportunity for reflection on the *honesty* and *accuracy* of what I was producing. Two other peers read the aspects of the work pertaining to masculinity and sexuality, both these men have substantive international experience in these areas and they also provided written feedback that became part of the audit trail. This aspect of trustworthiness is consistent with Potter’s (1996) criterion of reader’s evaluations, in which readers are able to make their own evaluations and suggest alternative interpretations.

As well, aspects of the work were presented at two international conferences; one, which focused on issues pertaining to masculinity and the other on medical and nursing history; each event provided the opportunity for challenge and reflection.

The tentative conclusions were also presented at two seminars in two different schools of nursing and aspects of work in progress appeared in nursing publications in

New Zealand and Norway; again challenge, reflection and revision ensued. As a final source of peer debriefing a weekly meeting with two other doctoral students occurred over a 10 month period in which findings and methodological issues were discussed and debated.

Member checks

Lincoln and Guba (1985) contended that:

The member check, whereby data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected is the most crucial technique for establishing credibility. If the investigator is to be able to purport that his or her reconstructions are recognizable to audience members as adequate representations of their own (and multiple) realities, it is essential that they be given the opportunity to react to them. (p. 314)

This occurred both during and post-analysis. Two of the co-researchers were provided with a copy of the work; one as it was being written and the other at the end of the writing up stage. Their comments were considered and this led to some re-thinking and re-writing of the analysis. Most saliently, neither of the co-researchers disagreed with the substantive findings of the work; indeed, both were positive that an alternative voice was emerging and one that acknowledged the complexities and difficulties encountered in their professional lives. It is arguable that this criterion is analogous with Potter's (1996) notion of participant's understandings.

Negative case analysis/deviant-case analysis

While the purpose of discourse analysis is often to reveal some pattern with respect to a phenomenon of interest some of the most useful cases may be those that appear to go against the pattern. Their singularity may provide confirmation of the pattern (Potter, 1996). Not all the co-respondents experienced the individual issues raised in the interviews as personally problematic; however, they were able to identify from their own position the standard pattern of the issue of interest and provided useful commentary from their perspective as to why that pattern existed.

Transferability.

Lincoln and Guba (1985) argued that it is not the responsibility of the researcher to “provide an *index* of transferability” (p. 316). The responsibility of the researcher lies in providing sufficient contextual data, or “thick description”, such that the reader can make a judgement of transferability. Thus, Sandelowski (1986) proposed the notion of *fittingness*:

A study meets the criteria of fittingness when its findings can ‘fit’ into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences. (p. 27)

To the extent that those nurses – both male and female – who have read this have all commented that they have found this study meaningful in the context of their own experience and provided an opportunity to view their experience from the perspective of another it can be contended that this work meets the criterion of transferability.

Dependability

A way in which the study can be shown to be dependable is through an audit (Lincoln and Guba, 1985). As Sandelowski (1986) noted a study and its findings are auditable when another researcher is able to follow the decision trail used by the investigator in the study. This requires explicit discussion of the theoretical, methodological and analytic choices taken throughout the study. Reflective note making occurred throughout the study and elements of this have appeared in the theoretical and methodological chapters that formed the first section of this work; the research decisions were signposted in those early chapters.

Confirmability

Confirmability according to Lincoln and Guba (1985) can be achieved as part of the audit to determine dependability: a process that is supported through the maintenance of a reflexive journal. Koch and Harrington (1998) also exhorted researchers “to incorporate a reflexive account into their research product by signposting to readers ‘what is going on’ while researching” (p. 882).

Over the years my attempts to maintain a diary or journal have never met with success over the long-term; I was doubtful that I would be any more successful at this stage of my life. Therefore, I maintained a reflexive *tool* throughout the research process. I developed a reflexive wall in my study upon which I posted insights, questions, issues to explore, matters to return to and so forth. The reflexive wall contained: (i) *personal notes*, upon which questions, emerging insights and new directions were posted; and, (ii) *methodological issues* which signalled areas for further exploration. It was this process that led to the change in the pre-enrolment period when I moved from a conceptualisation of a project around men's experience of prostate cancer to the focus on men in nursing and subsequently the revision of the methodology after the first year of engagement with the literature. My wall was a constant presence that was better suited to my more visual creative process and challenged my thinking as I wrote.

Authenticity

Guba and Lincoln (1989) proposed five authenticity criteria: fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity. As the authors themselves noted these criteria were also not received without challenge (Lincoln & Guba, 2000). It is difficult to assess to what extent this study has met the hallmark of authenticity as the last four criteria focus on the ability of the study to have social and political impact. Ontological and educative authenticity respectively relate to the raised awareness of both the research participants and those who surround them and the extent to which the research helps those involved one another's perspectives. Catalytic and tactical authenticities are concerned with the ability of an inquiry to prompt action on the part of the research participants and the involvement of the researcher in training participants in social and political action if wanted by the participants.

Responses such as "I hadn't thought about that" or "I want to get back to you about that" from some of the co-researchers during the interviews could be read as the first steps in raising the level of awareness with respect to some of the issues. While it is to be hoped that this study has generated new awareness and action amongst the participants that would appear to be a response that is better evaluated from a future perspective. As Bryman (2001) noted the authenticity criteria have generally not been as influential as the criteria of credibility, transferability, dependability, confirmability and it may be that the

criteria to determine authenticity are better associated with specific form of naturalistic inquiry such as action research.

The criterion of *fairness* is about balance, that “all stakeholders views, perspectives, claims, concerns, and voices should be apparent in the text” (Lincoln and Guba, 2000, p. 180). Thus, the evaluative focus is turned back on to the researcher as the key research instrument (Carpenter & Hammell, 2000). By my earlier declarations of my positioning, both biographical and philosophical, the reader has some measures with which to assess the extent to which my own positions have affected my engagement with the subject matter, data collection and analysis. The best I can argue is that by the reflexive process I have striven to ensure that the findings have emerged from the data and not from my own positioning.

Coherence

The final consideration with respect to rigor in this work is that of coherence. To what extent does this study draw upon previous work and provide a check of the adequacy of previous studies? Given the proviso that this is work is only one of the possible readings or explanations of men’s experiences of being nurses I would argue that it demonstrates coherence through building upon (and incorporating) the work of others in subject areas related to gender and nursing. It has challenged the adequacy of previous explanations of the male experience in nursing by suggesting that the use of normative templates to describe gender and the experiences of those who do not conform to gender norms do not account for the complexity of such a phenomenon. Incorporation of new research into and understandings of masculinity has allowed a new perspective on men who are nurses in New Zealand.

Synthesis

This study has highlighted that although men have a long and rich tradition of involvement in nursing they have been excluded, or at best marginalized as footnotes, in nursing’s history, such that a substantive study of men’s history in nursing has not yet been written. This work has provided an overview of men’s involvement in nursing and has placed the history of men in nursing in New Zealand within the international context.

One of the original aims of this study was the identification and analysis of the socio-political factors impacting upon the development and maintenance of the subculture of men in nursing. This has been achieved through the synthesis of the experience of New Zealand men who are nurses with that of other men who are nurses, within the context of the construction of Western masculinity, to highlight the points of congruence and the areas of divergence. In this way it contributes to the growing body of literature that investigates men's experience and, in particular, to the limited body of work within New Zealand with respect to men and nursing.

A serendipitous outcome is a contribution to the growing body of studies using discourse analysis that has recently emerged in nursing. It is surprising, as Brown, Crawford, Richards and Nolan (1999) noted, that "despite nursing being one of the most intensive 'people contact' jobs in existence, until recently the role of language in nursing has been curiously ignored by scholars and nurses themselves" (p. 23).

Outdated thinking about men, masculinity and nursing.

With respect to the nursing literature what emerged as the study evolved was the realisation that, to a considerable extent, the literature was outdated. Interestingly, and perhaps frustratingly, as I arrived at the point of writing this chapter I found a paper that highlighted this very point. Willis (1999) argued, in the Australian context:

This literature has failed to keep pace with the impact the workplace reforms of the 1990s that have produced flatter structures, up-skilling and multi-skilling of lower level nurses, opportunities for ward based innovations in the interest of efficiencies, and shifts in the mix of nursing levels but fewer opportunities away from the bedside. (p. 298)

This has considerable implication with respect to the notion of establishing where the areas of divergence and convergence are. The areas of divergence between the New Zealand men's experience and that described in the international literature may actually reflect the lack of contemporary literature. Therefore, the New Zealand men's experience may emerge as different not because of a different cultural context *per se* within which the studies are located, but because of the historical and sociocultural changes that have

occurred, over the last twenty years in particular, in understandings of, and operationalization of, masculinity.

Challenging orthodox readings about men and nursing.

The nursing literature with respect to the men in its ranks is not only out of date, but from prolonged in-depth engagement it is difficult not to conclude that it is biased, or at least blinkered, with respect to the prevalent discourse about men in nursing. By-and-large a negative reading emerges that does not consider alternative readings outside of the conventional orthodoxy of patriarchy and men's subjugation of women to their own interests. A paradox that emerges is the contrast between the literature that deconstructs and challenges thinking about women, nursing and caring yet perpetrates the stereotyping of traditional sex role theory with respect to men.

I am not wanting to blame nursing and researchers into nursing, *per se*, for adherence to essentialist stereotypes; given the overarching societal discourse of patriarchy it is understandable that women researching women would want to deconstruct their experience for their benefit. It may be that the time is now ripe to also widen that deconstruction to men in nursing as it may benefit nursing through the greater understanding of the contributions that both genders can make to the profession with respect to patient care and creating an environment that supports each individual's career aspirations equally.

It was suggested in Chapter Ten, with respect to sexuality, that nursing is a reflection of the society in which it is positioned and which continues to construct to nurses as female, holding to the notion, "Men, men aren't nurses, real men aren't nurses." As a profession; however, nursing has argued its primacy with respect to patient advocacy and claimed a greater focus on caring. It has also questioned the construction of nurses as the doctor's handmaiden; thus, it can be challenged with respect to its lack of advocacy for, and support of, men who challenge gender stereotypes by moving away from the "malestream" to develop careers in a caring profession.

With respect to one of the original aims described on page seven, the extent to which nursing values and supports the minority subculture within the dominant discourse, it would appear that the dominant reaction is ambivalence.

“Islands of masculinity” or gendered ghettos?

Nursing has challenged the subjugation of women, as nurses, to men, as doctors, within the wider patriarchal discourse of men’s domination of women. This challenge has not been extended to acknowledging that men who do not adhere to hegemonic scripts of masculinity are also subject to discrimination and practices of exclusion. As this study has revealed, the experience of men who are nurses in New Zealand has been one in which they have been actively kept out of nursing and, once allowed in, kept apart from nurses and the work of nursing. It is an experience that is paralleled in many countries. The interesting paradox with respect to this finding is that it has been rationalized by many writers on nursing that this exclusion has been men’s choice to maintain their masculine identity.

This work does not argue that men do not wish to maintain their identity as men; however, it does argue that the identity that has been constructed for them is limiting and that they seek to express themselves more fully as men. What is revealed here is that men have created “islands of masculinity” within nursing because for long periods much of nursing was denied to them; therefore, they took the avenues available. Thus, for example, denied entry into the professional nursing organizations they formed, or joined, unions. These unions, in some instances such as psychiatric nursing in New Zealand, negotiated better pay and conditions which benefited all nurses who worked in that area, not just men.

This work has shown that being denied the title nurse has not excluded men from caring, but that their care has been hidden by the labels placed upon them: keeper, warder, attendant, orderly and so forth. Because these words often have an association with a custodial role they mask the caring that can, and did, occur in these roles and encourage a focus on male strength and its use for restraint. This has created another of the paradoxes within the profession’s history: men being recruited for such duties, particularly within psychiatric nursing, and then being criticised for not connecting with the emotional aspects of nursing.

Ensuring masculine status or demonstrating an alternative masculine model?

An aspect of the male stereotype (or sex role) has been the notion that men must be self-reliant and assume roles of leadership. This has proven problematic within nursing. The unequal gender ratio in leadership positions in nursing, with men holding disproportionately a greater number of such positions, has led to theorising that it is a man's way to avoid the role strain attendant upon being both a man while simultaneously positioned within a "woman's" occupation. The co-researchers in this study have refuted that and provided rationale that talk about pursuing such roles being a way to better combine familial responsibilities – whether or not such notions are outdated – and career. They also suggested that career is a way of doing care; being in a position of authority allows one a greater opportunity to effect change: change which is directed toward improved patient outcomes. Interestingly, when this finding is compared against one of the more recent international studies of men in nursing congruence is found. According to Willis (1999) men move out of ward work "as they become frustrated with female nurses' refusal to change or modify working practices" (p. 304).

There is the possibility of another reading, or construction, of men's move into leadership. One of the meanings of the verb to *lead* is to "cause or go with one, esp. by guiding or showing the way or by going in front and taking a person's hand or an animal's halter" (Allen, 1990, p. 672); it is also defined as to "guide by persuasion or example" (*ibid*). It can be contended, therefore, that men who are able to move away from masculine stereotyping and demonstrate caring in a public forum are, indeed, "guiding", "going in front" and demonstrating an "example". That many men, at various times in their nursing careers, continue to exhibit such tendencies is, therefore, not surprising and rather than reflecting adherence to some expected male norm may reflect an inherent characteristic of their individual make-up. It has been shown that there is considerable pressure on men to conform to that expectation yet examples have been provided of men who have chosen not to, or else have been comfortable to step down from leadership roles. The interplay between gender, individual traits and career development is too complex to reduce to simplistic models of gender essentialism.

Avoiding physical intimacy or keeping oneself safe from harm?

With respect to men's movement away from ward work another reading can also be offered. Chapter Ten highlighted the issue of the problematization of men's sexuality, not only are men as nurses constantly required to defend and justify their career choice, but they are also painted as sexual predators whether homosexual or heterosexual and are subject to sexual harassment. Therefore, does the move away from ward work, in particular areas where intimate physical contact is required, also represent away of keeping oneself safe from accusations of sexual impropriety?

This study also challenges the long held belief that men in are nursing are likely to be homosexual. Not only does it appear to be an erroneous assumption but it is one that constructs a barrier for some men with respect to entering the profession and proves an obstacle for men to provide intimate care to one another. The fact that an assumption of homosexuality may be a deterrent to some men entering nursing and that barriers can be created between men demonstrates the institutionalised homophobic discourse which impacts upon all men who are nurses.

Emotional labour or labouring to avoid emotion?

This work has challenged long held beliefs about men's engagement in, and with, caring, especially the emotional labour of care, and reveals that men direct considerable effort to the psychosocial aspects of the nurse-patient interaction. The men who participated in this study have revealed that rather than wanting to avoid intimacy, it was a caring impulse that brought them into the role. The fact that they were more likely to enter nursing later than female counterparts is not surprising given that they must overcome the conditioning of the masculine stereotype in the first instance. The masculine stereotype requires men to eschew any demonstration of feminine behaviour and although its pre-eminence in men's lives may be weakening it still remains a potent force.

Rather than avoiding emotional intimacy their caring is based upon communication, developing empathy and the situational context. It is arguable that their exclusion from the conversations and cultural interests of their female colleagues gives them more time for greater focus on their patient's needs. The man working in the

nursing context is often isolated and perhaps, at times, lonely therefore his “spare” time is more likely to be spent sitting with and talking to the patients.

Within psychiatric nursing the development of, and common use of, psychotropic medication has lessened the need for masculine strength with respect to patient management, yet this area remains attractive to men entering the profession. No doubt part of its attraction is the fact that the stigma of homosexuality is less prevalent there and the greater numbers of men has created a culture that is less female-focussed; however, is it also possible that psychiatric nursing having greater emphasis on therapeutic communication is also what attracts men into the role?

The prevailing assumptions about men, masculinity and caring have created a situation in which there are more obstacles for men to overcome when wishing to demonstrate caring. There is less that they can take as given within the patient-nurse interaction and therefore they must labour to create a relationship of trust. Their focus is thus more on the psycho-social aspects of the patients’ care. This has lead to suggestions that men are lazy and less likely to engage in the domestic tasks of nursing. The men in this study refute this arguing that they work very hard to be seen as doing their share of the tasks.

It could equally be argued that nursing’s traditional emphasis on the domestic aspects of nursing care, particularly in general nursing, has enabled generations of nurses to avoid, or to have little time for, the emotional labour of nursing. Men’s putative avoidance of the nursing “housework” and less involvement with the feminine culture of nursing has possibly created a situation in which their focus is on understanding and providing for the patient’s articulated needs. That such a focus is valued is demonstrated both in studies that have emerged in the literature and in the positive feedback that the men in this study described.

Limitations and suggestions for further research

What are the possibilities left undisturbed, the passages not trodden, the doors left unopened? (Smythe, 1998, p. 246)

Smythe (1998) acknowledged the “voices that did not get an opportunity to speak” (p. 246) and I, too, feel that keenly as I reflect on those I would have liked to have talked to, continue to have referred to me and, perhaps, whom I should have included in this study. The voices of eighteen New Zealand men are heard in this study; however, numerous others, both from New Zealand and abroad, are given voice through the work of other writers which informs this research.

Within the context of bicultural New Zealand, a noticeable limitation is the fact that this work only provides a Pakeha male perspective. An attempt was made to include at least one Maori man in this study and although he agreed to participate we were unable to meet to conduct the interview before I departed for a year's work in Norway at the end of 2003. Any future study of this nature in New Zealand should reflect the multiethnic nature of the population and needs to include the experience of Maori, Pacific Island and Asian men, particularly as they are further marginalised by the script of hegemonic masculinity.

A problem has been the lack of literature about men and men in nursing in New Zealand. This work has predominantly had to rely on overseas literature. This can be perceived as a limitation with respect to the exploratory process that has occurred and the linkages that have been made between the international literature and New Zealand men's experience. Paradoxically, this is also a strength; this work breaks new ground and has illustrated the danger for nurses, both in clinical practice and in education, with respect to assumptions being made about male students and colleagues based on research and theorizing that does not reflect the local context.

The work is limited in its transferability by the lack of contemporary literature, both internationally and domestically, for comparison with respect to the findings. It has revealed, however, that what does exist is outdated. Therefore, it is risky to extrapolate into the contemporary context the findings of studies that emerged in a different period of gender relations.

To what extent is the study limited by my identification with the topic and the subjects? This is a question that has accompanied me throughout the process. Ultimately, it is up to the reader to determine. I believe the process of auditing has been rigorous enough to allow me some confidence that this work is trustworthy, yet there remains the question, "Have I seen what I wanted to see?" It is possible that this work will challenge some nurses to the extent that it will be dismissed as a biased *male* reading, that it is a work of male victimology.

I do believe still, however, that men, as individuals, can be the victims of patriarchy that restricts their professional and emotional choices. I doubt that any of the men who participated in this study would describe themselves as "victims" and in fact the contrary can be argued because they have refused to acquiesce to the narrow hegemonic definition of masculinity and notions of appropriate roles for men. Certainly they expressed frustration at times in the interviews but there was no sense of them identifying as victims. They have created fulfilling professional lives for themselves within nursing and when those roles no longer provided the requisite satisfaction they found alternatives.

It is possible that the wide scope of this work limits its impact. Each of the themes that has emerged in this work is worthy of in-depth exploration and could potentially provide the scope for a dissertation. During the writing of the analysis an internal debate occurred as to whether in fact there should be a specific focus on one particular aspect or theme, such as caring. Further change to the topic to encompass such a specific focus was ruled out. This decision was based, in part, on the fact that the interviews had been undertaken with the intention of capturing a broad picture of the co-researchers' experiences and, in part, because such a broad overview in the New Zealand context had not been undertaken before. It may be that such an overview will generate opportunities for more specifically focused research aimed at further unpicking, explication of, and challenge to the phenomena identified in this work.

I would argue that this thesis has highlighted the imperative to investigate nursing's preparation of its male practitioners given the complexity of the interaction between the profession, masculinity and caring. As well, further research is warranted into how men deliver care, its value to the patients and how nurses, both male and

female, can construct an ethic of care that blends differing approaches for the benefit of the recipients of care.

Concluding statement

I will own that I have seen what I wanted to see: the emergence of a different voice. This work has provided an alternative reading to prevailing discourse on men, masculinity and caring. It has challenged the majority voice in the literature and it counters what others have told me about men and nursing. It does not accurately reflect my story or my reality and no such claim would be made with respect to any of the men whose stories were shared in these pages. I would argue that it presents a closer approximation of reality for men in nursing than is generally found in the nursing literature.

What enables me to make such a claim? On page 381 the process of member checking of this work was described; the co-respondent who read this work used the analogy of a “rugby team”. He commented that each of the men displayed different strengths or had a different focus, or a different issue, but that there was a sense of “connectedness” that held them together as a team. For him there was a real sense of identification with the other men: “I know I didn’t say that, but I know what he means.” He also related that reading this work had been an emotional experience, because this work revealed to him the connectedness that he has with other men in the profession and because, he commented, the voices of men in nursing are rarely heard and this work provided a vehicle for this to occur in the New Zealand context.

The voices presented in this thesis offer the possibility to challenge taken-as-given assumptions about men, nursing and caring. It provides an opportunity for nurses to gain a different understanding of the experience of their male colleagues. It offers an opportunity to acknowledge that men who nurse are challenging essentialist stereotypes and providing other men (and women) with another model for what masculinity can be.

APPENDIX A: Participant information sheet

School of Nursing
FACULTY OF MEDICAL AND HEALTH



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

University of Auckland

Private Bag 92019

Associate Professor N.North

Post-Graduate Co-ordinator

School of Nursing

Ph. No. (09) 373 7599

Fax No: (09) 367 7158

PARTICIPANT INFORMATION SHEET

Title: Men Who Are Nurses in Aotearoa New Zealand: A Critical Study

To: Subjects

My name is Thomas Harding. I am a student at the University of Auckland enrolled for a PhD Degree in the School of Nursing, Faculty of Medical and Health Sciences. I am conducting this research for the purpose of my thesis on men who are nurses. I have chosen this field because I am a Registered Nurse and I would like to critically describe, with reference to historical and contemporary perspectives on masculinity, the experience of men who chose a career in what is a predominantly female profession.

You are invited to participate in my research and I would greatly appreciate any assistance you can give me. As part of my thesis I am asking a number of men who are currently employed as nurses, or who have been employed as nurses in New Zealand, to reflect upon their nursing careers and to describe the experience of being a man in a

female-dominated work force. If you agree to being involved in this project as a subject you may choose from two options as to how you will participate:

- 3) Face-to-face interview only, or
- 4) Provision of written personal written material in which you have reflected upon your career as a nurse, followed by a face-to-face interview to discuss the material provided. The written material can be selected from diaries and journals (or other material you think relevant) that you have kept during your career or else you may choose to write about your experience as a man who is a nurse from your current perspective.

I hope that you will consent to participate in this project, but choosing to read this information places you under no obligation at all to participate. I would anticipate that the interviews will take a minimum of two hours and that it is possible that there may be more than one. You do have the right to terminate the process whenever you wish. The interviews will occur at a time that is convenient to you. I would prefer to audio tape the interview but this would only be done with your consent and could be turned off at any time or you can withdraw information any time up to the commencement of the writing of the findings. It is anticipated that this will commence in July 2004.

You will be provided with an opportunity to read a transcript of the interviews and to withdraw material or alter material for the purpose of clarifying your intended meaning at the time of the interview.

If you do wish to participate in this project please let me know by filling in a Consent Form and sending it to me or by phoning me on Tel: 834-4976 after hours, or 815-4321 during work hours. Your name will not be used in any publication about this research. It is possible given the relatively small numbers of men who are nurses in New Zealand that there may be those reading the finished work who may assume that they can identify a particular respondent. I will endeavor to ensure that you will not be identifiable through the information you provide; names will be changed, geographical

data excluded, and the description of circumstance will be kept to a minimum as much as possible.

Thank you very much for your time and help in making this project possible. If you have any queries or wish further information please phone me at either of the numbers given above or write to me at:

The Division of Nursing
Faculty of Medicine and Health Sciences
The University of Auckland
Private Bag 92019
Auckland.

My supervisor is: Dr. Nicola North
Faculty of Medicine and Health Sciences
The University of Auckland
Private Bag 92019
Auckland.
Tel: 373-7999 extn. 82931

The Head of Department is: Associate Professor Judy Kilpatrick
Faculty of Medicine and Health Sciences
The University of Auckland
Private Bag 92019
Auckland.
Tel: 373-7999 extn.

For any queries regarding ethical concerns please contact:

The Chair
The University of Auckland Human Subjects Ethics Committee
The University of Auckland Research Office
Office of the Vice Chancellor

Private Bag 92019

Auckland.

Tel: 373-7999 ext. 87830

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS COMMITTEE on 12
March 2003 for a period of 3 years, from 12 /03/03.

Reference2003/038

APPENDIX B: CONSENT FORM

School of Nursing
FACULTY OF MEDICAL AND HEALTH



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

University of Auckland

Private Bag 92019

Associate Professor N.North

Post-Graduate Co-ordinator

School of Nursing

Ph. No. (09) 373 7599

Fax No: (09) 367 7158

CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Title: Men Who Are Nurses in Aotearoa New Zealand: A critical study

Researcher: Thomas Harding

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered.

I understand that I may withdraw myself, or any information traceable to me, without giving a reason at any time up to the commencement of the writing of the findings. It is anticipated that this will occur in July 2004.

- I agree to take part in this research
- I understand that the interview(s) will be audio taped.
- I agree that any written material I provide may be utilised as part of this research.

Signed:

Name:

(please print clearly)

Date:

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS COMMITTEE on 12
March 2003. for a period of 3 years, from 12 /03/03
Reference 2003 /038**

APPENDIX C: INTERVIEW SCHEDULE

The following is a list of questions or prompts that were used during the interview process:

- Describe the circumstances, which lead to your decision to pursue a career in nursing.
- Was becoming a nurse a long held career goal?
- Tell me about your nursing education.
- How did your family and friends react to your decision to become a nurse?
- Describe your experience as a man working in a female-dominated profession.
- Are there issues or events in your career that stand out because of their personal or professional impact in which you think your gender played a key role?
- How do/did the patients respond to you as a man who is a nurse? Are there any events or responses that particularly stand out?
- Tell me about how it is to provide intimate care for a member of the opposite sex.
- There appears to be a belief that many men who chose nursing are homosexuals. Is this true, do you think?
- Have there been any issues for you in relation to providing nursing care for other men?
- Tell me about the career moves you have made. What has lead to the choices you have made?
- Do you think there are constraints upon men's participation that women do not experience?
- Are there advantages to being a man in the nursing profession?
- Do you think that men and women practice nursing differently? Is there some quality or characteristic (beyond the mere physical attributes of gender) that men bring to the role?
- How important is moving upward, e.g., position of responsibility, to you in career planning?
- Where do you envisage your career taking you?
- What satisfies/ satisfied you about your nursing role(s)?

- **What dissatisfies/dissatisfied you about your nursing role(s)?**

APPENDIX D: KEY TO TRANSCRIPTIONS

[]	Material deliberately omitted
[text]	Clarificatory information
TEXT	Word(s) emphasized
Text -	Speaker interrupted
Text ... text	Long untimed pause

Example of original transcript

Yeah. Why? Probably the whole stems...when I was 13 my granddad died in those days of throat cancer when I was 13 and our doctor in Reefton...I always remember quite clearly, Thomas, there was 14 grandsons. I was in the middle of the age group and I was the only grandson who would go and see granddad...because he rung me up one night I was at a youth meeting and he said is Grant there? and the Priest Father Max said yeah, yeah and he said I think he needs to come now and see Grandad and I was the only grandson that went to see him now I don't know why, but I always remember that death even now.

Example of re-translated transcript

Probably the whole stems [from] ... when I was thirteen my granddad died [] of throat cancer [] And our doctor-I remember quite clearly, Thomas, there were fourteen grandsons; I was in the middle of the age group, and I was the only one who would go and see granddad – he rang up one night, I was at a youth meeting, and said, “Is Grant there?” [] “I think he needs to come now and see granddad.” [] Now I don't know why, but I always remember that death, even now.

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