

THE CONTEXTUAL PERFORMANCE OF MASCULINITY AND CARING BY MEN  
NURSES: AN EXPLORATION OF MEN'S CARING WITHIN A PROFESSION  
NUMERICALLY DOMINATED BY WOMEN

by

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Dedicated to:

My wife Lynda and my daughters Sophie and Julia for  
their love and support in all aspects of my life

My mother Brigid, the most influential Registered Nurse  
in my life who showed me what caring is

My father Neil, for always supporting me and  
encouraging me in my personal and professional life

My sister Anne, who has always been my best friend  
and an ongoing source of support

## Abstract

The transcripts of 21 individual interviews and three focus groups of Canadian men in nursing generated by the SSHRC funded study “Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female Dominated Professions of Nursing and Elementary School Teaching,” underwent secondary qualitative thematic analysis. Informed by the theoretical framework of masculinity theory, the study’s purpose was to describe how men nurses’ caring was conceptualized and expressed in their interviews. The *contextual performance of masculinity and caring* constituted the core theme, and a thematic map illustrated the relationships between eight performance sub-themes, two contextual sub-themes, and eight contextual elements accounted by this overarching theme.

Consideration of the generated themes in the context of existing literature demonstrated considerable support for the study findings, and clearly identified the performance of masculinity as a significant influence on expression of caring by men nurses.

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## Chapter 1

### Introduction

#### Study Background

All the world's a stage,  
And the men and women merely players;  
They have their exits and their entrances;  
And one man in his time plays many parts,  
His acts being seven ages (Shakespeare, pp. Act II, Scene VII, 139-143).

Men and women are engaged in a performance of gender throughout their lives based on socially constructed, and constantly revised, definitions of what it means to demonstrate masculinity or femininity in a given context (Connell, 1995; Connell & Messerschmidt, 2005). Furthermore, the performance of gender takes on special significance when the professional role an individual adopts falls outside commonly accepted performances of masculinity and femininity. Men in the nursing profession represent one interesting example that demonstrates the profound influence gender performance can have on men's choice of profession, their work practices, and their career paths. Men in nursing are engaged in a caregiving role, associated with essentialized notions of femininity (Fisher, 2009; Forrester, 1988; Poole & Isaacs, 1997). In addition, men in nursing are also concurrently engaged in a performance of masculinity, that must be deemed acceptable to them and the audience witnessing their performance (Connell & Messerschmidt, 2005). How do men nurses navigate the potential contradictions and tensions they face in their daily performance of nursing care and masculinity? This is the underlying question that precipitated the following qualitative exploration of the co-performance of masculinity and caring. In this study, a

preexisting data set of interviews and focus groups with Canadian men in nursing (Evans, et al., 2007) was subjected to thematic analysis. Informed by current perspectives on the complex, and often contentious, concepts of caring and masculinity, this study sought to clarify how the performance of masculinity influences the performance of caring, while also seeking to explain how the common patterns of masculinity and caring performance influenced the practice lives and career paths of the participants.

To be consistent with a social-constructionist perspective on gender, the use of the terms “male” and “female” are used sparingly in this thesis, except when the use of these terms is consistent with the concept being discussed, or when the perspectives of another person are being directly quoted. The terms “male” and “female” refer to the genetic assignment of chromosomes (XX and XY), which define the biological sexual characteristics of individuals; however, gender is a socially constructed performance by each individual (Coltrane, 1994). Performances of gender are often unique and subject to constant revision, and these performances are often not congruent with essentialized perspectives that assign a “sex role” based on biological sex. Therefore, “male” does not always equate with the performance of masculinity, and “female” does not always equate with the performance of femininity within a given context.

**Caring.** Caring is identified as a fundamental concept in the profession of nursing. However, debate and confusion abounds in the nursing literature regarding the nature and description of caring (Brilowski & Wendler, 2005; Gaut, 1993; Godkin & Godkin, 2004; Horrocks, 2002; Kapborg & Bertero, 2003; MacDougall, 1997; McCance, McKenna, & Boore, 1999; Milligan, 2001; Morse, Solberg, Neander, Bottorff, &

Johnson, 1990; Paley, 2001; Paterson, et al., 1995; Paterson, et al., 1996; Radsma, 1994; Scotto, 2003; Skott & Eriksson, 2005; Spichiger, Wallhagen, & Benner, 2005; Sumner, 2004; Wilkin, 2003). Many nursing scholars have attempted to articulate the common understanding of caring within nursing, which is socially constructed by the membership of this profession, and is made explicit through the literature and practice of nursing. Study after study has sought to provide comprehensive descriptions of what caring means to the nursing profession from a theoretical and practice point of view, through examination of what nurses and their clients have to say on the topic (Paley, 2001). The result of this ever expanding field of research has primarily been a growing collection of lists and models, that identifies categories, themes, factors, constructs, characteristics, attributes, and associations about the concept of caring (Paley, 2001). The performance of caring behaviors and interventions by nurses are inevitably interpreted through the lens of these common understandings, and are subsequently judged as being appropriate, or not, based on these socially constructed caring norms. If nursing judges the appropriateness of caring practices based on this collective understanding of what caring means to the profession, it becomes important to ask what socio-political factors have influenced the construction of this important concept. Of particular interest to the current study is the influence of societal gender perspectives on the concept of caring and the practice of caring by men nurses.

**The influence of essentialist notions of gender.** Since nursing is numerically dominated by women, there is common agreement that the profession is generally “feminized” by society (Anthony, 2004; Bartfay & Bartfay, 2007; Evans, 2004a;

Harding, 2005; Harding, North, & Perkins, 2008; Kelly, Shoemaker, & Steele, 1996; Meadus, 2000; Meadus & Twomey, 2007; O'Lynn, 2007a). Given its association with the “feminine”, the social construction of caring in nursing is undoubtedly influenced by essentialized perspectives on the performance of femininity held by many members of the profession, by other health care providers, and by the clients for whom nurses provide care (Coltrane, 1994; Forrester, 1988). The professional title of “nurse” also further contributes to the essentialized feminization of the role by conjuring up visions of mothering, breast feeding, nurturing, and gentleness which are consistent with essentialized notions of femininity (Forrester, 1988; Harding, et al., 2008). It is also worth noting nursing research articulating the concept of caring, has primarily relied on the analysis of words and perspectives of study samples predominantly comprised of women, without sufficiently addressing the influence gender may have on the formation of the concept of caring in nursing and society (Paley, 2001).

Men entering nursing generally tackle similar issues to women in the delivery of appropriate nursing care to their clients. In contrast to women, men may also have to overcome the additional barrier of proving themselves an acceptable and valid caregiver to their women colleagues and their clients of both genders (Evans, 2001; Harding, 2005). Essentialized masculinity is frequently presented as the antithesis of feminized caring with an emphasis on instrumental behaviors, assertiveness, autonomy, detached decision-making, dominance, strength, and power, thereby creating the potential for conflict between essentialized perspectives of masculinity and the performance of acceptable nursing caring (Coltrane, 1994; Forrester, 1988; Harding, et al., 2008). As a

result, men nurses may find themselves balancing on the imaginary line between masculinities and femininities, because as men they are still engaged in the performance of masculinity, while concurrently engaged in practicing caring within the feminized profession of nursing.

**Recognizing the limitations of gender essentialism.** Despite the pervasiveness of essentialist notions of gender in society, it should be noted essentialism has been soundly and scientifically dismissed as an oversimplified dichotomization of gender by most theorists in the area of gender studies (Coltrane, 1994; Connell, 1995, 2000; Connell & Messerschmidt, 2005). Multiple masculinities and femininities can be constructed based on the historical, cultural, social, political and contextual influences that contribute to their formation (Connell, 1987, 1995, 2000; Connell & Messerschmidt, 2005). There is therefore no single construction of masculinity or femininity, or one static form of masculinity for even a single individual, because any conceptualization of masculinity is under constant revision and renovation (Connell & Messerschmidt, 2005). Collective masculinities may exist within a given group like men in nursing, but these patterns of conduct can never fully represent any individual man's sense of masculinity, since each person may feel differing degrees of affinity for certain collective masculinities or aversion to others.

Although essentialist notions of gender have been shown to be inadequate in terms of addressing gender by scholars in the area, most people in society persist in conceiving gender in essentialist terms (Coltrane, 1994). It is therefore necessary to acknowledge the influence essentialism has on the day to day enactment of gender

performances. For example, if individuals are socialized to associate masculinity with being stoic, men may strive to present a brave front when experiencing pain and this expectation may be reinforced by others through statements like “be a man” and “suck it up”. If viewing this situation purely from an essentialist perspective, one might interpret the man’s stoic presentation as an inborn quality; however, viewing gender performance from an essentialist perspective fails to acknowledge the influence of social processes on the man’s performance of gender or the influence of audience composition. A young man may present a stoic performance of masculinity to his teammates following a hockey injury, but the presentation might be very different when the audience to his performance is his mother or girlfriend. For the purposes of the current study, the very real influence of essentialist notions of gender will be acknowledged; however, discussion of the performance of masculinity and caring amongst men nurses will be conceptualized with a recognition of the potential for multiple and contextual masculinities.

**The issue for exploration.** How do men perform caring in a feminized profession and environment that may define caring in accordance with values profoundly influenced by essentialized notions of femininity? Men in nursing are potentially faced with the dilemma of performing caring in accordance with feminized nursing norms, while also attending to the performance of masculinity. It will become clear during the literature review in chapter two, that men in nursing face some significant challenges in terms of navigating the nursing education and practice environments. On one side, men nurses sometimes have to distance themselves from essentialist or hegemonic notions of masculinity to be considered an acceptable caregiver, while at other times they may have

to overcome gender related biases towards certain performances of masculinity that have the potential to influence the therapeutic and caring relationship with clients (Evans, 2001; Harding, 2007). As the topic of men nurses performance of masculinity and caring was explored in this study, it became apparent that many aspects of men nurses' professional lives are influenced by the negotiation of their role as acceptable caregivers within the ever changing context of societal gender expectations, including their approach to delivering nursing care and their choice of practice setting.

### **Purpose**

In this study I explored men nurses' performance of masculinity and caring, while acknowledging the existence of multiple masculinities and femininities and the potential contextual factors that influenced men's conceptualization of caring and demonstration of caring behaviors within their practice (Connell, 1995, 2000; Connell & Messerschmidt, 2005). Data collected by the Social Sciences and Humanities Research Council (SSHRC) funded project "Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female Dominated Professions of Nursing and Elementary School Teaching" underwent secondary thematic analysis (Evans, et al., 2007). This secondary analysis revealed themes about how men nurses talked about the performance of the caring component of their work, how men nurses conceptualized caring, how they talked about the performance of caring, and how they described caring in their practice through exploration of the following research question: *How is men nurses' caring conceptualized and expressed in their discourse?*



## **Significance of the Study**

By exploring how the performance of masculinities influences the performance of caring displayed by the men nurse study participants, this study has the potential to make several positive contributions to nursing. First, the study creates an enhanced awareness of gender influences on the understanding and performance of caring among members of the nursing profession. Second, the study findings provide educators and practice leaders with knowledge and awareness related to potential gender influences on caring, which may lay the foundation for the future development of gender-sensitive evaluation criteria of caring behaviors in nursing. Third, this study adds to the body of knowledge that is informing efforts to address the under-representation of men in nursing. Fourth, the study findings provide a detailed description of the common patterns of caring amongst men in nursing, which sets the stage for a dialogue among men in the nursing profession around the influence of gender in their practice. Finally, this enhanced understanding of men nurses' caring may further contribute to the creation of structures and policy within nursing education and practice environments, that may promote both the recruitment and retention of men in this profession through acknowledgement of the multiple and gendered ways of knowing and practicing caring.

## **Why Qualitative Research and Thematic Analysis?**

Since masculinities and the performance of masculinity are socially constructed and subject to the contexts that influence their creation and expression, there cannot be one stable and consistent conceptualization of masculine caring, thereby preventing any meaningful exploration of this topic utilizing a positivist research approach (Connell,

1995). Engaging in qualitative analysis of the most comprehensive collection of interviews with Canadian men in nursing that currently exists, therefore presented an excellent option to explore the performance of masculinities and caring among men nurses. Thematic analysis (Braun & Clark, 2006) was chosen as the approach to identify themes, potential interactions between themes, and thematic patterns related to masculinities and caring within the previously established data set collected by the SSHRC funded study “Contradictions and Tensions in the lives of Men: Exploring Masculinities in the Numerically Female Dominated Professions of Nursing and Elementary School Teaching” (Evans, et al., 2007). Thematic analysis also presented an accessible and viable option for a rich description of themes around the common patterns of masculinity and caring within this data set, without the requirement to engage in confirmatory interaction or application of a method that requires a constant comparative approach (i.e., grounded theory) (Braun & Clark, 2006). By exploring the participants’ discourse around masculinity and caring, it was possible to give voice to the diversity of masculine conceptualizations and performances of caring, as expressed in the discourse of these men. The underlying assumptions of this thematic analysis included: utilizing a primarily inductive approach to analysis without an established a priori coding frame, and exploration of latent or interpretive level themes from a constructionist perspective (Braun & Clark, 2006). This approach to thematic analysis was congruent with the nature of the study topic because it acknowledged these emerging themes were socially produced rather than an inherent existing element of an individual. In addition, this

approach to data exploration acknowledged the socio-cultural context of the generated themes (Braun & Clark, 2006).

## **Chapter 2**

### **Study Context and Literature Review**

#### **Current Distribution of Canadian Men in Nursing**

There have consistently been low numbers of Canadian men in nursing over the past century (Evans, 2004b). In 2007, 5.8% of Canadian Registered Nurses were men, with 40 % of these men practicing in the province of Quebec, “27.5% in Ontario, 11% in British Columbia, 7.7% in Alberta, and 13.8% distributed throughout the remaining provinces/territories”(Canadian Nurses Association, 2009a, p. 2). There is no one definitive contributing factor that has caused this unequal gender distribution, but there are numerous interacting historical, social and political factors that have been identified in the literature as potential influences on men’s low participation in the nursing profession. Some of these contributing factors to the current gender distribution within nursing are explored more thoroughly in the following sections.

#### **Historical Context of Men in Nursing**

Men have been involved in the care of the sick throughout documented history, with men slaves providing care in ancient Greece, and Roman soldiers starting the practice of battlefield medicine in mobile tent hospitals (Brown, Nolan, & Crawford, 2000). In the middle ages, men continued to play a major role in the care of the sick through the work of various military religious orders such as the Order of St. John of Jerusalem, and “other military nursing orders such as the Knights of St. Lazarus, Knights Templars and Teutonic Knights” (Evans, 2004b, p. 322). Non-military monastic orders, such as the Brother’s of St. Antony founded in 1095, also provided nursing care to the

sick (Evans, 2004b). In Canada, the first men to provide nursing care were Jesuit missionaries in 1629, who ministered to the French colonists and Aboriginal peoples of the area for 72 years (Bartfay, 2007). These Jesuit missionaries primarily cared for men because seventeenth century social norms suggested it was inappropriate for men to care for women, consequently these missionaries requested women from a nursing order to come to Canada to help them in their work (Bartfay, 2007). Even in the eighteenth and early nineteenth centuries, men were involved in the care of men patients in charity hospitals in England, and in particular cared for potentially violent patient populations such as those who experienced a psychiatric disorder (Evans, 2004b).

Men's place in nursing took a negative turn in the mid-nineteenth century when the founder of modern nursing, Florence Nightingale, laid the groundwork for nursing as a woman's occupation (Brown, et al., 2000; Evans, 2004b). The nineteenth century also saw some significant philosophical shifts in the perception of masculinity, with a greater emphasis on the avoidance of sensitivity, nurturing and emotion by men (Brown et al., 2000). In addition, the Victorian climate in which Nightingale established her system of nursing education emphasized the separation of gender and a clear division of labor between the sexes (Evans, 2004b). Nightingale's assertion that women possessed inherent qualities that made them natural nurses and the suggestion that men were ill suited for the caring arts was well received in this social and political climate of Victorian England (Brown et al., 2000; Evans, 2004b). Nightingale's perspective on the training of nurses promoted nursing as an extension of women's domestic roles and perpetuated the gender-based power structure of the time that placed men physicians in the position of

power over women nurses and, therefore, created a social structure in health care delivery that was not consistent with the participation of men in the subservient nursing role (Evans, 2004b). In addition, the apprenticeship style of nursing education established by Nightingale also served as a barrier to men because hospital residences were established to accommodate women nursing students, and men students could not be accommodated in this residential based system of training (Evans, 2004b).

In the wake of the Victorian Nightingale era there was a significant decrease in men's participation in the nursing profession, and a perpetuation of discriminatory practices that ultimately resulted in the exclusion and marginalization of men in nursing. When self-regulation of British nursing began in 1919, men were restricted to a separate register apart from their women colleagues by the Royal College of Nursing (Evans, 2004b). Division of men's role in nursing was also reinforced by the redirection of men from general nursing tasks to the care of mentally ill patients because of men's physical size and strength (Evans, 2004b). Men working with the mentally ill also frequently received less education and training than women in general nursing practice, and the Society of Male Registered Nurses was formed in England in 1937 in an attempt to remedy this situation (Evans, 2004b). Despite a gradual increase in women's participation in professions traditionally dominated by men, the first two-thirds of the twentieth century were characterized by a general pattern of low participation by men in the profession, and policies that continued to create barriers to men entering and practicing nursing (Evans, 2004b). Some nursing programs still refused to admit men during this period and in 1961 only 25 of 170 Canadian nursing schools would accept

men as students (Evans, 2004b). In 1951, only 0.33% of all Registered Nurses in Canada were men and by 1966 this had only marginally increased to 0.45% (Bartfay, 2007; Care, Gregory, English, & Venkatesh, 1996). Even the military, which has often been a point of entry into the profession for many men placed restrictions on men nurses (Care, et al., 1996; Evans, 2004b). The United States Army Nurse Corps banned the participation of men until the 1950s, and the Canadian military did not grant commissioned officer status to men nurses until 1967, following an eight year long battle initiated by the Male Nurses Committee (MNC) of the Registered Nursing Association of Ontario (RNAO) on behalf of men nurses in the Canadian military (Care, et al., 1996; Evans, 2004b). Barriers to the registration of men as nurses in Canada existed as late as 1969 when the province of Quebec finally allowed men to be registered as nurses (Care, et al.; Evans, 2004b). Throughout this earlier period of modern nursing history and until the current day, there have been numerous calls to increase the number of men in the nursing profession, however their participation is still proportionally small, and the benefits of greater participation of men in nursing are still an area of debate in some nursing spheres (Evans, 2004; Ryan & Porter, 1993). Some of these ideas will be explored further in later sections of this literature review.

### **Addressing Low Numbers of Men in Nursing**

In response to the pervasive low numbers of men in nursing, there have been repeated calls to attract men to the profession since early in the twentieth century (Evans, 2004b; Meadus & Twomey, 2007). In recent years, this call has become louder and there has been an increasing emphasis on men as a potential source of nurses to address the

worldwide nursing shortage (Armstrong, 2002; Bartfay & Davis, 2001; Evans, 2004b; Meadus, 2000; Meadus & Twomey, 2007; Sherrod, Sherrod, & Rasch, 2005; Tosh-Kennedy, 2007; Villeneuve, 1994). Although it is questionable whether men are the ultimate solution to the nursing shortage, there is still a strong case to increase men's participation in nursing so the nursing workforce is more representative of society's cultural and gender diversity (Sullivan, 2000). If the number of men entering and practicing nursing is to be significantly increased, it is important to consider the supportive factors and barriers to recruiting men into nursing programs in the first place, and the factors that influence their retention and success in nursing education programs in the long run (Anthony, 2004; Brady & Sherrod, 2003; Meadus, 2000; Meadus & Twomey; O'Lynn, 2004).

### **Recruitment and retention of men in nursing.**

**Recruitment.** There are many factors that have been identified as influencing men's decision to consider nursing as a career. First, there is clearly a historical context of nursing being considered a woman's profession, and a pervasive public perception of nurses being women (Anthony, 2004; Bartfay, 2007; Evans, 2004b; Fisher, 2009; Harding, 2005; Kelly, et al., 1996; Meadus, 2000; Meadus & Twomey, 2007; O'Lynn, 2004; Okrainec, 1994; Villeneuve, 1994). The mass media has further reinforced and perpetuated stereotypical images of women in nursing that have done little to help women in the profession or acknowledge the role of men nurses, and there are very few men visible as nursing role models in the media (Anthony, 2004; Bartfay, 2007; Meadus, 2000; Meadus & Twomey, 2007; O'Lynn, 2004; Okrainec, 1994; Villeneuve, 1994). The



association of nursing with feminine roles within society creates a climate where many men may not consider nursing a viable option for them, and some may feel pursuing nursing as a career places their masculinity in question because being a nurse places them outside traditionally defined masculine roles (Evans & Frank, 2003; Meadus, 2000; Okrainec, 1994; Villeneuve, 1994). Unfortunately, there are still attitudes in society that view professions associated with women as less important, or a step down, and these attitudes have also contributed to men being unsupported or even criticized for choosing careers that are associated with women (Abrahamsen, 2004; Evans & Frank, 2003; Meadus, 2000; Williams, 2003). Equating nursing with femininity has also assisted in the propagation of the stereotype of men nurses being gay, and this also contributes to dissonance for some heterosexual men as they consider nursing as a career (Bartfay, 2007; Evans, 2002; Harding, 2007; Meadus, 2000; Meadus & Twomey, 2007; Whittock & Leonard, 2003). Studies that have examined the reason why men have chosen nursing as a profession, suggest some supportive factors to recruiting men include the opportunity to help people (“a calling”), salary, job security, career opportunities, opportunity to travel, and the presence of a nursing role model such as a family member (Bartfay, 2007; Kelly, et al., 1996; Meadus, 2000; Meadus & Twomey, 2007; Villeneuve, 1994; Whittock & Leonard, 2003). Consequently, placing emphasis on these supportive factors during recruitment efforts, debunking stereotypes and myths about men in nursing, increasing the visibility of men as nursing role models in media campaigns, and presenting nursing as a viable career option to young men during high school career counseling have all been suggested as ways to increase the number of men considering a

career in nursing (Bartfay, 2007; Kelly, et al., 1996; Meadus, 2000; Meadus & Twomey, 2007; Tosh-Kennedy, 2007).

***Retention.*** Once a man has chosen to pursue nursing as a career, it is also important the climate within nursing education and practice environments promotes the inclusion and retention of men; however, there is evidence to suggest this is not always the case and there are some gender-based biases within nursing education and practice (Anthony, 2004; Bartfay & Bartfay, 2007; Brady & Sherrod, 2003; Fisher, 2009; Harding, 2005; Harding, et al., 2008; O'Lynn, 2004, 2007a). It is difficult to find current and conclusive statistics that address the attrition of men in nursing programs and in practice. For example, the Canadian Nurses Association [CNA] and the Canadian Association of Schools of Nursing [CASN] nursing education in Canada statistics for 2006-07 do not report statistics related to gender composition in nursing programs or attrition rates in any form (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2008). Several authors have suggested that anecdotal evidence indicates the attrition of men nursing students may be higher than that seen in women (Bartfay, 2007; Brady & Sherrod, 2003; Tosh-Kennedy, 2007; Villeneuve, 1994). Halloran and Welton (1994) reported 85% of men students as compared with 35% of women students do not complete nursing education programs, although the source of these statistics is not reported. The American Association of Colleges of Nursing have also reported about half the men who enter baccalaureate programs in nursing leave the program by choice or because of academic failure (Poliafico, 1998). In addition, there is a possibility attrition may also be higher in practicing men nurses. For example, one

study in the United States suggests that in the period 1996-99, 7.5% of men nurses left the nursing workforce in the first four years following graduation, as opposed to an attrition rate of 4.1% in the comparable cohort of women (Sochalski, 2002). No comparable statistics were located for Canada.

**Experiences of men in nursing education and practice that influence retention.**

*Acceptance of men in the nursing profession.* There is little consistency in the literature regarding the acceptance of men nurses by members of the general public or by women in the profession (Bartfay & Bartfay, 2007; Ekstrom, 1999; McMillian, Morgan, & Ament, 2006; Morin, Patterson, Kurtz, & Brzowski, 1999; Villeneuve, 1994). Opinions on men in nursing range from outright support for their capacity to practice with the same degree of effectiveness, compassion, and caring as women, to overt hostility and criticism of men as nurses, and this variation is influenced by many factors including social norms, political factors, perceptions related to traditional views of masculinity, and the clinical practice area involved (Bartfay & Bartfay, 2007; Morin, et al., 1999; Villeneuve, 1994). In some cases, men even experience opposition or ridicule related to their nursing career choice from close family members and their social network (Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a; Villeneuve, 1994). In a study by Bartfay and Bartfay (2007) that looked at undergraduate nursing students in Ontario, Canada, men students perceived low levels of acceptance of men in their nursing program, while their women colleagues felt acceptance of men in their nursing program was fairly high.

***Gender-biased practices in nursing education.*** Even though nursing education almost universally and overtly supports men's participation in nursing at a policy level, there is some evidence to suggest informal practices in nursing education may create an unfavorable or even gender-biased climate for men students (Anthony, 2004; Bartfay & Bartfay, 2007; Brady & Sherrod, 2003; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a). Several authors have identified the fact that nursing textbooks frequently fail to acknowledge the role of men in the history of nursing by only focusing on the accomplishments of women such as Nightingale (Anthony, 2004; Brown, et al., 2000; Evans, 2004b; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a). In addition, textbooks frequently refer to nurses as "she", and faculty also frequently refer to nurses in feminine terms (Anthony, 2004; Harding, et al., 2008; Inoue, Chapman, & Wynaden, 2006; Kelly, et al., 1996; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a). This limited acknowledgement of men's role in nursing perpetuates the stereotypical image of women in nursing, marginalizes the role of men in the profession, and could cause men to question their own place in nursing.

Nursing programs have a tendency to view all students the same regardless of gender and cultural background and this supports the principle of equality, but does not address the principle of equity. Promoting equality over equity fails to acknowledge the potentially different learning and communication styles that are present in a diverse student population, or the unique cultural factors at play within sub-groups of students such as men (Grady, Stewardson, & Hall, 2008). A one size fits all approach to nursing education, therefore, has the potential to marginalize minority groups such as men, and

can be counterproductive despite the positive intent implied by applying the principle of equality. If the norms applied in the education of nurses have been established within the context of a profession numerically dominated by women, then applying these principles equally in the education and evaluation of all students, without regard to their gendered perspective, does not ultimately create a level and equal playing field. In one study examining faculty notions about caring in men nursing students, the women faculty interviewed held their women nursing students up as the frame of reference against which men students caring was judged (Grady, 2006; Grady, et al., 2008). Grady et al. (2008) go on to discuss how men nursing students may not feel comfortable displaying their unique ways of caring in an educational environment that does not recognize, acknowledge or value their perspectives as men engaged in nursing practice.

*Different expectations for men nurses.* Men nurses and nursing students have also reported a perception of different expectations for them by nursing faculty and their women colleagues, and a feeling of greater scrutiny of their actions given their minority status (Anthony, 2004; Evans, 1997a; Kelly, et al., 1996; Paterson, et al., 1996). Kelly et al. (1996) identify some men students felt that their peers expected them to be more assertive or display leadership qualities in their practice. In addition, men are frequently expected to take on physical roles such as heavy lifting of clients and equipment, and fulfill the role of security or enforcer when dealing with unruly or violent clients (Evans, 1997a, 1997b, 2001; Fisher, 2009; Harding, 2005; Kelly, et al., 1996). The generally larger physical size and strength of men has a profound influence on the gendered division of labor in society, and the expectation that men should fulfill these roles within

nursing perpetuates traditional societal gender roles in the health care workplace (Evans, 1997a, 2001). Men in nursing may approach this physical role with a certain degree of ambivalence, because fulfilling these more traditional and physical roles helps to reaffirm their masculine self-concept, but this ultimately sends the message that men are only good for physical tasks. This undermines their role as caregiver by associating them with strength, power and violence (Evans, 1997a, 2001; Hart, 2005). By placing men in physically-oriented traditional roles, women colleagues and the men nurses that embrace this role are ultimately complicit in perpetuating traditional gender roles within nursing, while creating a climate that has the potential to further undermine society's perception of men as acceptable caregivers (Evans, 1997a, 2001). In addition, there is some evidence to suggest this practice is also placing men nurses at physical risk, since one Canadian study identified that 46% of men nurses surveyed reported being physically assaulted by a patient in the past year as compared with a reported rate of 33% in women nurses (Crawford, 2009).

*Gender-based restrictions in clinical practice.* Another way men nurses are potentially marginalized during their education and practice is through the restriction of patient assignments based on the gender of clients and the virtual exclusion of men from certain practice areas such as obstetrics and gynecology (Chur-Hansen, 2002; Keogh & O'Lynn, 2007; Lodge, Mallett, Blake, & Fryatt, 1997; Morin, et al., 1999; O'Lynn, 2004, 2007a). Men in nursing frequently report situations when women clients have refused to have a man nurse care for them, and in some cases this refusal is precipitated by a woman colleague or nursing instructor asking the woman if they minded having a man nurse,

thereby informally implying there is an inherent problem with a man providing nursing care to a woman (Harding, 2008; Paterson, et al., 1996). It is unlikely a similar question would be asked of a man client, who has been assigned a woman nurse (Waters, 2006). This raises a question about what is different about the situation when a man nurse is in the role of caregiver (Waters, 2006). The answer may be gender stereotypes constructed for men in the discourse of society do not include physical and emotional nurturing, and therefore men entering into a caregiving role that requires physical and emotional intimacy are often viewed as suspect (Harding, 2008). Conditioned from childhood to accept women in a nurturing and caregiving role, many clients may readily accept a woman nurse, while a man nurse's credibility in this role may be questioned and his touch frequently sexualized (Evans, 2001, 2002; Harding, 2008). This idea will be explored more extensively in the next section as it has a significant impact on the practice of men in nursing.

Probably the practice area that has traditionally presented the greatest challenge for men nursing students has been obstetrics and gynecology, where there is a well-documented history of men students being discriminated against based on their gender by clients, nursing instructors, and medical and nursing staff (Anthony, 2004; Inoue, et al., 2006; Lodge, et al., 1997; Morin, et al., 1999; Okrainec, 1994). Obstetrics and gynecology is a required clinical component in most nursing curricula, and men nurses are held accountable for acquiring the knowledge and competencies to practice in these areas by nursing regulatory bodies and through the Canadian Registered Nursing Examination (CRNE). In many cases, men nurses may have received the theoretical

knowledge, without the opportunity to fully practice the necessary competencies during their education because of gender based restrictions on their practice. (Morin, et al., 1999; Okrainec, 1994; Waters, 2006). While acknowledging that a client has a right to self-determination, including the right to refuse care by a man nurse, the more interesting question is why men have such difficulty being accepted in the environment of obstetrics and gynecology? Morin et al. (1999) examined this issue through a focused ethnography utilizing a purposive convenience sample of 32 English-speaking women in the mid-Atlantic region of the United States. Some of the factors that influenced these women's feelings regarding the acceptance of a man nursing student included: their perception of their postpartum body image, a feeling of discomfort around men providing physical care to them during this personal and private time of their life, embarrassment regarding intimate care involving the perineum or breasts, the acceptability of a man nurse by their partner, the feeling that they cannot connect with a man nurse around the experience of childbirth and breastfeeding, and the personal characteristics of the man nurse (Morin, et al., 1999). When considering the personal characteristics of acceptable men nursing students, the women reported greater comfort with older men students, those that were married with children, and those students that were perceived as being professional and friendly by the women they were caring for (Morin, et al., 1999). An additional notable point was that some women reported the relationship with nurses was considered more intimate than the relationship with their physicians, therefore some women felt a man physician was more acceptable to them than a man nurse (Lodge, et al., 1997; Morin, et al., 1999). In Inoue et al.'s (2006) qualitative study involving 12 practicing men nurses



in Western Australia, the influence of this intimate relationship is also discussed from the perspective of men nurses. Inoue et al.'s participants not only identified the physically intimate components of nursing care as a challenge, but also discussed the challenges of the emotionally intimate components of caring for women clients. These participants went on to discuss the fact they also experience feelings of discomfort and embarrassment in the course of delivering intimate care to women, and suggest the issue is exacerbated with the care of younger women, such as those in the obstetrics and gynecology setting (Inoue, et al., 2006). Interestingly, one of Inoue et al.'s participants states this hyper-awareness of his gender in the course of delivering intimate nursing care to women is partially related to the fact that many women do not look at him as a nurse because of his gender.

*Cautious caregiving and the sexualization of men nurses' touch.* A paradox exists for men in the delivery of their nursing care, because the nursing profession frequently describes effective caring as requiring the demonstration of compassion and caring through touch, yet a common concern among men nurses is that their touch will be misinterpreted or perceived as sexual misconduct (Anthony, 2004; Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a, 2007b; Paterson, et al., 1996; Pullen, Barrett, Rowh, & Wright, 2009; Tillman, 2008). The theme of "cautious caregivers" was identified by Evans (2002) in her qualitative thematic analysis of semi-structured interviews with eight men nurses in Nova Scotia, Canada (p. 441). The participants in Evans' study reported feeling a sense of vulnerability when touching

patients in the course of their nursing care, and demonstrated caution when touching patients through the application of several strategies in their caregiving. Among the strategies employed by study participants were: taking the time to build trust before touching a patient; establishing a more formal relationship with their patients to establish a professional tone to the interaction; projecting the traditional image of nurse to reinforce men's place in the nursing role (e.g., use of a nursing uniform); working collaboratively with women colleagues when the situation potentially placed a man at risk of accusations of impropriety; trading off tasks that required intimate touching of women patients with women colleagues; or modifying the application of procedures to minimize the amount of touching and patient exposure.

The concept of "cautious caregiving" has subsequently been discussed by many authors including Harding et al. (2008) in the context of their discourse analysis of 18 interviews with men nurses in New Zealand. Harding et al.'s participants reported encountering refusal of their nursing care by both men and women clients and a sense of vulnerability and stress when utilizing touch in the course of their nursing practice. Among the strategies used to create an enhanced sense of safety among Harding et al.'s participants were: clear communication with the client, appropriate use of humor to overcome barriers of trust, trading off nursing tasks, and use of a woman as a chaperone. Similar strategies to negotiate the challenges of intimate care are also discussed in Inoue et al.'s (2006) study including: controlling feelings of anxiety or embarrassment while delivering intimate care to women, trading off of nursing tasks, use of chaperones,

utilizing humor or jokes to break the ice, providing detailed explanations about the care, and minimizing the exposure of women client's bodies.

Participants in Paterson et al.'s (1996) phenomenological study of the development of caring among twenty men nursing students also identified anxiety around the idea that clients would misinterpret their touch as sexual advances. Keogh and Gleeson (2006) report the theme "Fear of sexual allegations when caring for persons of the opposite sex" in their two qualitative studies examining the experience of six men registered psychiatric nurses and five general registered nurses in caring for women (p. 1173). Further support for the prevalence of fear related to the potential for false accusations implying sexual inappropriateness is reported in quantitative surveys by O'Lynn (2004) and Keogh and O'Lynn (2007) of men nurses in the United States and Ireland respectively. "Of the men who graduated prior to 1992, 28% reported fearing false accusations of sexual inappropriateness while providing care to clients as nursing students, and 45% of the men who graduated between 1992 and 2002 reported this fear" (O'Lynn, 2007b, p. 136).

The literature about men nurses frequently identifies the challenges associated with caring for women clients across all practice settings (Anthony, 2004; Keogh & O'Lynn, 2007; Morin, et al., 1999; O'Lynn, 2004, 2007b; Villeneuve, 1994); however, there has been less discussion with respect to the fact that men nurses also experience related challenges with adult men clients and pediatric client's of both genders (Evans, 2002; Harding, et al., 2008; Paterson, et al., 1996). Since society generally labels nursing as a woman's profession, men who choose to pursue nursing as a career frequently find

themselves falling outside of common essentialist definitions of masculinity, and this is further reinforced and evidenced by the common stereotypical association of men nurses with homosexuality (Evans, 2002; Harding, 2007; Harding, et al., 2008). These false generalizations have the potential to create barriers to the care of adult men clients who may perceive physical care by a man nurse as a potential threat to their heterosexual sense of masculinity (Evans, 2001, 2002; Harding, 2007; Harding, et al., 2008). This concern is echoed by one of Paterson et al.'s men nursing student participants, who expressed fear that a man client would think he was gay and "coming on to him" if he touched him in the course of providing nursing care. To counteract this perception, men nurses often go out of their way to project a masculine identity consistent with heterosexual and hegemonic perceptions of masculinity, and limit their physical contact with men clients to that which is absolutely essential so they are practicing within the acceptable bounds of masculine interaction (Evans, 2001, 2002; Fisher, 2009). The stereotypical association of men nurses as homosexuals also has an influence on their care of pediatric clients, because of the inappropriate conflation of homosexuality with sexual deviance, sexual predation, and pedophilia (Evans, 2001, 2002; Fisher, 2009). The presence of such stereotypes and false beliefs within society therefore places men nurses' care of children under a cloud of suspicion and implies men's touch is always potentially sexual in nature regardless of the recipient of the touch (Evans, 2001, 2002).

Given the fact that men nurses' motives for touching clients are frequently called into question, it is interesting to note men receive little if any instruction on the issue of appropriate touch and navigating the minefield of intimate nursing care during the course

of nursing education (Fisher, 2009; Harding, 2005; Harding, et al., 2008; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a, 2007b; Paterson, et al., 1996). O'Lynn (2007b) surveyed 111 men nurses and noted that 59% of graduates prior to 1992 and 69% of graduates between 1992 and 2002 had received no instruction on the appropriate use of touch from their instructors. Participants in Paterson et al.'s (1996) study expressed frustration about the fact women instructors did not always understand the challenges they were facing in relation to touching clients and conforming to the feminine expectations of caring that were closely aligned with the demonstration of caring and compassion through touch. Without formal instruction, navigating the potential minefield of touch and the demonstration of caring is particularly challenging for junior students; however, as men students progress through their program they learn to navigate these challenges by developing strategies and approaches to delivering care through experiential learning and watching role modeling by other men nurses (Paterson, et al., 1996). Since society is becoming increasingly litigious and there is increased media attention and public awareness on topics such as sexual abuse and harassment, not addressing the politics surrounding touch seems to be a significant deficiency in the education of nurses, and this is especially true for men students who are at particular risk for challenges in this area (Evans, 2002; O'Lynn, 2007b). The best approach to addressing touch and caring with men nursing students is still unclear as the research and development of policy or practice guidelines in this area is lacking (O'Lynn, 2007b). O'Lynn (2007b) has made the following recommendations including: assuming men students are innocent until proven guilty; not requiring automatic chaperones except in

exceptional cases; teaching men nurses to display confidence when touching clients; ensuring touch is accompanied by appropriate communication; teaching students to use progressive touch; giving clients as many options as possible in relation to their privacy; and teaching students to practice with an awareness of the cultural context of the client.

It is clear there are numerous factors that influence the acceptability of a man in the role of caregiver and nurse, and these factors combine in different ways depending on the client, the social and cultural context, and the qualities of the man nurse. It has been noted that older men nurses, those who are married, and those who have children are considered to be more acceptable caregivers to women, but the reasons why this is the case are less clear (Morin, et al., 1999). Perhaps these qualities give the impression these men are sexually safer, and therefore less suspect in their motivation for touch (Evans, 2002). Another possible perspective for the increased acceptability of these men caregivers may be their increased experience, confidence, and comfort in the caregiving role instill greater confidence in the recipient of the care. Experienced men nurses may have also learned through practice how to navigate the gender politics of their practice setting, making their interactions more effective in facilitating a positive therapeutic relationship with their clients. Many interesting questions present themselves when considering the issue of increasing the acceptability of men's caring and touch in the delivery of nursing interventions. By superficially drawing a man nursing student's attention to the politics of touch, are we helping them, or are we planting a seed of anxiety in their interaction with clients, that can germinate into tentativeness and uncertainty in their nurse-client interaction, thereby creating a self-fulfilling prophecy of

rejection by clients? If women instructors anticipate a student may not be acceptable to a client and explore this with the client, do they not reinforce any preexisting doubts a client may harbor about the acceptability of a man nurse? Although the experience of being rejected by a client is relatively infrequent, the participants in Paterson et al.'s (1996) study stated it was very distressing for them, and this has the potential to cast a shadow over future interactions by creating fears of rejection by other clients. How frequent is this occurrence, how can it be avoided, and how can both men and women nursing colleagues and instructors promote the acceptability of men nurses in their interactions with clients? It seems that a phenomena caused by such a complex interaction of factors will require more than a cursory discussion of what men should or should not do to be deemed legitimate caregivers. What is needed is a more in-depth exploration and discussion of the interaction of gender issues, politics, culture, policies and practices in the health care environment.

***Social Isolation.*** Both men nurses and nursing students have discussed the potential element of social isolation for men in the profession (Anthony, 2004; Evans, 2001; Harding, 2005; Kelly, et al., 1996; O'Lynn, 2004, 2007a). Kelly et al. (1996) stated that some of their study participants expressed feelings of loneliness and isolation during their nursing education, frequently being left out of conversations by their women colleagues. A second study by O'Lynn (2007a) also identified elements of social exclusion of men nursing students by the larger student group, that is predominantly comprised of women, such as not being invited to all student activities. When men in nursing are not accepted as full participating members of the larger social group, this

sense of isolation can also be further enhanced by the lack of opportunity to interact with men colleagues, teaching faculty, or nurses in the clinical setting, which has also been identified as a significant concern for many men in nursing (Anthony, 2004; Harding, et al., 2008; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a). However, it should be noted some men nurses in Evans' (2001) study actually embraced the sense of separateness from their women colleagues, and found this social separation to be more comfortable in terms of their relationship with their co-workers.

### **Men in Professions Numerically Dominated by Women: Do Men Have a Hidden Advantage?**

Although the majority of literature that addresses the topic of men in nursing is supportive of the participation of men in the profession, there are a few authors that have also suggested that men's increased participation in the nursing profession should be viewed with caution (Evans, 1997a; S. Ryan & Porter, 1993; Williams, 2003). Although men are definitely a minority group within the nursing profession, it is suggested this minority status has not always placed men at a disadvantage in the profession (Evans, 1997a; S. Ryan & Porter, 1993; Williams, 2003). Contrary to the hostility and discrimination experienced by women entering professions dominated by men, it is suggested that men's token status within professions numerically dominated by women has the potential to put them in a position of advantage given the greater status and power assigned to men within the context of the dominant patriarchal culture (Evans, 1997a; S. Ryan & Porter, 1993; Williams, 2003). Ryan and Porter (1993) cite the situation in the United Kingdom in the late 1980s as evidence of this relative advantage by discussing the



disproportionate representation of men nurses in administrative roles and as authors in the nursing literature. For example, in 1987 the overall proportion of men in nursing in Britain was 10%; however, men constituted over 50% of nurse administrators (S. Ryan & Porter, 1993). In a blind review, Ryan and Porter also illustrate their point by examining the gender of the contributing authors to several journals including the Journal of Advanced Nursing, Nurse Education Today, the British Journal of Nursing, and Senior Nurse. In all cases there was disproportionately high authorship by men in these journals when compared to the proportion of men in the profession at the time (S. Ryan & Porter, 1993).

Another frequently cited example of men nurse's relative advantage is the tendency to find higher proportions of men in certain nursing practice specialties including psychiatry, anesthesiology, critical/intensive care, and emergency care (Evans, 1997a; Williams, 2003). Some evidence of this trend can be seen in the Canadian Nurses Association's (2007) Registered Nursing Workforce Profile. Although men constituted only 5.8% of registered nurses in Canada at the time of this survey, higher proportions of men were noted in psychiatry/mental health (14.32%), critical care (7.6%), and emergency care (10.7%) (Canadian Nurses Association, 2009a, 2009b). It is suggested men may select these specialty areas because of their relatively high status within the profession and the association of these specialties with traits ascribed to the dominant societal perceptions of masculinity such as strength (psychiatry), technical skill (anesthesiology, critical/emergency care), autonomy (anesthesiology, critical care, administration), power (administration), and cool headedness (critical/emergency care)

(Evans, 1997a). Williams (2003) also suggests men are frequently encouraged to pursue administration and specialization by educators, administrators, and even by women colleagues who are complicit in reinforcing the dominant patriarchal culture. Williams further asserts that while women often hit a “glass ceiling” when it comes to advancement in professions dominated by men, men in professions numerically dominated by women experience the benefit of a “glass escalator” that encourages their advancement. It is also further asserted that men often experience more favorable relationships with men physicians and men administrators, and this may also assist them in the advancement of status and position within the professional ranks (Evans, 1997a; Williams, 2003).

In considering the reasons for men nurses’ movement into administration and specialty areas it should be noted there are likely numerous interacting and contributing factors that extend beyond the influences of patriarchal culture and gender status alone. It has been suggested that factors such as men’s tendency to hold full-time positions with fewer breaks in employment may be a contributing factor to this pattern (Okraimec, 1994; Villeneuve, 1994). However, this explanation may not adequately explain the increased representation of men in administrative roles in some cases. One study of the career patterns of nurses in a British urban district reported it took men an average of 8.4 years to become nursing officers as compared with an average of 14.5 years for women with no career breaks (Gaze, 1987). A similar pattern was reported by Ratcliffe (1999) in his study of career mobility among 368 British nurses. Men took an average of 4.59 years and women an average of 5.65 to reach the level of charge nurse when there were no

career breaks ( $p=0.028$ ) (Ratcliffe, 1999). Likewise, men who had not taken a career break took an average of 9.73 years to reach first level management grade, while women without a career break took 11.62 years to achieve a similar position ( $p=0.160$ ) (Ratcliffe, 1999). Ratcliffe reported there was no statistically significant difference between the average amount of time taken off by men and women who had experienced a career break; however, the number of years between qualification and promotion to charge nurse grade for nurses who took a career break was reported to be significantly different with a mean of 10.00 years for men and 18.22 years for females ( $p=0.019$ ) (Ratcliffe, 1999). Similarly, the average time taken to reach the first level management grade was 15.17 years for men and 22.25 years for women ( $p=0.064$ ) (Ratcliffe, 1999). In addition, the image of men as the dedicated family “breadwinner” (Abrahamsen, 2004) may also contribute to a disparity in career advancement between men and women nurses with children. Ratcliffe reported men nurses with children were 1.45 times more likely to be promoted than women nurses with children. Another possible factor that could be a significant player in men nurses’ choice of practice area and role is the challenge that men potentially face in the delivery of intimate care. Evans (1997) has also observed that most practice areas preferred by men can be characterized as high technology and low touch, and this is congruent with the problematic nature touch has within the context of men nurses’ caring practice and their apparent affinity for technology. Harding et al. (2008) also suggests the choice of a critical care practice setting may be related to a sense of safety because touch is less problematic for men nurses in these high acuity settings, men nurses are usually within view of another practitioner at all times (offering some

protection from false accusations), and because there is probably easier accessibility to colleagues as chaperones if necessary.

### **Caring as a Concept in Nursing**

There is common agreement that caring is a fundamental concept in nursing, in fact some authors have described it as the “essence” of nursing (Leininger, 1991; McCance, et al., 1999; Morse, et al., 1990). Despite the purported central significance of caring to the profession, there is little agreement in the nursing literature regarding the definition of caring, the core components of caring, or the process of effective caring (Morse, et al., 1990; Radsma, 1994; Stockdale & Warelow, 2000). In addition, the construction of caring as a feminine nursing attribute was reinforced by Nightingale and remnants of this perspective remain to this day in some spheres (Jinks & Bradley, 2004; O'Lynn, 2007b). Although nursing's conceptualization and understanding of caring remains a point of great debate, I will present an overview of caring as a concept in nursing by first reviewing the key points of several major nursing theories related to caring in nursing. Although neither of these major nursing theories can be considered a collective explanation of nurse caring, they are presented because of their influential nature on the conceptualization of caring within the profession. In an attempt to gain consensus on the concept of caring, there have also been several efforts to describe caring by drawing on the perspectives of numerous nursing theorists and scholars that have studied or written about caring. These efforts provide the most comprehensive summaries of caring from a nursing perspective, therefore, the findings of three of these studies will also be presented. In addition, the literature that has explored caring among

men nurses will be reviewed to demonstrate the need for a greater understanding of men nurses' conceptualizations and performance of caring.

**Leininger's theory of culture care.** Madeline Leininger was one of the first nursing theorists to examine the concepts of care and caring during the development of her theory of culture care starting in the 1950s (Radsma, 1994). Leininger stated, "care is the essence and the central unifying and dominant domain to characterize nursing" (Leininger, 1984, p. 4). A significant component of Leininger's theory is the idea that care must be connected to the culture of the client (McCance, et al., 1999). Keeping this in mind, Leininger defines caring as:

The direct (or indirect) nurturant and skillful activities, processes, and decisions related to assisting people in such a manner that reflects behavioral attributes which are empathetic, supportive, compassionate, protective, succorant, educational, and others dependent upon the needs, problems, values, and goals of the individual or group being assisted (p. 4).

As is suggested by the theory name, the primary goal of Leininger's theory is to provide culturally acceptable care to the client (individual, family, or community) that is respectful of their health beliefs (McCance, et al., 1999). To explore these health beliefs, Leininger introduces the idea of cultural care universality and cultural care diversity (McCance, et al., 1999). In explaining these terms, she defines cultural care universality as, "the common, similar, or dominant uniform care meanings, patterns, values, lifeways or symbols", while cultural care diversity refers to "the variables and/or differences in meanings, patterns, values, lifeways, or symbols of care" (Leininger, 1991, p. 47; McCance, et al., 1999). By exploring both the universality and diversity of cultural care

within an individual, group or community, it is ultimately hoped the nurse can implement a culturally sensitive plan of care based on the values, goals and beliefs of the client.

**Watson's theory of human care.** Jean Watson's Human Science and Human Care theory is based on the philosophical traditions of humanism and metaphysics, and also identifies caring as a major focus in the practice of nursing (Watson, 1985, 2005).

Watson suggests the goal of caring in nursing is to establish harmony and balance in all aspects of a client including mind, body, and spirit through the application of human care transactions and the establishment of an intersubjective relationship with the client in which the nurse and the client are co-participants in the caring relationship (Watson, 1985). While discussing the interventions related to human care processes, Watson (1985) describes ten "carative factors" including:

1. Humanistic-altruistic system of values
2. Faith-hope
3. Sensitivity to self and others
4. Helping-trusting, human care relationship
5. Expressing positive and negative feelings
6. Creative problem-solving caring process
7. Transpersonal teaching-learning
8. Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. Human needs assistance
10. Existential-phenomenological-spiritual forces (p. 75).

A fundamental concept in Watson's Theory of Human Care is the idea of transpersonal caring in which the two way interaction between the nurse and the client creates a relationship that allows the nurse to assist the client in acquiring existential meaning from the experience of their illness and suffering, and ultimately self-knowledge, control, and restoration of inner harmony (Watson, 1985). Watson suggests

both the nurse and the client are changed by the transpersonal caring interaction because although the client benefits from the caring interventions of the nurse, the nurse also is changed by the interaction and experiences professional and personal growth. The spiritual dimension of nursing care also features prominently in the Theory of Human Science and Human Care since nursing is presented as a human interaction and the “moral, spiritual, and metaphysical components of nursing care cannot be ignored or replaced” (p.54).

**Roach’s description of caring.** Simone Roach’s work on caring is not formally identified as a theory, however it does describe one system of values and beliefs related to caring in the nursing context (McCance, et al., 1999). Situated within a philosophical, theological context and influenced by existential philosophers such as Heidegger, Roach’s conceptualization of caring and nursing is therefore influenced by these traditions (McCance, et al., 1999). Roach states that although nursing cannot claim caring, she feels caring within the nursing context is unique and foundational to the practice of nursing (McCance, et al., 1999; Roach, 1984). Central to Roach’s description of caring are the five attributes of caring, that she later described as “a broad framework suggesting categories of human behaviour within which professional caring may be expressed” (McCance, et al., 1999; Roach, 1987, p. 69). The five Cs of caring include compassion, competence, confidence, conscience, and commitment (Roach, 1984). Compassion is referring to the nurse’s ability to be sensitive to the experience and suffering of another person, and the ability to make room to share this experience with their clients (Roach, 1984). Competence refers to the professional competence of the

nurse in all domains including knowledge, skills, judgment, and experience; thereby this attribute acknowledges the responsibility of nurses to maintain their professional competence in order to practice in a caring manner (McCance, et al., 1999; Roach, 1984). Confidence is identified as a fundamental quality which lays the groundwork for trusting nurse-client relationships (Roach, 1984). Conscience refers to a state of moral awareness that enables the nurse to practice in a moral and ethical manner (Roach, 1984). Finally, commitment requires the nurse to deliberately practice in accordance with their values and professional obligations (Roach, 1984).

**Boykin and Schoenhofer's theory of nursing as caring.** Boykin and Schoenhofer state, "the unique focus of nursing is posited as nurturing persons living caring and growing in caring" (Boykin & Schoenhofer, 2001, p. 11). The underlying premise of this theory is that all individuals are caring by nature of their essential humanness, and individuals express caring by demonstrating a commitment to know self and others as caring (McCance, et al., 1999). Boykin and Schoenhofer (2001) also identify some additional assumptions of their theory including the idea that "persons are whole and complete in the moment" and "... live caring moment to moment" (p. 11). Furthermore, Boykin and Schoenhofer state that "Personhood is a process of living grounded in caring" and "... is enhanced through participating in nurturing relationships with caring others" (p.11). Knowing the client as a whole person is an important element of caring within the theory because it demonstrates respect for the individual as he or she exist (Boykin & Schoenhofer, 2001; McCance, et al., 1999). Boykin and Schoenhofer also suggest the holistic focus of caring within nursing is a key factor that makes the expression of caring



unique in the profession when compared to other helping professions (Boykin & Schoenhofer, 2001). Another core concept within the Nursing as Caring Theory is the “nursing situation” that is defined “as a shared lived experience in which the caring between nurse and nursed enhances personhood” (Boykin & Schoenhofer, 2001, p. 13). Each nursing situation is the product of the interaction of the lived experience of at least two unique people who are both willing participants of the interaction, therefore every nursing situation is unique and requires personal investment and trust by all participating parties (Boykin & Schoenhofer, 2001). By engaging completely with the client as a caring and whole person, the expertise and knowledge the nurse brings to the situation is adapted based on that unique nursing situation to enhance the caring interaction (Boykin & Schoenhofer, 2001). When the nurse and client engage with one another in such an open way, “caring between” develops and the personhood of both the client and the nurse is nurtured through increased awareness and growth of their caring self that comes from this interaction (Boykin & Schoenhofer, 2001).

**Benner and Wrubel’s primacy of caring.** In their book, “The Primacy of Caring”, Benner and Wrubel (1989) discuss caring from an ontological perspective rather than from the intentional operational perspective presented by many nursing scholars (Edwards, 2001; Horrocks, 2002). Benner and Wrubel’s perspective on caring is based on the work of Heidegger, and affirms caring as a fundamental human trait and way of being in the world (Benner & Wrubel, 1989; Edwards, 2001). Caring is viewed as the means by which an individual ascribes value to what really matters to them and conversely devalues those things that do not matter (Benner & Wrubel, 1989). In other

words, caring is primary in that it lays the foundation on which both nurse and client values, beliefs and actions are built. Caring about another person's welfare and well-being, or caring about certain principles of good nursing practice, enables the nurse to establish an effective and trusting nurse-client relationship (Benner & Wrubel, 1989). This trusting relationship then creates the possibility of meaningful interaction with the client and collaborative intervention. Likewise, caring in the client establishes what matters to them, what creates stress for them, and what possible course(s) of action they are willing to pursue to cope with stress or illness (Benner & Wrubel, 1989). "Caring is primary because it sets up the possibility of giving help and receiving help" (Benner & Wrubel, 1989, p. 4). Within this perspective, caring is contextual and cannot be reduced to particular techniques or caring interventions, because the contextual perspectives of the various parties engaged in a caring interaction affect the behaviors that will be interpreted as caring within that context (Benner & Wrubel, 1989). In other words, effective interventions in one caring context, cannot necessarily be generalized to another situation, therefore the creation of a list of caring behaviors or interventions is inherently problematic.

#### **Attempts to gain consensus on caring in nursing.**

*Morse et. al.'s perspectives of caring.* Morse et al. (1990) sought to create some common ground and clarity related to nursing's perspectives on caring by performing a content analysis of the works of 35 major authors who have addressed caring in the nursing context. The result of this analysis was the identification of five perspectives on the nature of caring and two client-centered outcomes of caring (Morse, Bottorff,

Neander, & Solberg, 1991; Morse, et al., 1990). The five perspectives on caring included caring as a human trait, caring as an affect, caring as a moral imperative, caring as interpersonal interaction, and caring as a therapeutic intervention (Morse, et al., 1990). The two outcomes of caring identified included the patient's subjective experience and the patient's physical response to caring (Morse, et al., 1990).

Caring as a human trait, acknowledges the perspective that caring is an inherent component of human nature, and suggests all human beings have the potential to care (Morse, et al., 1990). This perspective is congruent with the positions of many authors including, but not limited to, Roach, Leininger, and Benner and Wrubel (Morse, et al., 1991; Morse, et al., 1990).

Caring as a moral imperative or ideal suggests that "caring is a fundamental value or moral ideal in nursing" that provides the underpinnings for all nursing actions (Morse, et al., 1990, p. 4). Examples of writers that support this perspective on caring include Watson and Gadow, who assert that caring involves commitment to the client's dignity and integrity (Gadow, 1985; Morse, et al., 1991; Morse, et al., 1990; Watson, 1985, 2005).

Caring as affect acknowledges the perspective that caring is an extension of empathy or emotional investment in a client or their experience (Morse, et al., 1990). Some of the nursing writers who have supported this perspective on caring include Bevis, Fanslow, Forrest, Gendron, and McFarlane (Morse, et al., 1991).

Caring as an interpersonal relationship acknowledges the perspective of many nursing scholars that the nurse-patient relationship establishes the foundation of caring or

the medium through which it is expressed (Morse, et al., 1990). Some writers have suggested the nurse-patient relationship is the essence of caring and it both defines and expresses caring (Morse, et al., 1990). This perspective acknowledges the contributions of such writers as Benner and Wrubel, Horner, Knowlden, and Weiss (Morse, et al., 1991).

Caring as therapeutic intervention emerges from perspectives that have articulated caring in terms of nursing interventions or actions aimed at creating the conditions that contribute to the establishment of a caring interaction (Morse, et al., 1990). Some authors examined by Morse et al. have delineated specific caring actions that nurses should employ, while others suggest that all nursing interventions aimed at assisting patients are caring in nature. In addition, some authors have emphasized that knowledge and competence must be present for nursing interventions to be caring in nature (Morse, et al., 1990). Among the writers that support this perspective on caring are Brown, Gaut, Larson, Orem, Swanson-Kauffman, and Wolf (Morse, et al., 1991).

By drawing on the works of many nursing scholars in their examination of caring in nursing, Morse et al. (1990, 1991) have made a significant contribution to the understanding of caring within a nursing context, and have created a useful framework for examining the concept of caring in a comprehensive and straightforward way.

***Brilowski & Wendler's evolutionary concept analysis of caring.*** Brilowski and Wendler (2005) applied an evolutionary method of concept analysis to identify the core, enduring aspects of nursing caring within a sample of 61 articles that addressed nursing caring and were written between 1988 and 2002. This analysis resulted in the

identification of five attributes of caring within nursing including: relationship, action, attitude, acceptance, and variability.

Relationship was presented as the foundation of nursing, and the important characteristics of a caring relationship were identified as trust, intimacy, and responsibility (Brilowski & Wendler, 2005). Trust and intimacy were presented as essential to the professional caring relationship, and a trusting relationship was characterized by openness, sincerity, love and patience (Brilowski & Wendler, 2005). Brilowski and Wendler also stated that a professional caring relationship places the responsibility, for promoting the well-being of the patient, on the person who is providing care (Brilowski & Wendler, 2005).

Action was presented as the dominant theme in the conceptual analysis, and referred to doing for the patient or being with the patient (Brilowski & Wendler, 2005). Four actions of a caring nurse were identified: providing nursing care; use of caring touch; using self as a tool to be totally present; and, maintaining clinical competence (Brilowski & Wendler, 2005).

Attitude referred to the importance of the nurse engaging in nursing action with a positive attitude or disposition (Brilowski & Wendler, 2005). In other words, caring was not just about what interventions were carried out, but also about the attitude or approach the nurse presented in the course of providing their nursing care (Brilowski & Wendler, 2005).

Acceptance of another human being, including a recognition that everyone is worthy of dignity and respect, was also presented as an attribute of caring (Brilowski &

Wendler, 2005). Brilowski and Wendler (2005) suggest this attribute can be demonstrated by acknowledging those receiving nursing care as intrinsically valuable, recognizing patient perspectives as important, and being as concerned for the patient's spiritual well-being as with their physical and emotional well-being.

The final attribute of caring was variability, which recognized the fluid and changing nature of caring in response to the circumstances, the environment, and the people involved in the caring interaction (Brilowski & Wendler, 2005). In addition, variability was also presented as an aspect of care that developed in response to experience as a practitioner; therefore, the appearance of caring will change or evolve as practice experience and proficiency increases (Brilowski & Wendler, 2005).

Brilowski and Wendler's (2005) evolutionary concept analysis has certainly added to the efforts directed at gaining consensus on the concept of caring by drawing on perspectives and findings of a large number of recent publications by scholars who have explored nursing caring. Unfortunately, one potential weakness of Brilowski and Wendler's analysis was the omission of the original work of many major nursing theorists in their study sample.

***Fingeld-Connett's meta-synthesis of caring in nursing.*** Fingeld-Connett (2008) performed a meta-synthesis of caring in nursing, informed by a theoretical framework of grounded theory. Purposive sampling was carried out to identify 49 qualitative reports and 6 concept analyses on nursing caring that were published between 1988 and 2006 (Fingeld-Connett, 2008). A "constant and comparative method was used to analyze the data and a process orientation (e.g. causal conditions, context,

action/interactional strategies and consequences) framed the study” (Finfgeld-Connett, 2008, p. 198). Finfgeld-Connett presented caring as “an interpersonal process that is characterized by expert nursing, interpersonal sensitivity, and intimate relationships” (p. 198). Antecedents to this process included “a need for and openness to caring on the part of the care recipient”; “professional maturity” of the nurse; the presence of the “moral underpinnings” of caring within the nurse; and, a work environment that is conducive to caring (Finfgeld-Connett, 2008, p. 198).

When presenting the process of caring, expert nursing practice was identified as a critical attribute of the caring process, and it was characterized by the ability to identify the nuances and meanings of another’s situation through strong assessment skills, and the application of holistic nursing interventions (Finfgeld-Connett, 2008). Interpersonal sensitivity was framed as the key to the caring process and was characterized by intuition and empathy about another’s suffering (Finfgeld-Connett, 2008). According to Finfgeld-Connett (2008), interpersonal sensitivity is demonstrated by going beyond the routine, applying creativity and simple gestures like attentive listening, use of touch, and offering verbal reassurances. In addition, the antithesis of interpersonal sensitivity was considered nursing practice that was hurried and mechanical (Finfgeld-Connett, 2008). Interpersonal sensitivity also respected each person and required the personalization of nursing care based on their unique situation (Finfgeld-Connett, 2008). Finally, the caring process required the development of open, honest, and trusting intimate relationships where nurses are deeply involved with their clients (Finfgeld-Connett, 2008).

For the caring process to occur, clients must first present with physical, psychological, and/or spiritual needs, and an openness to receive caring (Finfgeld-Connett, 2008). A second antecedent to the caring process was the professional maturity of the nurse and this included a solid knowledge base, the ability to cope, and competency in knowledge acquisition, decision-making, and the actual execution of nursing skills (Finfgeld-Connett, 2008). The third antecedent to the caring process is the presence of the moral foundations to engage in caregiving such as commitment, benevolence, ethical ways of knowing, conscientiousness, and being responsible (Finfgeld-Connett, 2008). Finally, Finfgeld-Connett identified the presence of a practice environment conducive to engaging in caring as a necessary antecedent to the enactment of a successful caring process. Among the qualities that contributed to a conducive environment were adequate resources, the time to carry out caring, and the presence of caring and support within the health care team (Finfgeld-Connett, 2008).

Finfgeld-Connett's (2008) study findings certainly echoed many perspectives about nursing caring that were previously identified by Morse et al. (1990) and Brilowski and Wendler (2005); however, the main contribution of this study was the articulation of nursing caring with a process orientation and the inclusion of more recent literature in the analysis.

**Caring and men nurses.** Despite the extensive examination of caring in nursing, there is relatively little literature addressing caring from the perspective of men nurses (Milligan, 2001; O'Lynn, 2007b). Caring has most commonly been associated with essentialist notions of women and mothering, and in nursing's history several writers



including Nightingale have even questioned men's capacity to be as caring as women (O'Lynn, 2007b). It is apparent these attitudes still remain a significant issue for many men in nursing today, since a recent survey of men nurses in the United States identified "being perceived as uncaring" as one of the top three hurdles men nurses face (Hart, 2005, p. 48). Jinks and Bradley (2004) surveyed 100 novice nursing students in the United Kingdom and compared the findings of this survey to a similar survey they conducted in 1992. Although the proportion of women nursing students that agreed with the statement, "women are more affectionate and caring than men" was only 21% in 2002 as compared with 71% in 1992, this finding still suggests that a large number of women in the nursing profession may still question men's ability to be caring (Jinks & Bradley, 2004). If caring is a fundamental inborn "human trait" as some philosophers and nursing theorists have suggested, then it is counterintuitive to suggest men nurses have any less capacity to be caring than women nurses (Morse, et al., 1990; O'Lynn, 2007b). Boughn's (2001) grounded theory study findings support this position; because both men (n=12) and women (n=16) nursing students demonstrated comparable commitment to care for their patients. However, it should be acknowledged that the expression of inborn or fundamental traits is still influenced by social processes; therefore, performance of essentialized conceptualizations of masculinity by some men may result in behaviors considered inconsistent with essentialized perspectives that associate caring with femininity. Since masculinity is not a static concept, and can probably best be conceptualized by acknowledging the multiple and contextual masculinities that can exist, it is problematic to suggest there would be one masculine nursing perspective on

caring (O'Lynn, 2007b). However, there is some evidence to suggest men nurses frequently understand and demonstrate caring in a different way from their women colleagues, and this will be illustrated through an examination of the literature exploring caring among men nurses (O'Lynn, 2007b).

Ingle (1988) explored men nurses' caring by interviewing 12 baccalaureate prepared men in nursing and subjecting the transcripts of these interviews to qualitative content analysis. The overriding theme identified by Ingle was "the business of caring". Three categories with further subcategories were identified including: "supporting physical well-being (enacting skills, maintain safety, and surveillance); supporting psychological, emotional, and spiritual well-being (verbal and nonverbal support of time and being there, touch, listening, eye contact, and facial expressions); and supporting individuality (advocacy and respect)" (Ingle, 1988, pp. iii-iv). The participants in Ingle's study discussed the relationship with their patients in terms of a contractual business relationship where the business was the provision of professional nurse caring and the service was to provide for the holistic needs of their patients. The establishment of a relationship with the patient was purposefully, rationally, and intentionally initiated by the nurse to provide the services desired by the patient (Ingle, 1988). The three categories and further sub-categories represented the means by which this business of caring was enacted (Ingle, 1988). The participants in Ingle's study stated professional nurse caring was an innate attitude made explicit through the actions of the nurse and as such, caring could not necessarily be taught. Several participants did acknowledge the role of their professional education and the role of nursing practice experience/maturity as an

antecedent to providing nurses with the knowledge and skills to effectively utilize this existing caring orientation to engage in an effective therapeutic relationship with their patients to meet patient needs (Ingle, 1988). Some participants also stated professional nurse caring behaviors may be acquired through the experience of seeing them role modeled (Ingle, 1988). Ingle concluded her participants demonstrated feelings of empathy for their patients, and exhibited traditional behaviors associated with nursing such as compassion, acceptance, consideration and kindness. In addition, Ingle also noted her participants demonstrated contemporary nursing behaviors of independence, assertiveness, self-esteem, and confidence.

Paterson et al. (1996) examined gender issues related to caring in their phenomenological study of 20 men nursing students. This study identified the category “caring as male” which included the theme clusters “gender difference in caring”, “experiencing the difference” and “being prepared for the difference” (Paterson, et al., 1996, p. 29). The junior and senior student participants in this study acknowledged they had experienced gender difference in care delivery during their clinical education (Paterson, et al., 1996). These men students identified that women nurses and faculty frequently suggested men students should care for patients in a sensitive and demonstrative way like they did, and the men students frequently found this expectation frustrating because this feminine approach to caring for patients was not consistent with their socialization as men up to this time (Paterson, et al., 1996). In addition, the men students did not feel they could discuss these challenges with women nurses and faculty because as women they would not understand the masculine perspective or the reasons

they were having difficulty caring from a feminine perspective (Paterson, et al., 1996). Senior students identified they had gradually incorporated some “female” elements into their caring as their education progressed to create an amalgamated version of caring that consisted of both female and male perspectives (Paterson, et al., 1996). These senior students did feel that the masculine approach to caring, that they described as more of a friendship, was not well recognized or valued in the profession as compared to the feminine approach to caring (Paterson, et al., 1996). Other significant factors affecting men’s caring were identified through the theme cluster “experiencing the difference” in which the men students discussed the challenges of caring for clients while experiencing rejection of themselves as a caregiver, and the challenges the use of touch in caring presents for men nurses (Paterson, et al., 1996).

The findings in the Paterson et al. (1996) study are further affirmed by O’Lynn’s 2003 survey of 111 men nurses, who had graduated from 90 different schools of nursing in the United States (O’Lynn, 2007b). O’Lynn (2007b) reports that 30.9% of the men stated that their nursing faculty had emphasized a feminine style of caring, and 46.4% felt this emphasis was a barrier for men students. In addition, 53.6% stated no discussion of a masculine style of caring was presented or discussed, and 56 % of participants felt this lack of discussion was a problem for them (O’Lynn, 2007b).

Milligan (2001) examined the concept of care in eight men acute care nurse’s work utilizing an ontological hermeneutic qualitative approach, and proposed a “model of male nurse caring”. Five themes were identified including: “care and caring”, “communication with patients, significant others and the multidisciplinary team”,

“significant others and the shifting focus of care”, “the nature and limits of emotional work”, and “gender and being a male nurse” (Milligan, 2001, pp. 11-13). When considering the theme of “care and caring”, Milligan (2001) identified the participants felt care was a difficult concept to define, and tended to initially place emphasis on general and bio-physical needs of clients. In addition to physical needs, Milligan’s participants also identified the importance of psychological care and identified barriers to care including lack of time in the acute care setting. The theme of “communication with patients, significant others and the multidisciplinary team” was developed because participants felt clear and effective communication with the patient and significant others in their lives was a key component of care, and all participants voiced communication with the multidisciplinary team, was essential (Milligan, 2001). The third theme “significant others and the shifting focus of care” was created to capture the fact several participants shifted the focus of care away from the patient to significant others and even to issues such as questioning the medical focus of care when they saw these areas as higher priority based on the situational context (Milligan, 2001). The fourth theme “the nature and limits of emotional work” represented comments by the participants about the importance of addressing the emotional impact of illness and death on family members and significant others, and the emotional work and impact on the nurse as caregiver (Milligan, 2001). Several participants in Milligan’s study, also went on to discuss how they were able to put emotional work into perspective, sometimes through limiting emotional commitment to the patient’s situation. Interestingly, the study participants also identified their relationship with emotional work was different than their women

colleagues by suggesting women nurses might be more sensitive to patient feelings, and also by discussing how men nurses were expected to suppress emotion as opposed to women nurses, who are socially permitted to display emotion more openly (Milligan, 2001). The final theme “gender and being a male nurse” focused on comments from the participants about how their gender affected their work lives (Milligan, 2001). Several participants discussed how they were called on for more physical tasks such as heavy lifting or dealing with unruly patients (Milligan, 2001). Other participants discussed how being a man could contribute to restricted access to some patients, and one participant felt being a man could have both positive and negative effects on the role as a nurse depending on the practice context (Milligan, 2001).

Utilizing a life history method, semi-structured interviews were employed by Fisher (2009) to gather the life stories of 21 men nurses in New South Wales, Australia. Fisher explored the labor processes associated with physical nursing care (“bodywork”) among his participants as one part of a broader study on the social practices that configure masculinity in the lives of men nurses (p. 2668). Fisher stated the ability of men nurses to effectively engage in “bodywork” is dependent on the way in which they “do” (perform) gender. Men in nursing must adjust their presentation of masculine identity based on the patient’s ideological understanding of what it is to be a man in a specific context (Fisher, 2009). In addition, men nurses must also attempt to counter false stereotypical representations of the man nurse (“homosexual, pedophile, heterosexual deviant”) that may affect their ability to effectively engage in nursing practice (Fisher, 2009, p. 2668). Fisher also discussed how current nursing education and

clinical practices fail to acknowledge the complexity of the performances that men in nursing must employ. In addition, Fisher suggested the nursing profession needs to move beyond its essentialist ways of considering nursing care with an emphasis on the feminine.

These findings are significant for any discussion of caring from the point of view of men in nursing, because they clearly identify how the performance of masculinity by men in nursing influences the establishment of an effective caring relationship (Fisher, 2009). The establishment of a trusting and effective nurse-patient relationship is foundational from the perspective of many nursing theorists because it is the medium through which nursing caring occurs, therefore anything affecting this relationship has the potential to affect the expression and interpretation of nursing caring (Benner & Wrubel, 1989; Morse, et al., 1990).

The dearth of studies examining caring amongst men in the nursing profession is clear, and the few studies completed are based on a relatively small number of participants, and do not adequately compare their findings with existing models of caring within the nursing profession as a whole (O'Lynn, 2007b). In addition, the research approaches exploring men nurses' caring has frequently utilized methods that asked men to report or reflect on their practice through surveys or qualitative interviews. While this type of research is definitely of value, there has not been any research on men nurse's caring that involves direct observation of their caring practice. What can be concluded based on the existing literature is that men and women perform caring in different ways, and men do have an inherent capacity to care prior to becoming nurses (O'Lynn, 2007b).

Although men clearly establish interpersonal relationships with their clients, including connecting with their clients on an emotional level, there is some evidence suggesting the nature of some men nurses caring interactions may be more congruent with the model of friendship or a business relationship rather than the more demonstrative and affective caring approach characteristic of women nurses (Ingle, 1988; O'Lynn, 2007b). Men nurses' caring may be "viewed as competency in anticipating and meeting client needs through nursing tasks, teamwork, communication and advocacy" (O'Lynn, 2007b, p. 132). In addition, there is some evidence the performance of masculinity by men in nursing may affect the therapeutic relationship with their clients, therefore men may adjust their presentation of masculinity to present a performance of masculinity deemed acceptable to their clients in a given context (Fisher, 2009). There is also some suggestion men nurses' perspectives on caring may be undervalued when compared with the predominantly feminine caring perspectives of the nursing profession (Fisher, 2009; O'Lynn, 2007b; Paterson, et al., 1996). It is difficult to make definitive conclusions based on the limited state of literature addressing men nurses' caring however, so there was certainly benefit in continuing to explore this concept more extensively during this study.

### **Men and Masculinities**

Gender is a complex concept that has the potential to be defined in a variety of ways depending on an individual's philosophical, social, cultural, historical, political, and intellectual perspective. Some individuals and institutions construct gender as a simple mutually exclusive dichotomy (Coltrane, 1994); however gender studies theorists have



articulated the complexity associated with a socially constructed and dynamic understanding of gender (Coltrane, 1994; Connell, 1987, 1995, 2000; Connell & Messerschmidt, 2005). It is a challenging task to define masculinity and femininity from a social constructionist perspective because these concepts are constantly under revision and redevelopment, and may be constructed differently by each person at any given point in time. In addition, the conceptualization of gender that is adopted has significant political implications. Attempts to articulate differences between genders are frequently accompanied by hierarchical assignment of relative value to these conceptualizations, that may ultimately perpetuate the existing social order in a society that is still significantly influenced by patriarchy. It is with an acknowledgement of the fluid nature of gender construction that I present a brief review of the major conceptualizations of gender within the field of masculinities and articulate my conceptualization of gender for the purposes of the current study.

**Pervasiveness of an essentialist understanding of gender.** The concepts of biological sex and gender are frequently used interchangeably by many people because of the pervasiveness of a biological essentialist understanding of gender (Coltrane, 1994; Connell, 1995, 2000; Connell & Messerschmidt, 2005). Biological essentialism ascribes gender difference to chromosomal assignment (XX versus XY), and conceives gender differences as innate characteristics based on biological variances such as hormonal differences between the two sexes (Coltrane, 1994; Connell, 1995). Although essentialism fails to acknowledge the complexity of gender by assigning gender to mutually exclusive dichotomous categories, this perspective is still presented as an

incontrovertible truth by some social institutions including religious groups that conceive gender as clearly defined God given differences between men and women (Coltrane, 1994). However, this perspective is not limited to traditional religious and political institutions, since essentialism has also been a part of popular mythopoetic movements such as that articulated in Robert Bly's (1990) book "Iron John". Bly suggests that modern men have lost touch with their masculine roots, and that this is the source of many men's problems (Bly, 1990). Reconnecting with this innate masculinity through all-men retreats and rituals, is proposed as a solution to this modern "crisis" of masculinity (Bly, 1990; Coltrane, 1994); however these movements may be considered as buying into a "cult of an imaginary past" (Connell, 1995, p. 27).

The quest to explore the differences between men and women received greater attention when the existing gender order was challenged in the late nineteenth century; however, the influence of these ongoing attempts to articulate gender difference continues until the present day (Connell, 1995). Generations of researchers from many disciplines have sought to describe the differences between men and women on various dimensions including: emotions, attitudes, personality traits, mental abilities, values, and interests (Connell, 1995). This sex difference research has emphasized the conceptualization of masculinity and femininity as mutually exclusive opposites, and this perspective has thereby contributed to societal processes that resist women's political and social emancipation (Connell, 1995). Within the context of patriarchal culture, constructing femininity as the polar opposite of masculinity establishes femininity as

relationally subordinate, thereby contributing to the hegemonic enforcement of the patriarchal gender order (Connell, 1995).

If biological essentialism holds true as a concept, then innate masculine and feminine qualities should be constant across all people regardless of social, political, historical, and cultural influences. A large body of research in the social sciences clearly demonstrates a unified conceptualization of gender does not exist across groups, thereby discrediting the validity of gender essentialism and lending support to the idea of gender as a social construction (Coltrane, 1994; Connell, 1995, 2000). Despite the overwhelming evidence to the contrary however, many people persist in conceptualizing gender in essentialist terms, and these essentialist notions continue to have a significant influence on how gender is performed and interpreted in society (Coltrane, 1994).

**Sex role theory.** In the middle of the 20<sup>th</sup> century, the concept of sex role gained popularity as an alternative to biological essentialist explorations of sex differences, and since this time, the concept of sex role has firmly established itself in society's collective vernacular during discussions of gender (Connell, 1995). In many ways, sex role theory was a significant step forward in the conceptualization of gender because it acknowledged the influence of societal and cultural norms on the construction of male and female sex roles; masculinity and femininity could therefore be described as the internalization of socially defined sex roles (Connell, 1995; Connell & Messerschmidt, 2005). Since the sex role conceptualization of masculinity and femininity acknowledges the influence of social norms that could potentially be changed by social processes, it is therefore inconsistent with the idea of a static and innate conceptualization of masculinity

and femininity as suggested by biological essentialists (Connell, 1995). Although sex role theory discredits the idea of innate pre-established gender qualities, it still presents a relatively essentialist notion of masculinity and femininity as mutually exclusive collections of attributes that are inherited and learned through social and cultural norms (Connell, 1995; Forrester, 1988). In other words, sex role theory acknowledges the changing definition of masculinity and femininity in society, but it still treats gender as a dichotomous category (male and female) with relatively well defined and internally consistent characteristics (Connell, 1995; Connell & Messerschmidt, 2005). As a result, the main criticism of sex role theory is similar to the criticism of biological essentialism in that it perpetuates the promotion and potential internalization of female and male sex roles that could contribute to the patriarchal oppression of women (Connell, 1995, 2000). In addition, researchers in the area of gender studies have also recognized that the use of sex role theory as a means to explain gender may not only contribute to the subjugation of women, but also to the oppression of men through the promotion of a male sex role that does not always contribute to favorable social outcomes for many men (Connell, 2000).

The male and female sex role categories seek to describe the gender role for the collective groups of men and women, but fail to adequately acknowledge the potential for individual variation in the expression of gender or the influence of social power relations. Male sex role is characterized by instrumental “behaviors including: an achievement orientation, assertiveness, autonomy, decision-making ability, dominance, endurance, strength, and power” (Connell, 1995; Forrester, 1988, p. 601). Conversely, the female

sex role emphasizes expressive and communal behaviors including: nurturance, “abasement, affiliation, deference, passivity, submissiveness, and succorance” (Connell, 1995; Forrester, 1988, p. 601; Harding, et al., 2008). Individuals that do not fall neatly into the male or female sex role, and demonstrate a combination of male and female traits are considered to be fulfilling an androgynous sex role (Forrester, 1988).

The description of sex roles subsequently led to the development of positivist tools such as the Bem Sex Role Inventory, which are used to assess an individual’s degree of affiliation with the established sex roles (Bem, 1978; Loughrey, 2008). The inherent appeal of a survey-based quantitative tool in the study of gender has led to its utilization in many gender orientated research projects; however, the utilization of sex role theory as the underlying conceptual framework fails to acknowledge the potential complexity of gender performances and can contribute to the perpetuation of a relatively essentialized consideration of gender.

**Social constructionism.** A socially constructed conceptualization of gender has been embraced by masculinities researchers in the last two decades in response to a growing body of evidence supporting this perspective (Connell, 2000). Social constructionism acknowledges that individual and institutional conceptualizations of masculinity and femininity are constructed in relation to the social, cultural, historical, and political contexts that influence their formation (Connell, 1995, 2000). Masculinities exist in action and are in a constant state of active construction or redevelopment, so there is never one stable conceptualization of masculinity that exists beyond a specific contextual instant in time (Connell, 2000).

**Multiple masculinities.** Numerous field studies, primarily utilizing the methods of ethnography and life-history, have documented the multiple constructions of masculinity situated in a variety of cultural, institutional, historical, and geographical contexts (Coltrane, 1994; Connell, 2000; Connell & Messerschmidt, 2005). It is therefore more accurate to talk about masculinities in the plural rather than a monolithic conceptualization of masculinity (Connell, 1995, 2000). There is no one form of masculinity evident, even within a given location, time, and socio-cultural context, and plural masculinities exist even amongst a demographically homogenous group situated in a common context (Connell & Messerschmidt, 2005). Masculinities are performed and exist in action, social interaction, and through demonstrations of symbolic difference (Connell, 1995, 2000). Masculinities are also constructed in relation to femininities as each concept influences the understanding of the other (Connell, 1995). Even in the case of an individual man, multiple performances of masculinity will emerge, and these performances may change over the course of his life history in response to social forces that contribute to the constant remodeling of his performance of masculinity (Connell, 1995; Connell & Messerschmidt, 2005).

**Hegemonic masculinities.** Multiple masculinities may be in existence in any given context; however, they will not necessarily be considered equal in the sphere of social relations (Connell, 1995, 2000; Connell & Messerschmidt, 2005). Some masculinities may be desirable or dominant, while others may be subordinate or less socially desirable (Connell, 2000; Connell & Messerschmidt, 2005). Hegemony refers to the dominance of one political or social perspective over another, and Connell (1987)

introduced the concept of hegemonic masculinity in his discussion of social and power relations between masculinities. In simple terms, hegemonic masculinity is the most honored or desired form of masculinity within a social context (Connell, 2000). Connell (2000) noted that the hegemonic form of masculinity does not necessarily have to be the most common or comfortable form of masculinity, but it is the revered form against which other masculinities are measured (Connell, 2000). In reality, most men may have a distant or tension filled relationship with the hegemonic forms of masculinity in their lives; however, their performance of masculinity may still be profoundly influenced by hegemonic masculinities (Connell, 2000).

Hegemonic masculinity is constructed through social interaction, and can be understood as the pattern of practice that allows men's dominance to continue (Connell & Messerschmidt, 2005). The mechanisms of hegemony might include the reification of a certain pattern of masculinity in the media, or may involve the direct censure of subordinate masculinities through practices like name calling, or even creating an environment where criticizing the hegemonic or dominant form of masculinity is unthinkable (Connell & Messerschmidt, 2005). Not all men actively participate in the mechanisms of hegemony; some men contribute to the perpetuation of hegemony through the performance of silent and complicit masculinities (Connell & Messerschmidt, 2005). It should also be noted that patterns of hegemonic masculinity do not consist entirely of toxic behaviors such as the use of physical violence, aggression, and intimidation in the oppression of others (Connell & Messerschmidt, 2005). Hegemonic patterns of masculinity may also include "positive" behaviors such as bringing home a wage and

being a father, because the performance of negative and toxic behaviors such as violence and self-centeredness might facilitate dominance, but they would not engender support for the perpetuation and institutionalization of hegemonic masculinities by “subordinate” groups (Connell & Messerschmidt, 2005).

Since the term hegemonic masculinity was introduced into the language of masculinities, many people have misinterpreted the intent of the concept and discuss hegemonic masculinity as if it is a fixed type of masculinity, or that it is merely the dominant form of masculinity at a particular time (Connell & Messerschmidt, 2005; Martin, 1998). Connell and Messerschmidt (2005) suggest that the usage of hegemonic masculinity as a fixed transhistorical model should be eliminated. Like any socially constructed concept, hegemonic masculinity is not static and is constantly being reworked based on the context that contributes to its formation (Connell & Messerschmidt, 2005). In addition, it is probably more accurate to talk about hegemonic masculinities, since there are many performed masculinities that are hegemonic in their practice (Connell & Messerschmidt, 2005). What unites the various hegemonic masculinities are: their contribution to hegemony in the society-wide gender order, the role they play in creating a model for relations with femininities and subordinate masculinities, and their role in articulating solutions to problems of gender relations (Connell & Messerschmidt, 2005).

In a critique of Connell’s original presentation of hegemonic masculinity, Demetriou (2001) suggested that hegemonic masculinity can be potentially divided into two forms: internal hegemony and external hegemony. External hegemony refers to the



institutionalization of men's oppression of women, while internal hegemony refers to the dominance of one group of men over other men (Connell & Messerschmidt, 2005; Demetriou, 2001). Demetriou suggested that the internal hegemonic relationship between the various masculinities has frequently been discussed in a simplistic way that does not adequately acknowledge the interplay and influence of subordinate masculinities in the formation of hegemonic masculinities. Demetriou further proposed that the articulated pattern of hegemonic masculinity may in fact represent a hybrid of pragmatically useful elements of all masculinities which contribute to the best strategy for the perpetuation of external hegemony.

**Collective masculinities.** Masculinity can be considered a unique construct for an individual man at a specific time; however masculinities exist beyond the individual level, are defined collectively in a culture, and are sustained in the institutions of that culture (Connell, 2000). In other words, there is interplay between the construction of masculinity at the individual level and the collective construction of masculinity among groups of men. For example, an institution such as the military might construct multiple masculinities and establish the relationship between these masculinities within the institution (Connell, 2000). This collective construction and performance of masculinities therefore contributes to common patterns of performing masculinity within an institution or community of practice; however, it is important to note that these common patterns of masculine performance do not represent the position or practice of every individual, or sub-group, in the community (Connell, 2000; Connell & Messerschmidt, 2005). The practice of masculinity by individual men frequently does

not directly correlate with a particular conceptualization of masculinity within the collective, since these individual men may feel different degrees of attachment or aversion to the various patterns of masculine performance within the larger group (Connell & Messerschmidt, 2005). Never-the-less, these common patterns of masculinity still have the potential to contribute to common performance elements that illuminate the collective masculinities within an institution or community of practice.

**Contradictions and tensions in the performance of masculinity.** Since masculinities are not fixed and homogenous entities, it is not surprising that the alignment with, and performance of, masculinities is fraught with contradictions and complexity at an individual level (Connell, 2000). Men may feel affiliation or ambivalence towards certain elements of both hegemonic and subordinate masculinities, and may therefore experience dissonance between their present perspective and group norms (Connell, 2000). This internal dissonance may subsequently contribute to performances of masculinity that contradict these group norms, and this may open the door to censure by the larger group (Connell, 2000). Since total conformity with a particular pattern of masculinity is unlikely, men frequently have a tenuous and precarious relationship with their personal understanding of masculinity, and this is manifested in a state of tension and contradictory performances of masculinity in their daily lives.

**Application of masculinities theory to the nursing context.** Men nurses are sometimes viewed as a gender curiosity because they have chosen to participate in a feminized professional role that is overwhelmingly numerically dominated by women (Anthony, 2004; Bartfay & Bartfay, 2007; Evans, 2001, 2004b; Harding, 2005; Kelly, et

al., 1996; Meadus, 2000; Meadus & Twomey, 2007; O'Lynn & Tranbarger, 2007). The study of men in nursing frequently examines how men nurses are different from their women colleagues, often questions why men have chosen to pursue a feminized professional role, and theorizes if men nurses hold a different conceptualization of masculinity from men in general. In many ways, men in nursing provide an excellent opportunity to examine the construction and performance of masculinity, because they find themselves engaged in the performance of masculinity while also balancing the challenges of working within a primarily woman's profession that engages in a caring role that is more consistent with society's essentialized notions of femininity.

Because many people fall prey to the simplicity of categorizing gender from an essentialist perspective, there is a temptation to focus the exploration of masculinity among men nurses on the articulation of how they are similar or different from their women colleagues or men in society in general. Loughrey's (2008) study, that sought to quantitatively describe the gender role perceptions of men nurses in Ireland through the utilization of the short-form Bem Sex Role Inventory, provides an excellent example of the limitations of examining masculinity from this perspective. Loughrey reported that overall, 75% of the sample (n=104) identified with more female gender role norms than male norms, 20% identified more strongly with male gender role norms, and approximately 5% identified equally with male and female sex roles. These findings led Loughrey to come to the astounding conclusion that adherence to the female gender role may be an important pre-requisite to caring, and that it might be helpful to attract men to nursing who identify more strongly with the female sex role in order to address the

recruitment and retention issues among men in nursing. In addition to the leap of logic here, there is no acknowledgement of the limited theoretical perspective that sex role theory offers to the study of gender, and no acknowledgement of the socially constructed nature of masculinity. Fortunately, the majority of recent studies examining masculinities among men nurses are on a much firmer theoretical footing and acknowledge the socially constructed nature of masculinity, the presence of multiple masculinities, and the influence of hegemonic masculinities on the performance of masculinity by men in nursing (Abrahamsen, 2004; Evans, 2001, 2002; Fisher, 2009; Harding, 2005, 2007, 2008; Harding, et al., 2008; Holyoake, 2002; Tillman, 2008).

It is apparent from a review of the literature that the performance of masculinity is inseparable from the performance of nursing practice for men in the profession. Evans (2001) noted that notions of masculinity profoundly shape the experience of men in the nursing profession, and that these notions also play a significant role in the structuring of their work lives. In addition, Evans discussed how gender is a fundamental organizing factor in the lives of men nurses, because their participation in a feminized profession positions them as spoiled men and subjects them to the stigma of suspected homosexuality. Likewise, Harding (2005) suggested that men nurses contend with the construction of them as inferior men and as inferior nurses as compared to their women colleagues. The construction of men nurses as failed or somehow lesser men demonstrates the influence of societal hegemonic masculinities on the positioning of men nurses as a subordinate form of masculinity (Connell & Messerschmidt, 2005). This positioning of men nurses as a subordinate form of masculinity inevitably creates some

dissonance for men considering nursing as a career, and also sets the stage for the challenges men face in their interaction with both men and women clients (Evans, 2002; Harding, et al., 2008). The disparity between societal hegemonic masculinities and the performance of masculinities within the feminized nursing context also constitutes an example of the contradictions and tensions that men nurses face in the performance of masculinity and their professional nursing role (Evans, 2001; Evans & Frank, 2003; Harding, 2005).

Given the potential for the construction of multiple masculinities within a group or an institution, it is a logical progression that there are multiple constructions of masculinity within communities of nursing practice, and that certain constructions of masculinity will be considered more desirable than others (Connell, 2000). What may be interesting about the construction of masculinities amongst men in the nursing profession is that men remain a significant minority in most nursing workplaces and therefore there are fewer men colleagues present to enforce the performance of hegemonic masculinities in the course of nursing practice. The performance of masculinities among nurses is undoubtedly impacted by the influence of hegemonic masculinities within their private lives, and society as a whole; however, the femininities that are so pervasive in their workplace may also have an influence on the construction of masculinities amongst men in nursing. Holyoake (2002) explored male [sic] identity in three British mental health units utilizing an ethnographic approach. Holyoake's findings identified that his mental health nurse participants felt the need to balance the performance of the feminized practices of gentleness and caring with maintaining a sense of masculine identity. One of

the key themes that emerged from Holyoake's study was the theme of "soft masculinity", described as being a man who is more in touch with his feminine side and attends to things such as caring and politeness. This performance of masculinity with soft edges was not only seen as beneficial for the establishment of an effective therapeutic relationship with their clients, but was also identified as being necessary to facilitate a good working relationship with women colleagues (Holyoake, 2002). Incidentally, the discussion of men nurses' need to create a hybrid form of caring was also discussed by Paterson et al.'s (1995) senior student participants, who identified their caring approach as incorporating feminine elements. Holyoake's participants also discussed that although "soft masculinity" was considered an acceptable form of masculinity to nurses of both genders on their units, men had to be careful not to behave in a non-macho or effeminate way, because this performance of masculinity would not be valued, and may place the man's sexual orientation under suspicion. What is interesting about Holyoake's findings is the fact that we can clearly see the hierarchical assignment of value to different constructions of masculinity among the men nurses. In addition, there is also some suggestion that the construction of masculinity for the men in this study was profoundly influenced by their relationship with feminized professional norms and women nursing colleagues (Holyoake, 2002). While "soft masculinity" is acceptable in this workplace context, one wonders if it would be assigned the same degree of acceptability within the context of wider societal hegemonic masculinities. Both Holyoake and Paterson et al. have presented excellent examples of how the performance of masculinity may be shaped by the contextual influence of femininities in nursing workplaces. However, Holyoake's

use of language such as “masculine side” and “feminine side” in his explanation of “soft masculinity” unfortunately demonstrates an example of the tendency to essentialize gender by categorizing values and actions as either masculine or feminine. Although “soft masculinity” clearly represented a social construction, the socially constructed nature of gender performance was inadvertently undermined by a simplified explanation of its building blocks in essentialized terms (Holyoake, 2002).

Holyoake’s (2002) “soft masculinity” might also serve as an example of a collective masculinity within the study population’s community of practice. The performance of “soft masculinity” may be a common pattern of masculine performance amongst the men nurses on the three mental health units; however, it would be inappropriate to suggest that it was the pattern of masculinity for every man nurse at all times on these and other units (Holyoake, 2002).

### **Summary of Key Points from the Literature Review**

**Men in nursing.** Men have been involved in the care of the sick since ancient times; however, Florence Nightingale’s establishment of nursing as a profession for women in the Victorian era has led to persistently low participation by men in the nursing profession worldwide (Brown, et al., 2000; Evans, 2004b). In 2007, only 5.8% of Canadian Registered Nurses were men (Canadian Nurses Association, 2009a) and there have been persistent calls in the nursing literature to encourage men to pursue nursing as a career (Bartfay & Davis, 2001; Evans, 2004b; Meadus, 2000; Meadus & Twomey, 2007; Villeneuve, 1994). A significant influence on men’s participation in nursing is the common societal perception that nursing is a woman’s profession, and the ongoing

affiliation of nursing with essentialized feminine qualities (Anthony, 2004; Bartfay, 2007; Evans, 2004b; Kelly, et al., 1996; Meadus, 2000; Meadus & Twomey, 2007; O'Lynn, 2004; Okrainec, 1994; Villeneuve, 1994). This affiliation with femininities may contribute to some dissonance on the part of some men when considering nursing, because it situates nursing as a role that is external to the essentialized performance of masculinity, contributes to the stereotype that men in nursing are homosexual, and may imply that nursing is a lesser valued profession within the context of a patriarchal society (Evans, 2002; Evans & Frank, 2003; Meadus, 2000; Meadus & Twomey, 2007; Whittock & Leonard, 2003).

When men enter nursing education programs or nursing practice, they may also struggle with some challenges associated with their gender, since anecdotal and research evidence suggests that there is a higher attrition rate for men during nursing education and initial years following graduation (Bartfay, 2007; Brady & Sherrod, 2003; Sochalski, 2002; Tosh-Kennedy, 2007; Villeneuve, 1994). Among the factors that influence the retention of men in nursing are: inconsistent support for men's participation in nursing within society and the nursing profession (Bartfay & Bartfay, 2007; Keogh & O'Lynn, 2007; McMillian, et al., 2006; Morin, et al., 1999; Villeneuve, 1994), men's lack of preparation for working in a workforce predominantly composed of women, and potentially gender biased practices in nursing education (Anthony, 2004; Brady & Sherrod, 2003; Grady, et al., 2008; Harding, et al., 2008; Inoue, et al., 2006; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a).



Men's nursing practice is also shaped by their generally larger physical size and essentialized perspectives on masculinity (Evans, 2004a). Men are often expected to be more assertive, display leadership qualities, and take on physical roles such as "lifter", "protector", and "enforcer" and these roles do little to affirm men as caregivers (Evans, 1997a, 1997b, 2001; Kelly, et al., 1996). Essentialized perspectives on gender contribute to the association of caring and nurturing with femininity; therefore, men in nursing often have their capacity as caregivers questioned, and their touch is frequently sexualized (Evans, 2002; Harding, et al., 2008). As a result, the appropriateness of men nurses working with some client populations like women and children is frequently called into question and men may face restrictions on their practice such as the need to trade off nursing tasks or utilize chaperones when performing intimate care (Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Paterson, et al., 1995). Men nurses are also not immune to challenges when caring for other men. The societal affiliation of homosexuality with men nurses means that some men clients view men's nursing care with suspicion. Men nurse's response to the suspicion of their nursing care is to practice with caution to increase client comfort and decrease the risk of false accusations of impropriety. Evans (2002) introduced the idea of "cautious caregiving" and this concept has since garnered considerable support from other researchers who identify it as a significant influence on the nursing practice of men (Fisher, 2009; Harding, 2005; Harding, et al., 2008). Although the challenges faced by men in nursing are well documented, it is also surprising to note that men and women in the nursing profession

receive little instruction around the politics of touch (Fisher, 2009; Harding, et al., 2008; Keogh & O'Lynn, 2007; O'Lynn, 2004; Paterson, et al., 1995).

**Caring.** There is agreement that caring is a central concept in the profession of nursing; however, there is little agreement on the definition of caring or what constitutes effective nurse caring (Morse, et al., 1990; Radsma, 1994; Stockdale & Warelow, 2000). Morse et al. (1990) sought to clarify nursing's perspectives on caring through the content analysis of the works of 35 major authors who have addressed caring from a nursing perspective. The results of their study provide a useful structure for understanding the concept from a nursing perspective. Morse et al. identified five perspectives on caring from the literature including caring as a human trait (Benner & Wrubel, 1989; Boykin & Schoenhofer, 2001; Roach, 1987), caring as affect, caring as a moral imperative (Gadow, 1985; Watson, 1985, 2005), caring as an interpersonal relationship (Benner & Wrubel, 1989), and caring as therapeutic intervention. Brilowski and Wendler (2005) also attempted to clarify nursing's understanding of caring through an evolutionary concept analysis of caring which accessed 61 articles written about nursing caring between 1988 and 2002. The resultant core attributes of caring identified in this study included relationship, action, attitude, acceptance, and variability (Brilowski & Wendler, 2005). Finally, Finfgeld-Connett (2008) identified caring as a context-specific interpersonal process through her meta-synthesis of 49 qualitative reports and 6 concept analyses on nursing caring written between 1988 and 2006. Expert nursing practice, interpersonal sensitivity, and intimate relationships were presented as the key components of the caring process (Finfgeld-Connett, 2008). In addition, a need and openness to caring by the

client, professional maturity, the presence of the moral foundations to caring, and a conducive work environment were presented as the necessary antecedents to the caring process (Finfgeld-Connett, 2008).

The examination of caring from the perspective of men in nursing is fairly limited. O'Lynn (2007b) identified that nursing's construction of caring has been associated with femininity since Nightingale, and this sets the stage for men nurses' caring to be misinterpreted within the context of feminized caring norms in the profession. Participants in Ingle's (1988) study identified caring as an innate human quality that cannot be taught and Ingle concluded that her participants demonstrated empathy, compassion, acceptance, consideration and kindness. These findings are consistent with Morse et al.'s idea of "caring as a human trait". There is some evidence to suggest that men nurses approach caring differently than their women colleagues as this was expressed by participants in several studies (Fisher, 2009; Ingle, 1988; Milligan, 2001; Paterson, et al., 1996). Men in nursing may approach caring as a business relationship (Ingle, 1988) or a friendship (Paterson, et al., 1996), and may shy away from the more affective components of caring (Milligan, 2001). Men may also emphasize the enactment of therapeutic interventions such as meeting the bio-physical needs of their clients although they also acknowledge the need to attend to psychological care (Milligan, 2001). The importance of communication and establishing a good working relationship with their clients was articulated by men nurse participants in several studies (Fisher, 2009; Ingle, 1988; Milligan, 2001). Fisher (2009) adds significantly to the understanding of men's nursing care by linking the acceptability of a man nurse's

caregiving to his client's acceptance of the nurse's performance of masculinity. Fisher's discussion of men nurses' caregiving is a significant step forward because it articulates the link between the performance of gender and nursing care, while acknowledging the potential for multiple performances of masculinity and caring by a single nurse. In other words, it affirms that there is not one approach to men's nursing care.

**Men and masculinities.** It is clear from the masculinities literature that any comprehensive exploration of masculinity among men nurses must acknowledge: the active and ongoing social construction of masculinities in response to changing contexts; the existence of multiple masculinities; and the influence of hegemony and hierarchy on the value assigned to various constructions of masculinity (Coltrane, 1994; Connell, 1995, 2000; Connell & Messerschmidt, 2005). It is also important to acknowledge that men nurses' masculinities are likely constructed in relation to pervasive presence of femininities within nursing. (Connell, 1995). It is possible that the influence of femininities on the construction of masculinities within professions which are numerically dominated by women is significant, since men are required to balance an acceptable performance of masculinity with practices commensurate with feminized professional norms (Holyoake, 2002).

## **Chapter 3**

### **Methodology**

#### **Research Question**

In this study, the data were subjected to thematic analysis with the intent of discovering knowledge related to the following research question:

- *How is men nurses' caring conceptualized and expressed in their discourse?*

#### **Ethical Considerations**

The study “Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female Dominated Professions of Nursing and Elementary School Teaching” received ethical approval from Dalhousie University’s Social Sciences and Humanities Human Research Ethics Board (Appendix A), and the University of Manitoba’s Education/Nursing Research Ethics Board. Informed consent was obtained from all participants during the primary study (Appendix B & C). As the current research study does not depart from the original research study, and represents a portion of the original research project, the terms under which the original participant informed consent was obtained have not been violated. In addition, the primary investigator of the original SSHRC study, Dr. Joan Evans, sought advice from the Dalhousie University’s Research Ethics Board to ensure that my addition to the study team as a graduate student was in keeping with ethical standards before adding me to the protocol (Evans, et al., 2007). All aspects of the current study have been carried out in accordance with the Tri-Council guidelines for the ethical treatment of human subjects, and this study received ethical approval from Memorial University’s Human

Investigation Committee (HIC) (Appendix D) and from the University of Lethbridge's Human Subject Research Committee (HSRC) (Appendix E). Access to the data was not granted by the project team prior to the ethical approval by HIC and HSRC. As a secondary researcher there was an added level of confidentiality and anonymity because there was no direct contact with the original study participants, and the supplied data was anonymous. At no time did I have knowledge of the participant's names or identities, and all names utilized in the presentation of the study findings are pseudonyms assigned at the time of coding. Data were stored in a locked filing cabinet in my private office at the University of Lethbridge; computer files were encrypted for additional security.

### **Participants**

Purposive convenience sampling was utilized by the researchers to recruit participants at three study sites (Halifax, Winnipeg, Vancouver) during the original study: "Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female Dominated Professions of Nursing and Elementary School Teaching" (Evans, et al., 2007). Person-centered interviews (Hollan, 2005; Levy & Hollan, 1998) were subsequently performed with each participant resulting in access to a total of 42 individual interviews with men nurses from across the country (Appendix F). Focus groups were also performed at each site (Halifax, Winnipeg, Vancouver) to explore the themes that emerged from the individual interviews resulting in access to a total of three nursing focus groups (Appendix G). During analysis, theoretical saturation was reached after 21 individual interviews (the first seven conducted at each study site), and three focus groups (one per study site) were coded. The resulting thematic model was

then utilized in the review of the remaining 21 individual interviews to determine if there were any individual cases that contradicted the findings. A more detailed breakdown of the distribution of individual and focus group participants is presented in Table 3.1 below.

Table 3.1  
Participant Summary - Contradictions and Tensions in the Lives of Men: Exploring masculinities in the numerically female-dominated professions of nursing and elementary school teaching

	Halifax	Winnipeg	Vancouver
Nurse Interviews (# of participants)	11	21	10
Nurse Focus Group (# of participants in each site's focus group)	2	3	5

When exploring any aspect of masculinity, it must be acknowledged that any interpretation based on gender is firmly rooted in its socio-cultural context, given the socially constructed nature of gender (Connell, 1995). The qualitative data set accessed in this study consists of transcribed records of individual interviews and focus groups

collected in Halifax, Winnipeg, and Vancouver, which places the context of this study firmly within the Canadian landscape of masculinities and nursing. Because of the large number of study participants and the fact they were geographically distributed across Canada, the findings of this study will likely have the potential for a significant degree of transferability to the experience of Canadian men engaged in nursing; however, it would be inappropriate to consider any potential research findings as generalizable or representative of all Canadian men in the profession (Lincoln & Guba, 1985; Sandelowski, 1986; Streubert Speziale & Carpenter, 2003).

### **Setting of Data Collection**

Individual interviews were conducted by the original researchers in a variety of settings according to participant preference including participant's homes, workplaces, hotel meeting rooms or other neutral locations. Focus groups were conducted in hotel meeting rooms.

### **Theoretical Framework**

Masculinity theory (Coltrane, 1994; Connell, 1987, 1995, 2000; Connell & Messerschmidt, 2005) served as the central theoretical framework that informed all stages of this research study. The performance of masculinity by the men study participants was the key factor that ultimately distinguished their common patterns of caring from those exhibited by their women nursing colleagues. Therefore, masculinity theory provided the ideal vehicle to explain and comprehensively describe the performance of masculinity and caring by the men nurse participants, while also acknowledging the conceptual complexity that exists when exploring gendered perspectives.



## **Data Analysis**

The interview and focus group transcripts accessed during this study were generated through the method of person centered interviewing (Hollan, 2005; Levy & Hollan, 1998) by the primary researchers (Evans, et al., 2007); however, these data were subjected to thematic analysis during the current study to explore the concept of men nurses' caring. Thematic analysis is a flexible approach to data exploration that is used in many different qualitative methods (Braun & Clark, 2006). Although it is a useful approach for the purposes of the current study, thematic analysis is not a clearly demarcated process when compared to many method-informed qualitative approaches (Braun & Clark, 2006). Therefore, a clear articulation of how thematic analysis was applied in the course of this research is warranted (Braun & Clark, 2006). It is also important to reiterate the underlying assumptions of my approach to thematic analysis including: utilization of a primarily inductive approach to analysis without an established a priori coding frame; exploration of themes at the latent or interpretive level; and, examining the socially constructed concepts of caring and masculinities from a constructionist perspective (Braun & Clark, 2006)

**Phase one: Becoming familiar with the data as a whole.** The first stage of the analysis focused on gaining a familiarity and a sense of the transcribed individual interview and focus group data as a whole (Braun & Clark, 2006; Creswell, 2003). The process of reading all these data at least once before starting the formal coding process was particularly important in this case, because the interviews and transcription had already been completed during the primary study. Therefore, I was not starting with the

same degree of familiarity with the data, as compared to the primary researchers (Braun & Clark, 2006). During this first phase, formal coding was not done; however, initial notes were made concerning the major ideas expressed in the transcripts, and any musings about these data were memoed utilizing the NVIVO 8™ software package (Braun & Clark, 2006; Creswell, 2003; NVIVO, 2008).

**Phase two: Initial coding.** Once general familiarity with the corpus of the data was achieved, the process of formal coding of the data commenced using NVIVO 8.0 qualitative research software (NVIVO, 2008). As I read each interview or focus group transcript, interesting elements or features of the data (semantic or latent content) were coded by associating a segment or a “chunk” of the transcript text with an appropriate label (Braun & Clark, 2006; Roper & Shapira, 2000; G. W. Ryan & Bernard, 2000, 2003). Codes refer to “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). Throughout this stage, I was careful to code all relevant elements of the transcripts, including exceptional cases that contradicted the general patterns evident in these data. All elements of these data were therefore considered as the analysis progressed (Braun & Clark, 2006; Roper & Shapira, 2000). As each text excerpt was coded, I was also careful to keep some of the surrounding data around the coded excerpt to retain the context of the excerpt (Braun & Clark, 2006). These coded segments of text were then collated and aggregated to identify repeated patterns and eventually themes during the next phase of data analysis (Braun & Clark, 2006). In

addition, each individual coded excerpt of text was sorted into as many different themes as necessary during phase three (Braun & Clark, 2006).

**Phase three: Compiling themes.** In the third phase of the analysis, the long lists of coded excerpts from phase two were collated and combined into broader themes (Attride-Stirling, 2001; Braun & Clark, 2006; G. W. Ryan & Bernard, 2000, 2003). Utilizing the tools built into the NVIVO 8.0 software package, coded excerpts were combined to create themes, and these themes were organized into a possible hierarchical structure (“core” theme, sub-themes, thematic elements, and thematic sub-elements) (Braun & Clark, 2006; NVIVO, 2008). NVIVO’s modeling capabilities were also used to create a nascent thematic map to explore the potential relationships between themes and different levels of themes (Braun & Clark, 2006; NVIVO, 2008).

**Phase four: Refinement of themes.** Once there was a set of potential themes or sub-themes and a candidate thematic map, the next phase of analysis focused on the refinement of these themes (Attride-Stirling, 2001; Braun & Clark, 2006). During this stage of analysis, I considered each candidate theme to determine if there was sufficient data to support it (Braun & Clark, 2006). Some themes were eliminated altogether because of lack of supporting data while some themes were combined or collapsed into a larger theme; other themes were further divided into separate themes or sub-themes (Braun & Clark, 2006). As I engaged in this phase of data analysis, I ensured that data placed under a theme were cohesive and relatively homogenous in content; however, I also ensured that there was a distinct difference (e.g. characteristics) between each theme (Braun & Clark, 2006).

I examined each theme label to determine if it was an appropriate representation of the coded text extracts that had been assigned to the theme. If the theme label did not fit the data then I had to decide if certain data did not fit within that theme, whether the theme needed to be reworked/re-labeled, or whether a new theme needed to be created (Braun & Clark, 2006). During this stage, unassigned excerpts were also considered to see if they belonged in an existing theme or whether they should be discarded from the analysis (Braun & Clark, 2006). Once the candidate themes appeared representative of the data assigned to them, I then engaged in a secondary analysis of how the themes worked in relation to the data set as a whole (Attride-Stirling, 2001; Braun & Clark, 2006).

With the candidate themes and working thematic map developed, I then read through the entire data set, including the 21 individual interview transcripts that were not line by line coded, following the declaration of theoretical saturation. This was done to determine if the articulated levels of themes and thematic map were valid within the context of the entire corpus of the study data (Braun & Clark, 2006). As the data set was re-read it also provided an opportunity to code any data that may have been missed in the initial coding stages (Braun & Clark, 2006). Once the study data supported the articulated themes, sub-themes, elements, and sub-elements presented in the thematic map, the analysis moved on to the next phase (Braun & Clark, 2006).

**Phase five: Defining and naming themes.** Once a comprehensive thematic map was developed, the next series of tasks included the further refinement the theme names, augmented definition of the themes, and refinement the thematic map so that it coherently

represented the study data (Braun & Clark, 2006). By examining the data extracts associated with each theme, I attempted to capture the essence of each theme by writing an internally consistent account of what each theme represented, while illustrating this account with appropriate excerpts from the data (Braun & Clark, 2006). Each component of the thematic map was analyzed, illustrated, and clearly articulated so that the reader developed a comprehensive sense of how the different themes, sub-themes, elements, and sub-elements interacted with one another to form a coherent story of men nurses performance of masculinity and caring (Braun & Clark, 2006). The ultimate goal of this research phase was to clearly describe the scope and content of each theme in the thematic map and the relationship between these components in a clear, comprehensive and concise manner (Braun & Clark, 2006).

**Phase six: Writing the final report.** The final undertaking in performing the thematic analysis was to write a comprehensive account of the thematic analysis process, and tell the story of the study data in a way that provided support for the conclusions and resulting thematic structure (Braun & Clark, 2006). Dynamic extracts from the data were presented to illustrate each component of the thematic map that articulated the contextual performance of masculinity and caring (see Chapter 4). I have also strived to go beyond a mere listing of findings by articulating the complexity and nuances of the analysis, to present a comprehensive and interesting account of men nurses performance of masculinity and caring (Braun & Clark, 2006).

### Phases of the Study (Non-linear)

Although application of thematic analysis to explore qualitative data does not necessarily follow a linear and sequential process, Figure 3.1 is a visual representation of the general phases of this study's thematic analysis, which were discussed in much greater detail in the previous section.

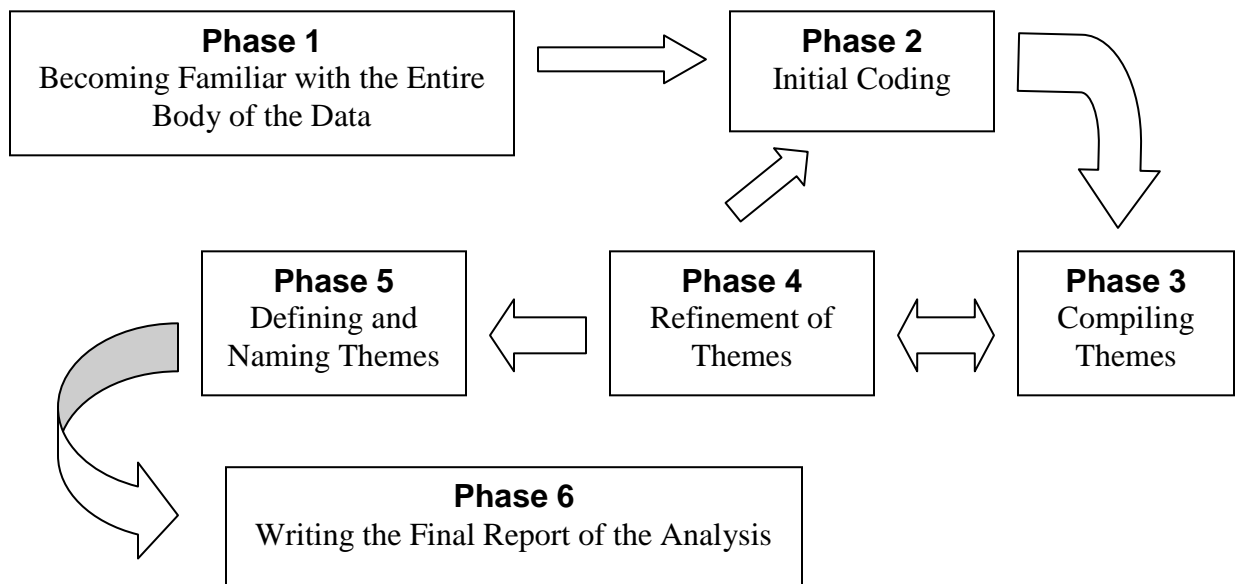


Figure 3.1. Phases of thematic analysis adapted from (Braun & Clark, 2006).

### Utilization of Research Software and Other Research Processes

As mentioned in the data analysis section, NVIVO 8.0 qualitative research software was utilized as a tool in the organization and management of the study data (NVIVO, 2008). Electronic versions of the transcripts from individual interviews and focus groups (in Microsoft Word format) were first imported into the NVIVO project library as individual cases. Case nodes were established for each individual transcript

and a pseudonym was assigned to each case so that I could recognize each case by name and present the study findings in a more dynamic and personal manner (NVIVO, 2008). By establishing a case node for each individual participant, I was also able to establish attribute variables to collect potentially useful demographic data about the participants based on their answers to questions posed in the primary study's interviews. The attribute variables collected during this study included: age, age cohort, current practice setting, education, employer type, geographical location, marital status, sexual orientation, the answer to the question "Would you choose nursing again?", and year of graduation. NVIVO 8.0 software was of major assistance in the coding of text excerpts from these cases, and helped to track and organize emerging themes across the numerous transcribed case files. In addition, NVIVO allows a researcher to record memos on thoughts, ideas, and hunches throughout the analysis, with links to the transcript data or project objects that informed these hunches (NVIVO, 2008). This capability therefore assisted in maintaining an audit trail to demonstrate the rigor of my approach to qualitative analysis (Sandelowski, 1986; Streubert Speziale & Carpenter, 2003). Finally, NVIVO also helped significantly with its ability to record hypothesized relationships between the emerging themes, which assisted in creating thematic maps of the hypothesized relationships and patterns between themes through the utilization of modeling tools built into the NVIVO 8.0 software (NVIVO, 2008).

The Statistical Package for the Social Sciences (SPSS) version 11 was also utilized in the statistical comparison of demographic characteristics for coded participants versus non-coded participants, to determine if the coded sample of participants was

representative of the entire sample of potential participants that was available (SPSS, 2001).

### **Methodology Strengths and Limitations (Rigor)**

**Strengths.** There are several strengths in the study methodology, which support a rigorous approach to research and adherence to the principles of trustworthiness, credibility, dependability, and confirmability (Creswell, 2003; Lincoln & Guba, 1985; Sandelowski, 1986). First, the question posed in this study was conceptually close to the questions considered during the data collection for the original study, which enabled the data set to adequately represent the topic of this study. Second, the original data set was collected with the method of thematic analysis in mind, thereby enhancing the fit of the existing data set with the current study methodology (Thorne, 1994). Third, the presence of the primary investigator for the original study, Dr. Joan Evans, and her co-investigator Dr. David Gregory, on my thesis committee provided an opportunity for discussion about the original study and data set including elements such as process, variation, “strategy shifts, implicit preconceptions and biases, sources of timing of inductive inspiration, and eventual coding and interpretation” (Thorne, 1994, p. 272). This contact with the original research team, assisted me to gain insight regarding the influence of artifacts in the original research process (Thorne, 1994). Fourth, my thesis supervisor, Dr. Robert Meadus (Memorial University), and my advisors Dr. David Gregory (University of Lethbridge), and Dr. Joan Evans (Dalhousie University), all have extensive experience in qualitative research, and have all completed studies in the areas of men in nursing. Having this wealth of experience on my thesis committee therefore assisted me to engage



in a rigorous and thorough research process. Trustworthiness of the findings was also enhanced through regular dialogue with the onsite member of my thesis committee (Dr. David Gregory) throughout coding and thematic analysis, and by sharing this ongoing analysis with the entire committee for their review and validation. Fifth, the presence of data triangulation in the form of an extensive data set collected from three geographical sites, and utilizing both individual interviews and focus groups enhances the credibility and dependability of the current research findings (Creswell, 2003; Lincoln & Guba, 1985; Sandelowski, 1986; Streubert Speziale & Carpenter, 2003). Sixth, my thesis supervisor was not part of the original research study and he was able to approach the assessment of my findings with a fresh perspective free from any bias related to previous contact with the study content (Creswell, 2003). This also enabled him to assess the degree of rigor that has been applied in the support of research conclusions (Creswell, 2003). Finally, an additional strength was my background as a Registered Nurse, which provided me with insider knowledge of the profession and culture of nursing.

**Limitations.** Several potential limitations to the study methodology exist, although in some cases the careful and purposeful research process utilized likely minimized the effect of these limitations on the quality and trustworthiness of the research findings (Creswell, 2003; Lincoln & Guba, 1985; Sandelowski, 1986). As a man and Registered Nurse, I acknowledge a certain degree of reflexivity and potential for bias in my interpretation/analysis given my shared experience as a man working in a profession numerically dominated by women. This potential bias was blunted through reflection on my existing perceptions and biases related to the study topic prior to

embarking on the research analysis and thereafter. By making my existing assumptions and biases explicit, my committee members and I were better able to challenge my interpretation of the data to ensure that the resultant themes were represented in the data and were not influenced by my existing preconceptions (Creswell, 2003). Another significant limitation related to the secondary nature of the analysis is the inability to go back to the original participants to clarify or further explore emerging themes beyond the existing data set. Thorne (1994) suggests that one possible approach to dealing with the question of confirmability of findings during secondary qualitative analysis is to utilize the original researchers as a possible source of validation, and the involvement of the original study primary investigator and a co-investigator on my thesis committee were invaluable resources to dealing with this challenge. In addition, confirmability of any potential research conclusions were supported through thorough documentation of the research process and decisions using memoing and journaling. There is a clear audit trail to support these conclusions (Sandelowski, 1986; Streubert Speziale & Carpenter, 2003). Finally, as a secondary researcher, I was not as aware of the context of the original data set such as the temporal or historical influences, or conditions related to the subjects and environment (Thorne, 1994). This was partially addressed by the participation of two of the original research team members on my thesis committee, who were aware of the context in which the original data set was constructed.

## Chapter 4

### Study Findings

Experienced men Registered Nurses from three Canadian sites were interviewed by investigators during the primary study: “Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female-dominated Professions of Nursing and Elementary School Teaching” (Evans, et al., 2007). The transcripts of these individual interviews, and three focus groups, were subsequently accessed for the current study and subjected to a secondary qualitative thematic analysis. As the analysis of these data progressed, it was evident that the performance of masculinities among study participants significantly influenced the co-performance of professional nursing care by these men. Since it would be inappropriate to consider the performances of masculinity and caring as mutually exclusive, the co-performance of masculinity and caring by men in nursing is presented as a compound performance of masculinity and caring from this point forward.

The central overarching theme was the *contextual performance of masculinity and caring* (See Figure 4.1 p. 91). Three key performance sub-themes of masculinity and caring were identified including: *cautious caregiving, caregiving as strength, and technical-instrumental caregiving*. In addition, eight performance elements were also identified that supported to the performance sub-themes of masculinity and caring: *cautious touch, identification of marital status, trading off nursing tasks, use of women as chaperones, humor as a tool to establish a therapeutic connection, choice of practice*

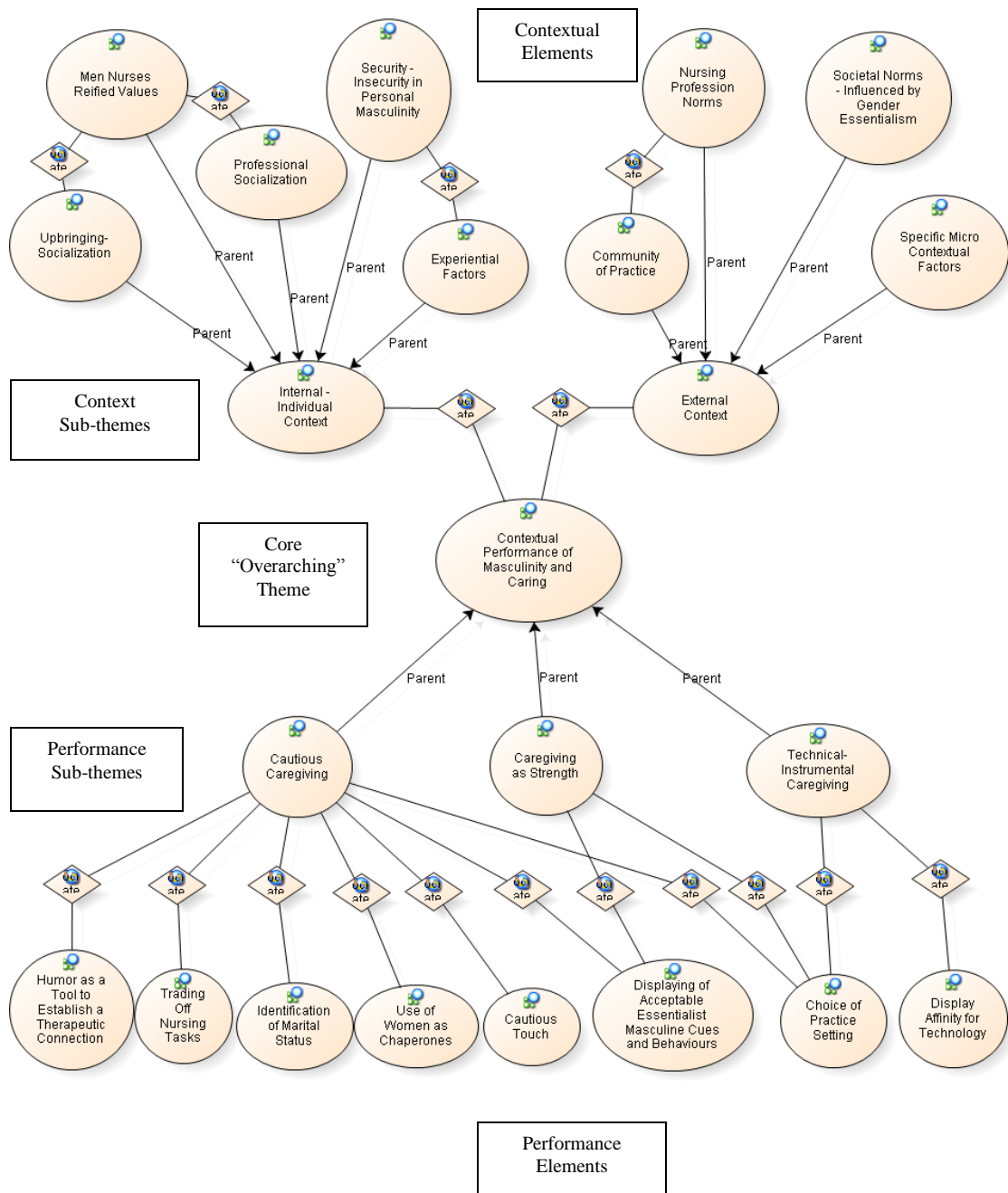


Figure 4.1. The Contextual Performance of Masculinity and Caring among Men in Nursing

*setting, displaying an affinity for technology, and displaying acceptable essentialist masculine cues and behaviors.* These performance sub-themes and elements are presented as common patterns of masculinity and caring performance amongst the study participants. However, they cannot be considered a description of every participant's or every man in nursing's performance of masculinity and caring.

Consistent with theoretical perspectives of masculinity and caring, the concurrent performance of masculinity and caring was also considered a social construction, subject to adjustment or revision, and influenced by the unique context in which the performance occurred. In other words, each performance of masculinity and caring was contextual and unique. Potential influences on the performance of masculinity and caring were grouped under the context sub-themes of *external context* and *internal-individual context* (See Figure 4.1 on p.91). The sub-theme *external context* revealed several contextual elements that represented potential external influences on the performance of masculinity and caring including: *societal norms influenced by gender essentialism, nursing professional norms, community of practice, and specific micro-contextual factors (gender and age of the client audience and other individual audience factors-feedback)*. The sub-theme *internal-individual context* revealed contextual elements that were associated with internalized beliefs, values, or factors among men nurses such as: *upbringing-socialization, men nurses' reified values, professional socialization, experiential factors, and security-insecurity in personal masculinity.*

Following a review of the participant demographic characteristics, each of these themes are described in greater detail. Verbatim quotations from the transcribed discourse

of the study participants (identified by pseudonyms) support and illuminate each theme. In some cases, text excerpts were used to illustrate more than one theme as there was some interdependence or overlap noted between some of the identified themes. In addition, Figure 4.1 (p. 91) identified the potential interaction among the various themes to clearly articulate the contextual performance of masculinity and caring by the participants.

### **Demographic Characteristics of the Study Participants**

A total of 42 individual interview transcripts were accessible from the data set collected by the original study, “Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female-dominated Professions of Nursing and Elementary School Teaching” (Evans, et al., 2007). Demographic information was recorded for each participant utilizing NVIVO 8.0’s classification tools to record participant attributes including: age, age by cohort, study site, nursing education level, type of nursing employer, current practice setting, sexual orientation, marital status, year of graduation from their nursing program, and the answer to the question “Would you choose nursing again as a career?”. These demographic characteristics were recorded during the review of the participant interview transcripts as there were no structured demographics collected for all participants during the primary study. In some cases, it was impossible to determine certain participant characteristics from the interview transcript; therefore, all presented demographics are based on the available transcript data only. An additional variable, years of practice, was also calculated by subtracting each

participant's graduation year from the year that the primary study interviews were completed.

During the course of data analysis in the current study, theoretical saturation was attained following the line by line thematic coding of 21 of the individual interview transcripts (the transcripts for the first seven interviews conducted at each study site: Halifax, Winnipeg, and Vancouver) and the three site-specific nursing focus group transcripts. After this point, the remaining 21 transcripts were reviewed for their consistency with the resultant thematic model. In order to determine if the coded sample of 21 transcripts was demographically representative of the overall potential sample of 42 nursing transcripts, a statistical comparison of the two group's demographic qualities was performed (coded transcripts versus non-coded transcripts) with the assistance of the Statistical Package for the Social Sciences [SPSS] (SPSS, 2001). Differences in the demographic characteristics between the coded participant transcripts and the potential uncoded participant transcripts were tested using independent t-tests for the continuous scale variables and chi-square for categorical variables. The assumption of normality was statistically verified with the Kolomogorov-Smirnov and Shapiro-Wilk tests of normality for all continuous scale dependent variables prior to application of the independent t-test. Unfortunately, the chi-square test assumption, that no cell in the cross-tabulation will have an expected count less than five, was violated for all the categorical dependent variables except for "study site". This was unavoidable because of the relatively small sample size and the presence of a large number of categories in the majority of the categorical variables; therefore, the violation of this test assumption may

have affected the reliability of the chi-square results. The results of this statistical comparison are presented in Appendix H and it was determined that there were no statistically significant differences noted on any of the demographic variables between the transcripts that were line by line coded and those that were not.

**Summary of participant demographic characteristics.** The first seven participant transcripts were coded from each of the study sites: Halifax, Winnipeg, and Vancouver. Study participants had a mean age of 43.3 years ( $\sigma=7.37$  years). When grouped into age cohorts of five years, the frequency distribution was bimodal, with the categories 40-44 years and 45-49 years containing six study participants each. The mean year of graduation was 1987 ( $\sigma=8.37$  years), and the mean number of years that the participants had been practicing nursing was 16.9 years ( $\sigma=8.37$  years). The most common level of nursing educational preparation was a Registered Nursing [RN] diploma with seven participants in this category. Four participants had an RN diploma with specialty training, four had a baccalaureate degree in nursing, one had a baccalaureate degree with specialty training, three had a master's degree, and two held a doctoral degree. The most common type of nursing employer among study participants was a provincial health organization with 13 participants in this category. Ten study participants reported being married, nine reported being single, and two did not identify their marital status. Fifteen participants identified themselves as heterosexual, five identified as gay, and one participant did not identify his sexual orientation. The most common practice setting was nursing education with four participants in this category; however, participants were drawn from a diverse practice background in general. Three



participants practiced in critical care (intensive care unit, critical care unit, neonatal intensive care unit), two in emergency room/trauma, two in medical settings, one in a surgical setting, one in mental health, one in occupational health, one in gerontology, one in nursing administration, and five from a variety of specialized settings. When participants were asked if they would choose nursing again, 15 participants said “yes”, two said “no”, two were uncertain, and the answer was unknown for two participants. For a more detailed breakdown of participant demographic characteristics with charts, please refer to Appendix I.

### **The Contextual Performance of Masculinity and Caring**

The core “overarching” theme identified during data analysis was *the contextual performance of masculinity and caring*. This central theme acknowledged the combined performance of masculinity and caring exhibited by the study participants, and the influence that the context of the nurse-client interaction had on this performance. The following statement by Blaine presented an excellent example of *the contextual performance of masculinity and caring* because it illustrated how he adjusted his performance of masculinity during his caring interactions, based on the client and the context of the interaction.

Blaine

So whether ...I can be masculine, in, ... putting my foot down with the behaviors of drug users when they're using on the unit, when we have these psychotic episodes, so yup, I might act like a tough guy, I might run to the side of a younger female nurse you know, and play that role, and probably puff myself up and don't even know it ... I'm sure I even lower my voice, you know, and even use different words, like tough guy words; yeah, I'm sure I do that. ... Now, I might sound like a cheerful flight attendant, with a little old lady from England, when

I'm interacting with her instead. But that's interesting ...? When it gets difficult or when it gets dangerous, yeah, I put on a cowboy hat I guess.

The *contextual performance of masculinity and caring* is the result of a complex social process, in which the internal-individual context and external context of a nurse-client interaction inform the man nurse's actual performance of masculinity and caring. This performance is then commonly manifested through the use of strategies represented by the performance sub-themes and elements as illustrated in Figure 4.1 on page 91.

In the following sections, each of the performance and contextual sub-themes and elements that contribute to the *contextual performance of masculinity and caring* are explored thoroughly in an attempt to unravel and illuminate the complexity that is inherent in the gendered performance of nursing care by men.

### **The Performance Sub-themes of Masculinity and Caring**

Three key performance sub-themes were identified during thematic analysis including: *cautious caregiving*, *caregiving as strength*, and *technical-instrumental caregiving*. These sub-themes were present in virtually every transcript, and explain the majority of the participants' performance of masculinity and caring.

**Cautious caregiving.** *Cautious caregiving* served as a strategy to address men's concern that their nursing care, and particularly the intimate physical care they provide, will be misinterpreted as inappropriate or sexual misconduct. Rooted in societal essentialized gender perspectives that situate men as unlikely providers of physical touch in a caring context, men acknowledged that their nursing care was frequently viewed with suspicion by clients and sometimes by colleagues. The study participants therefore utilized *cautious caregiving* as a means to increase their acceptability as caregivers while

also decreasing the risk that their care would be misinterpreted or lead to false allegations of misconduct. *Cautious caregiving* was the most pervasive sub-theme emerging from the analysis of the transcripts with 52 coded references drawn from 22 out of the possible 25 coded transcripts.

In the following text excerpts, participants (identified by pseudonyms) discussed how it can be very awkward to initiate the provision of intimate nursing care to women clients, especially in the early stages of their career.

Robert

I ... was working ... on Obstetrics, and I have to go in after she had her ... little one, and ... check her pads, and I was standing outside her door trying to figure out, how am I going to go in and approach this, to tell somebody take their clothes off so I can take a look.

Edward

Now I had to work through comfort, initially, as a young man, giving intimate care, and as I got older, it's less and less of an [issue].

Many of the participants also acknowledged that nurses are obligated to perform intimate care that has the potential to make their clients feel uncomfortable; therefore, it was not unexpected that these men in nursing experienced challenges in the provision of intimate nursing care. There was also a pervasive sense that men must demonstrate extra caution in their interactions with clients.

Boyd

I've had males telling me that they think that they have to be careful with what they're doing, and the very interesting thing is because of our profession, I mean, by law, and by our goal, we are able to do things with people, male or female, it doesn't matter who it is, and we would be arrested for [doing these things] on the

street. And they're legally and professionally obligated to them, and yet we're supposed to do this in a way that this person is not supposed to feel in the least bit upset about it, well that can be difficult.

Participants reported exercising caution in the provision of nursing care to both men and women clients and took steps to avoid potential misunderstanding of their nursing care by their clients. With men clients, the potential for misunderstanding frequently centered on the common stereotype that men in nursing are homosexual, and this often remained a factor in interactions with men clients regardless of the actual sexual orientation of the nurse.

Dale

I've never put myself [in] a position I think where I felt unsafe. I had concerns when I was in the outpatient department, where we had such a large flow of folks coming through. There was a whole lot of hands-on there, primarily because it was a vehicle for pre-op assessments or post-op reassessments, but I always had in the back of my mind, that if I'm in a cubicle by myself with a female, there could be some potential issues from that. There could also be some potential issues from the male side of patients as well. I am a gay man, and so I thought, well there could be some repercussions from that, but there haven't been.

John

I think maybe one or two [men] patients, may be looking uncomfortable until they've known me for about half an hour, because they may think ... I am gay.

Participants also reported a hyperawareness that they were at risk for accusations of sexual misconduct, especially when potential cases of misconduct by men nurses were featured in the media. When these cases received publicity, clients potentially perceived men nurses in a less favorable light and these men nurses may have felt that their

performance of physical care was subject to greater suspicion. The need for caution is thus reinforced for them.

#### Vancouver Focus Group Participant

When I started my career, this was big in the news, I don't even know if any of you will remember it, but the male nurse in Michigan who was ... accused that he groped a woman when he was putting his hand up under her gown to put a lead on. And I went to work for the next couple of weeks very, very conscious, and I still am, very, very conscious of when I'm putting leads on and reaching up under her shirt.

#### Boyd

I mean, men in our society unfortunately are still the aggressors and the case just in Toronto ... of course, because he's a male nurse, well, my God, here it is, the result is male nurses, they're all terrible and, and that one situation is just going to put a whole different picture that people are going to look at every male nurse who works in pediatrics now, with some kind of a look. ... do we have to worry about it? Yeah, we do. And do we do things about it? I'm certain.

Although men in nursing were concerned about the potential for false allegations of sexual misconduct, another significant motivating factor for *cautious caregiving* was the desire to establish a comfortable, caring, and trusting relationship with their clients. The participants asserted that they were capable of providing professional and competent physical care to clients of both genders; however, they employed a number of strategies to mitigate client discomfort or the potential for misinterpretation of their care such as the use of chaperones, or trading off nursing tasks with their women colleagues. It should also be noted that expectations that men should hand off certain tasks to women colleagues and exercise caution in their practice was reaffirmed by women nursing colleagues. A cautious approach to intimate care by men in nursing was often entrenched in the common attitudes and processes of many communities of nursing practice.

Chris

Mostly I'm concerned about the patient being comfortable ... it's not a big deal to me, any aspect of care with a person, but ... I tend to ask the patient if they're comfortable with me doing it, and if they're not, then I would request that the woman do that, and same with female catheterizations.

Edgar

Yeah, you know, it's funny; when I first got out of nursing [school], I felt, you know what, I am trained to do everything, [including]... catheters, on a man and a woman, and so that's what I'm doing, because I'm trained to do it all, and it doesn't matter what sex [the patient]... is, I am a professional, and that's what I'm doing. And that's how I really ... started my career. And as I got through my career more, more people started telling me, you need to watch yourself, ... you've got to protect yourself when you're putting the catheter into females, you know, that kind of thing you've got to trade off.

Richard

But as far as inappropriate touching or the allegation of inappropriate touching, that's always an issue when you're doing psychiatric nursing, and they're aware of it. Like if you're doing rounds, you're opening up doors, you're going into rooms alone at night, ... there could be a double lock room, or it could be a private room and ... there are certain types of personality disorders where that would be more common, those false allegations. But they're aware of that, and you just make sure that, you know if you're alone with somebody who's possibly going to do that, that you have a female in the room, like if you're doing their medical exam or admission assessment, or whatever.

Peter

Sure, we are more vulnerable ... we can be placed in situations where we can be left to defend ourselves; where it's my word against her word, so that's one issue that I've been very cognizant of throughout my career, there are some situations that I have refused to - perform my duties, for example, I will not give a female patient an IM, unless there's somebody else in the room, whether it be, I don't care if it's a doctor, I don't care if it's another woman, I don't care who it is. But I will not give a female patient an IM, one on one, without somebody else there, and so I have in the past, when that situation's arose, had somebody else there.

*Cautious caregiving* was a pervasive sub-theme in the performance of masculinity and caring; therefore, a number of the performance elements that were described by the study participants contributed to this sub-theme. *Cautious caregiving* will therefore be revisited in the description of several performance elements later in this chapter, and these descriptions will serve to further illustrate the complexity and significance of *cautious caregiving* for the participants in this study.

**Caregiving as strength.** Another performance sub-theme, *caregiving as strength*, was also densely represented in participant interview transcripts, with 49 text excerpts coded to this theme, representing 23 out of a possible 24 coded transcripts. *Caregiving as strength* acknowledged the role that greater physical size and strength frequently played in men nurses' practice. This common reality manifested in the tendency for men to take on the roles of lifter, enforcer, and protector in the course of their caregiving. Since men in nursing find themselves in a professional role that is associated with essentialized notions of femininity, many men embraced this physical role because it provided a familiar and comfortable means to contribute to the nursing team, while also enabling them to engage in an essentialized performance of masculinity that associated men's caregiving role with that of physical protector. In examining this sub-theme it was also evident that, although men nurses may have embraced the emphasis on their physical contribution to nursing care, this role was also frequently reinforced by women colleagues and by the health care system in general.

In the following text excerpts, participants discussed how the role of “lifter” was a significant part of their practice, and how the expectations of colleagues and supervisors have contributed to this practice.

Tom

I know when I started nursing ... I was the only male nurse on the unit, ... well you know, you're stronger, you come and help lift, ... this person needs to get pulled up in bed, so [I was] used more for strength. And not knowing any better ... you went along and did that. Once in a while you still hear like, oh [Tom] can take them down the other end ....

Harry

I know in my experience, when I was casual, I was regularly assigned to orthopedics ... or neurosurgery, because of physical capacity, ... [men] seem to be very valued - the manager at that time, seemed to value a lot, the presence of male nurses.

Tim

Moving and lifting, I've done a lot of moving and lifting, a lot of help, and I think it's expected, because you are a man, that you're stronger, come and help out, and I think every guy on the floor has a bad back now ... it's not that we're expected to do it, it's just that role, it's the societal role that men are stronger and, you should be able to do this, and help us out.

The participants also found themselves being called on to deal with aggressive or physically violent clients in the hopes that their physical presence would be a deterrent to violent behavior. These nurses were also placed in the position of having to physically intervene or restrain clients.

Richard

I think I have an advantage when it comes to dealing with difficult patients. Agitated patients and aggression, aggression that occurs on the floor, ... you would think of it as more of a psychiatric thing, there's been several times where things have arose, and all eyes shift to me to take care of it, and I have been able



to take care of that, so I suppose that's a pro versus a con. ... In some, it was physical restraint, I had to restrain one guy for 45 minutes one night when he had the DT's [delirium tremens] ... , and was aggressive, trying to get out of bed and he was in traction ... with a fractured hip. His femur was also broken, I was concerned he was going to end up with, you know, slicing his femoral artery and was going to bleed out, and I'm one of two people who are trained in CPI [crisis prevention], and actual restraining techniques that are effective and don't harm the patient at all.

Chris

... our patient population here tends to either be drunk when they get here, or have a history of alcohol or drug use, so I do tend to deal with more of the physically aggressive patients, even if I'm here in my educator role. If someone's being aggressive, physically or verbally towards any of the people that work here, I tend to go and speak with them. ... I've had quite good results with people that are ... acting out, or being physically aggressive to me just being in the room, ... and standing at the end of the bed while the nurse does something, I've had positive reactions to that ... .

While asking, or expecting, men nurses to take on the role of security guard may have served to reinforce their sense of masculinity, or even given them a sense of accomplishment in fulfilling this role, this practice remained problematic. Some participants felt that they should not be placed at risk of physical harm and expected to take on the role of security in addition to their nursing responsibilities.

Vancouver Focus Group Participant

But in the Emergency Department [where] I worked previously, when there was a violent or aggressive person or somebody who was maybe a little bit on the unsavoury or distasteful side, I would get them. Because, you know, I could deal with it better. I was ... used in a role because our security ... is often very inadequate, and I almost feel like sometimes I'm lumped in with nursing and security, like if there's a violent situation. ... I had to call on my charge nurse one day and I'm like, how come whenever there is somebody in who's acting up you want me to go over and be involved in it.

In addition, many participants did not feel prepared to fulfill this role, and some suggested that the use of physical aggression in the course of caregiving was inconsistent

with professional nursing care. What was evident in the transcripts was the ambivalence that several participants assumed toward the emphasis on their physical contribution to nursing practice. These participants expressed that it was inappropriate for them to be treated as “muscle”, but they also expressed pride in their ability to deal with difficult clients or protect their women colleagues. There was also some degree of acceptance that acting as security was somewhat inevitable. This suggested that some of these men may have subscribed to essentialized perspectives of masculinity that viewed women as dependent on the physical protection of men.

Boyd

When I graduated, now this goes back 20 years, 23 years ... it was in the first 6 months of graduation, I was working nights one night, and I was on one floor, and the supervisor came down and asked if I could go upstairs to help out because they could use some help, and I went up. . .I'll never forget it. I walked up there and there's a fellow standing in the middle of the hallway with half of an IV pole in his hand, and he doesn't understand a word of English, and he's suffering the DTs [Delirium Tremens]. And, and there's like two little female nurses behind him ...with that look on their face, and he's kind of swinging this pole, and I'm thinking to myself, this isn't in my job description. But, absolutely, obviously called me because I think I was like the only guy in the hospital

**Technical-instrumental caregiving.** The third sub-theme that provided support for men nurses' performance of masculinity and caring was *technical-instrumental caregiving*. While not as pervasive as *cautious caregiving* and *caregiving as strength*, this sub-theme was still densely represented with a total of 17 text excerpts coded to this theme from 11 of the 24 transcripts. This sub-theme not only referred to men nurses' apparent affinity for technology, but also to the tendency for many of the participants to place greater emphasis on technical proficiency and the instrumental aspects of nursing

tasks. Some participants perceived an affinity to technology as an extension of men's societal gender role, or as a manifestation of men's inborn qualities, thereby suggesting that these men held a more essentialized view of gender.

#### Winnipeg Focus Group Participant

... society has dictated the stereotype [that] men are supposed to be more technologically orientated, men are supposed to be more skilled kind of orientated, and there seems to be a belief or value system or whatever you want to call it that if a guy comes in, the patient knows that this guy is going to know what he's doing and [be] very efficient.

In some cases, the study participants' comments also suggested that they did not place as much relative value on the affective components of nursing care, which were affiliated with femininities in the profession. In other words, they expressed the opinion that technical proficiency was paramount, while the nurturing and compassionate elements of caring were desirable but of lesser importance.

#### Edgar

I think that more [the] technical areas probably are, the ICU's or in the Emergency Departments, I think [they] are probably easier places. Now, why? I know that a lot of guys like the technical part of things. They like to see results fast. A lot of men tend to not have a lot of patience, and we like to see things done fast. I think that technical aspect in ICU and CCU ... and Emergency, almost overwhelms, or ... overshadows, I guess, the part of nursing that's very, I don't want to say caring, but attentive to the basic caring needs. And you know, I don't know how to phrase this, I think, first and foremost, a lot of male nurses want the technical part of it, the science part of it, the immediate results part of it, first, and they'll do the caring part, the compassionate part ...; it's there, but it's not there first.

#### Vancouver Focus Group Participant

I would like the knowledge base ... that's what I would be drawn to ICU for ... But, the thought that ... my entire day would be bed baths and wiping people's

bums and changing them and turning and rolling them, that's not what I went to school for.

Halifax Focus Group Participant

Yeah, give me a guy who cares a little but knows his stuff, as opposed to a nurse who cares a lot but hasn't got a clue what she's doing.

One interesting element in the discourse of some of the men participants was the tendency to use the term “caring” to refer to the affective component of nursing work, as if caring was separate from knowledge and technical skill. In addition, some participants positioned the affective components of caring as being subordinate to technical and knowledge competencies. In the following excerpt, from the Halifax focus group, it was notable that the “art of nursing” was associated with the affective, and affiliated with general medical/surgical nursing units. Reference was made to the fact that there was more science in critical care environments as compared to the “inexact and unscientific” art of nursing practice as seen in the medical/surgical environment.

Halifax Focus Group Participant

The conversations seem to be more based in science in the ICU, whereas on the floor they have a tendency to be more based on the art of nursing, patient needs, the pain medication, because this sort of thing, ...the dynamics of their getting up and moving around and getting moving toward wellness and going home, are such that the patient needs this. So there's a bit more of an art to nursing on the nursing units as there is ... more of a science to nursing in intensive care units.

Barry

I'm not big ...[on] hand holding at the bedside, but I will help people that are in a great deal of distress. I was quite successful when I worked in psychiatry, which involved a lot of therapeutic use of self, but you know, it didn't involve being tender and loving. ... I think because we're a minority, we have to be very good at what we do, we have to be very competent; you have to have a lot of self-

confidence, you can't waffle, you have to make decisions, and you have to make decisions quickly, and you've got to be right, or at least on the right track.

In some transcripts, participants expressed frustration about what they perceived as “unnecessary” affective and relational elements of nursing practice, and suggested that there needs to be more emphasis on the instrumental and “essential” elements of nursing care that are necessary to “get the job done” efficiently. In the following text excerpt, it is interesting to note that the participant also essentialized the communication practices of his women colleagues as being less efficient in the course of making his point.

#### Winnipeg Focus Group Participant

Report is the best example. Go and listen to report. And you have some women who giving report, the report lasts X amount of time. You get report from a guy, you're out of there in 5 minutes. ... I don't need to know that Mary's aunt's cousin came in and they had their little baby and, and, oh, she was so cute ...Who cares. Tell me what happened to the patient last night, tell me what's going on with him right now, that's all I need to know, to get my job done. And it's not task orientated, it's just that I don't need all that extraneous ... information, because it's not going to make me take care of this person any differently. So it's that communication that's, there's so much different I think in women.

Not all participants devalued the affective components of nursing care, and some observed that men in nursing could learn a lot from women colleagues with respect to affective skills such as empathetic communication and further considering client comfort.

#### Jacob

I find that the women tend to be much better at the empathic communication, ... not only the clinical part, but getting in there and making the patient comfortable. The men tend to be a little hard-assed about it, so I find that, although many of them are good clinicians; they know their stuff, they're solid, you need to reinforce with them at times that, you know, touch your patient, talk to your patient. Don't just look at the numbers ... Talk to your patient as a person; make them comfortable. You can have control of the situation, but make sure that

they're comfortable with it, you know? There's that difference between the two. So I find that a lot of them relate to their patients very differently than female nurses do.

### Performance Elements of Masculinity and Caring

Eight performance elements of masculinity and caring were evident in the transcripts. They were designated as performance elements because each of these micro-performances had the potential to contribute to one of the three key performance sub-themes. Please refer to Figure 4.2 below to see the potential relationships that exist between the various performance related themes.

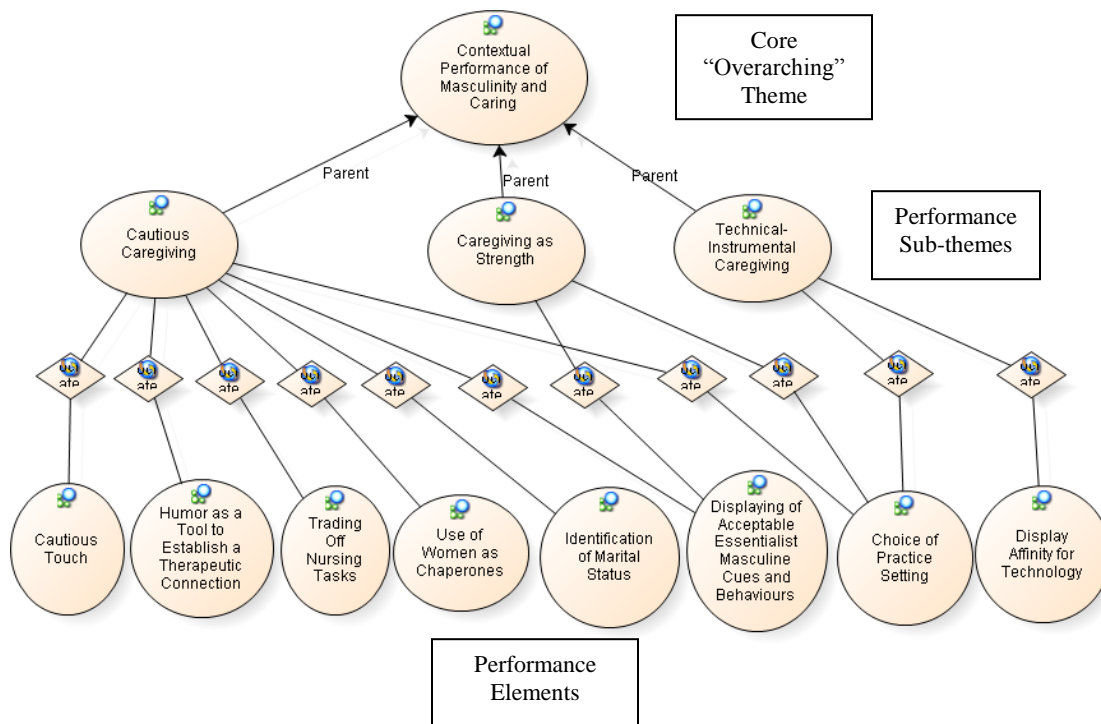


Figure 4.2. Performance Sub-themes and Elements in Men Nurses' Performance of Masculinity and Caring. Note: When performance elements undergird a performance sub-theme, this relationship is illustrated by a line (with a diamond shape) that links the performance element to the related sub-themes.

The performance elements were representative of the common strategies or approaches the study participants utilized in their performance of masculinity and caring; therefore, each can be considered a potential element or facet of one or more performance sub-themes. An individual nurse may not utilize all of these performance elements in the course of his practice, but these performance elements represented common patterns of practice that the participants used in addressing the performance sub-themes: *cautious caregiving*, *caregiving as strength*, and *technical-instrumental caregiving*.

**Cautious touch.** *Cautious touch* was one performance element that was closely related to *cautious caregiving*. Utilizing caution in physical contact with clients was one way in which the participants expressed *cautious caregiving*, and twelve text excerpts were coded to this thematic-element from six transcripts. The following excerpt illustrates the complex relationship that some participants had with touch in their practice. In some cases a certain type of touch such as putting an arm around someone was acceptable and appropriate, while at other times it could be misinterpreted. Exposure of the client's body was particularly concerning to the nurse because client nudity could have sexual overtones.

#### Winnipeg Focus Group Participant

I mean, if you think for a second that the potential isn't there, that's when you're going to get into a problem. And it also depends, too, on the type of touch, and putting a hand on the shoulder, you know, putting your arm around somebody's shoulder if they're in a situation that ... they need it, it's a whole different ball game than going and, you know, lifting a gown up because you're looking at the dressing. Or, you know, ... doing a catheterization. I mean, that's a whole different story, different kind of touching, that to me is, the touch from there is more professional touch versus a female touch. Which [are] two different things

The participant was also careful to distinguish “professional touch” from “female touch”, although the underlying reason for this distinction is unclear. Perhaps this statement was an attempt to distinguish between touch that is given in the context of professional nursing care as opposed to touch performed in a “nurturing” or “loving” way? In other words, the participant may be trying to underline the fact that they are merely touching clients in the course of performing professional nursing skills and that their touch was not associated with emotional or sexual intimacy. Perhaps the participant suggested that men’s touch was professional, while “female touch” was less professional?

One participant also described his observations regarding the different way that men nursing students approached physical nursing care as opposed to women nursing students, and the fact that men were much more cautious in their initial interaction with clients.

#### Vancouver Focus Group Participant

When I see my students, the guys will always operate from like a three foot thing, ... and the girls are like right in there, you know, to the point where the girls are stepping over that line way sooner than they should be. You know, like, you're not the mother yet ... like calm down here .... Anxious to be ...the caregiver stroking. . .But the guys take forever. Like, their first bed bath is really cool to watch ...

Another participant identified that men nurses’ caution with respect to touch may have some positive spin-offs for clients because they may be more gentle or considerate in the course of delivering physical care to women. Because men are careful about how they touch their clients, they may have the potential to be more respectful of client privacy because of the fear that their care will be misinterpreted. Thus the men nurses



may be particularly careful in the application of touch in the course of delivering nursing care.

Winnipeg Focus Group Participant

Studies and stuff that I've read about it, you know, most women who've had a male take care of them said that, in maternity L & D [labor and delivery] ... men are more tender at caring than the females are. My own belief is that I've been washing myself and cleaning myself for all my life and I know how much I can push, pull, prod, and yank, and not hurt. Whereas if I'm working with a woman, ... I don't know how much I can rub ... therefore, when I'm taking care of a female I'll probably be more gentle than I would be with a male. And on the reverse, I'm thinking that [a] woman would know that same thing about themselves and therefore they know what they push, press, pull, prod and so therefore they may be a little less gentle with females than they would be males. But I don't know if there's ever been a study on that, but that's a theory I have.

**Trading off nursing tasks.** Another common strategy (performance element) utilized by the study participants, which contributed to men nurses' cautious approach to caregiving, was the practice of trading off intimate nursing tasks with women colleagues (28 coded references from 18 transcripts). In some cases the decision to trade tasks with a woman colleague was made in response to a client objecting to a man performing physically intimate care.

Richard

I have made a switch with females, ... when they request it, always, and sometimes when I think that they are uncomfortable, but they're just not confident enough to come out and say that ... , and many elderly women I think are, especially people that live in nursing homes, are very reluctant to express dissatisfaction or ... [discomfort] with a particular person.

Participants did not generally object to trading tasks with women colleagues when the client requested a switch, because they wanted their clients to be comfortable with the care they were receiving.

Robert

A 41-year-old lady who just gave birth, and she said I had enough men probing and prodding me, and I don't need another man doing the checks, and surprisingly enough, I didn't feel upset by her decision, I just called for another nurse, female nurse, and she walked in and took over, and didn't harm me any, hurt me any, it was her wish so I said fine.

Richard

The way it is with females is, if they request it, I always make the change, and if I feel that they'd be more comfortable, I'll initiate the change, and some of them, the people that I work with, like an LPN [Licensed Practical Nurse] that's assigned to me ... I'll try to switch with them, but they tend to dislike that kind of thing, especially if they've done anything for that other patient, because now they think, okay, I've done all that for him and now he's going to give me another patient and that's going to make my work more. ... But I try to let them know that, you know, I think it's one in four women have been sexually assaulted in their life, and ... there's a great big segment of those people that are uncomfortable with me, and that's why they're uncomfortable. It's the last thing I want to do is make the trauma worse by exposing them to something they're not comfortable with. I've mentioned it to some of the people I've worked with, I'd love if they did accept me, because maybe then they'd see that not all men are evil, not all men are going to you know, molest them

Dale

Most of the time, there was at least one other female around, so keeping in mind that some patients may not feel comfortable with that, and if need be, there was always somebody as a backup that I could call upon to be able to look after this one particular patient if need be, it would be fine to you know, switch with somebody.

One participant expressed frustration about situations in which a third party, such as a family member, was the one making the request for the switch because these cases were felt to be based on projected feelings about the possible unsuitability of a men nurses rather than an actual stated discomfort by the client receiving the care.

Richard

I've had a few patients that ... [had dementia], had no idea where they were, and yet their ... daughters requested that they not have a male RN, and the reason given is that they know that their mother wouldn't be comfortable with this, when the mother doesn't even know where she is, she doesn't know who's who, what's going on, may have aphasia, can't even speak anymore, so I think it's the daughter who's not comfortable with the idea. ... But anyway, it doesn't matter, in all those instances, I've switched, but it can kind of be a slap in the face.

In some practice settings, trading off tasks was identified as a common or even expected practice, which was beneficial to all parties. Women nurses will do intimate nursing care for women clients of men nurses, while men nurses will look after intimate care for men clients or take over aspects of care for men clients who are being sexually aggressive with women nurses.

Blaine

There are very few things that we trade off, cause generally, everyone's pretty comfortable doing everything for everyone there, but we're very sensitive, ... for instance, catheterization on a female. My patient needs to be done, I will always ask her first-hand, before I do it, do you want a woman to do this? So the approach that we use there, is really patient-focused. So the female nurses will [ask] do you want one of the guys to do your catheter? So it's usually around those intimate kinds of things that are related to sexuality, the deep, dark secrets related to being a woman or a man or whatever it is, so we do trade those things off. You know, otherwise, we share the load equally.

## Vancouver Focus Group Participant

But, I'll often get out of doing female catherizations, not because I ask for it, but they'll offer it. And I'll say, fine, I don't care, if you want to do that, it's not exactly the funnest [*sic*] task in the world, it's sometimes it's kind of a not fun task. So if they're willing to take that on, fine. And it, sometimes it saves me.

## Tim

We do trade off tasks with them, we've had problems with females having problems with male patients, and more, the patient being sexually aggressive, or sexual overtones, a bit, and I will have nurses who come up to me and say, [Tim] can you take the assignment, can you go and deal with this person? And usually I do, I'll step in there and I'll do their treatment for the time being.

## Edward

Because even up north, like we bartered and traded for things, you help me with this patient, I'll help you with mine, kind of thing. ... You knock on my door at three o'clock in the morning to help you with someone who's intoxicated and needs suturing, and I'll call you in when I have to do a pap smear and the patient's uncomfortable at three a.m. in the morning, so we negotiated that.

## Edward

If the men thought they had a sexually transmitted disease, they asked for that man nurse. And my colleagues would often say, would you take this patient, because, you know, I just don't want to, so I would do that. But then I would also, I would always say to the women, are you comfortable, with this pelvic exam or not? I mean, if you're not comfortable, I'll get my colleague. No, no, no, I'm fine, nurse, go ahead. But I'd always have a chaperone with me. Always have a chaperone with me in any kind of gynecological examination.

One participant also acknowledged that he would trade off intimate nursing care for clients who might find care by a man to be inappropriate or uncomfortable because of cultural or religious reasons.

Ben

Females that are Muslim, I don't do too much with them. ... For the reason that, how they keep their hair, they don't want their face seen by a male, and it's part of their religion, you know, ... Just because, we do mostly cardiacs, and to put cardiac leads on, the placement, you know, you have to expose them a bit, and you don't want to do that to, because they're very, I don't know what the term is, but they hide a lot of their skin, and that's their, religious beliefs

**Use of women as chaperones.** The performance element, *use of women as chaperones*, captured another common strategy utilized by the study participants during the course of the performance of *cautious caregiving* (7 coded references, from 5 transcripts). Participants identified that one key way in which they protected themselves from accusations of inappropriate contact with clients (especially women clients and children) was to utilize a woman to chaperone their interaction with their clients.

John

I would say it's, for me anyway, much more concerning [with] my female patients. Especially if they're intoxicated with whatever, especially if they've been assaulted by a male, and especially if there's some sort of mental issue there. ... especially if it's in a private situation, you know, like a closed door situation. ... Yeah, I have somebody with me. A curtain there is fine, but a closed room, if I feel uncomfortable or if they make me feel that they're uncomfortable, I get help.

Eric

I catheterized [women], but you always had someone there with you, always. ... same with suppositories, it's really safe, absolutely. Yeah. ... it's protective, and you had to have someone, well, I always had someone there, always, and, especially with the kids, and so I'd often, and then with kids, I'd get the mom.

In some practice settings, such as the military examples which follow, it was an expectation that a man should always have a chaperone as common practice. In other

settings it was left up to the nurse to decide if a chaperone was required based on the situational context. The need for a chaperone was particularly emphasized if the client's mental status was compromised in any way. In either case, the participants tended to err on the side of caution and utilized chaperones whenever they felt the situation was hazardous to protect themselves against false accusations.

Robert

The military has a little bit different slant to that, because a lot of times ... - when it's a female, a female should be in the room present, just for security measures. While on civi-street in the Emerg Departments or wherever, it's not a demand or request to have another female present, but ... sometimes ... we'll do something where we request a female to come into the room. Just to make sure that everything's on the level, keeping it secure for me and for the patient so that if she yelled something, at least I have an innocent bystander.

Robert

The women have done men in the military. I'm just trying to think have I ever done a woman in the military? I've done them on civi-street, no problem, but in the military, yes, but it would be where I would have the female nurse in the room or a female Med Tech, and assisting more than being the initial person to be called. ...that is a difference, it is a written rule that when women look after women, men look after men, but then they can request for me to go in there, and for the security again ... I'd probably go in a room with a woman patient, but I should have a woman beside me. ...As an observer in case something happens in that room, same with the doctors ... Just because there's been too many people yelling different accusations that sometimes, a lot of times, aren't true. ... we've learned, probably over time, that we need the protection, because if somebody doesn't like what's said or done then that accusation ... it takes a long time to resolve it.

Richard

Like if you're doing rounds, you're opening up doors, you're going into rooms alone at night, you know there could be a double lock room, or it could be a private room and you know, there are certain types of personality disorders where that would be more common, those false allegations. But they're aware of that, and you just make sure that, you know if you're alone with somebody who's

possibly going to do that ... [then] you have a female in the room, like if you're doing their medical exam or admission assessment, or whatever. And I think females that you're working with in those settings are very supportive of that, they understand the reason for that, and they're willing to do that. But again, there's that perceived need that they need the men, so this is something that they have to do in order to keep the men safe, to work in that environment. Now on the floor where I work, there's less of that support. I had a patient that had a borderline personality disorder, and I had to give her suppositories, and she was you know, a street person and she was a prostitute, and she had these personality disorders, and I really felt that she was every bit of a risk ... , and I asked several nurses if they would come down and not do anything, just be there while I'm doing this, and was refused about three times before it finally was accepted, because I don't think, either they didn't understand the danger, or they didn't care. But one of the other people understood it, and her husband happens to be an RCMP officer, so she was aware that you do have to take these precautions ... Because whether it's true or false, that allegation is, if it doesn't cost my job, it would cost my reputation.

**Identification of marital status.** One particularly interesting performance element was *identification of marital status*. Identifying themselves as married was a strategy that four participants employed in the course of performing *cautious caregiving*. By identifying themselves as married, or married with children, these participants affiliated themselves with heterosexuality and parenting in an attempt to be considered a more acceptable or credible caregiver by their clients.

Harry

It started even before I went [deployed on a peace keeping mission] so, I was single, Francophone, and working with an Anglophone unit, so my [*supervisor*] approached me and said ..., you know, in order for you not to have any problem, I suggest you buy a wedding ring, a wedding band. ... and I was probably a bit naïve when she asked me that, but yeah, I went and I buy a wedding band, ... she said it's an infantry environment ... working in a hospital you will see is very different than working in the field, it was for me the first time I worked in the real army environment, ... and I did have a difficult experience because of ... the fact that I was a male ... I removed it weeks after because for me ... one of the values I really put importance on is integrity, and for me, that was not showing integrity by wearing that, it was just a mask of trying to hide.

Richard

Some people will say, are you married, and I'll say yes, do you have any children, no not yet, and I think when I'm able to say yes, we have a child, it will become a more believable marriage, but I think many of them ask that question. Then they wonder whether it's a you know, marriage of convenience or whatever, but I've been facing that kind of thing my entire life, you know, I think I was probably five years old the first time somebody told me I was gay, and certainly had no idea about homosexuality, much later on, and yeah, it's an old issue for me. It was something that probably caused more pain back when I was a teenager, and so on and so forth, when yeah, I was different than a lot of people, not just men, but women as well. But ... my peers at that time, people that I went to school with, I don't think they had the language to be able to describe me, so that was where I got sort of pigeonholed, into that. So I find now, I'm in my thirties, that kind of thing just doesn't bother me anymore, you know. People think I'm gay, they think I'm straight, it doesn't matter because I know what's up, you know. I'm probably straighter than most men, you know.

By self-identifying as heterosexual, men in nursing were indirectly countering or distancing themselves from the stereotype of homosexuality that is pervasive in relation to men in nursing, thereby making themselves a more acceptable caregiver to homophobic men. Asserting heterosexuality may have also decreased suspicion related to men's care of children amongst clients who conflate homosexuality with pedophilia. Married men with children may also be perceived as less of a sexual threat to women, and may gain some credibility as a caregiver with all clients in light of participating in the roles of husband and father.

Boyd

I think what traditionally what most men will do, and including myself probably is that we do let the patients know that we're married, or else the patient will ask. You know, are you married? And if you're married, that's fine. And with the ladies, if you're married, that's one thing, but the next thing is, do you have kids? So if you have kids and you're married, you're okay. ... If you're not married, then, then there's the thing, well I wonder if the guy's gay. I mean, that's just from things that you've heard all the time. ... I think that that's part of it. But it's also



just another, again, when you are, when you are doing things to people's bodies, when you're touch them, observing, poking, prodding, ... all the things that you have to do as nurses, I think that the patients, whether they're male or female feel more comfortable when they know that this is somebody who has perhaps some experience with the human body, other than their own, ... if they are a person who is married, then yes, you're probably safe to be able do some of these things to them in the end. And if you are married, well then you're probably not going to be gay and so forth. ... make them feel comfortable, or more comfortable.

#### Winnipeg Focus Group Participant

That's one of the first things that'll come out, are you married. So, if you're married, well, you're probably not gay. And if you're a female asking that question, so are you married, and the next question is, do you have kids. Because now, if you have kids and you're married, then that must mean that you know how to care. So, therefore, it's okay now for you to take care of a female. And those two it seems are just almost like a given.

**Humor as a tool to establish a therapeutic connection.** Some participants clearly used humor to counter stereotypes about men in nursing or to decrease the discomfort that some caring interactions provoked for the nurse or his client. These cases were collated under *humor as a tool to establish a therapeutic connection* and six references from four transcripts were coded to this sub-theme, which ultimately contributed to the performance sub-theme of *cautious caregiving*.

In the following text excerpt, Ben addressed the common assumption that nurses are women by making a joke that emphasized his masculine characteristics and reinforced the fact that he was still a nurse despite his gender.

Ben

I'd say I'm the hairiest nurse you've ever met, so that way they'll remember that I am a nurse. ... Yeah, it works. And you know what? They have a big laugh at it too.

Boyd also successfully used humor to diffuse the discomfort he and his woman client were feeling around the performance of intimate nursing care.

Boyd

So, I went in and my instructor told me what we were going to do, but I was embarrassed for her. And so, the situation was absolutely horrible for that one day and I came out of there that day saying to myself, you know, if I don't get my act together and start thinking, this is what I have to do, this is my job, and I have to learn to deal with this kind of stuff. And so the next day I went in and essentially cracked a joke about the day before, and she laughed, I laughed, and everything was fine after that.

The use of humor during the performance of nursing care was utilized to establish a good working relationship with both men and women clients, but it served a particular role in establishing a relationship with men clients. Men in nursing may use humor to show men clients that they are still “one of the guys” and therefore acceptable. Jokes with men included chauvinistic or crude humor at times, and also involved some reinforcement of hegemonic and essentialized masculinities. In the following excerpt, the participant verbally teased the man client in a way that questioned his masculinity by implying that the client might need a “night light”, while also addressing the fact that he was not a woman through a crack about shaving his legs. This type of verbal sparring was a common way in which men joked with one another, and was undoubtedly tied to the performance of masculinity by the nurse.

Winnipeg Focus Group Participants

... some patients, you can tell they're more at ease ... I'll walk in and ... if I know the patients, you know, seem readily, whatever, friendly, I say, yeah, ... I'm sorry but ... I don't have the night light, oh, you're my nurse and look disappointed and

stuff, I say, yeah, you know, I don't have bow legs and so I'm really sorry, but maybe tomorrow I'll shave them, so. Ha, ha, ha, and so we're buddies and stuff. And then there's that, too, with, I mean, with male patients.

And you mentioned about the humor, too, and you are right, because like you do treat the guys differently. I can certainly say things to another guy patient that I wouldn't say to some females. But we still use humor in their situation, just a different focus of it, or just. . .emphasis, I guess. But humor is a really important factor of any kind of care, for taking care of them. Humor, . . . I'll use it and it doesn't matter if they're male or female. Surgical area, the person has to get up walking, and they're not going to get up walking, or they don't want to get up walking, so that's fine, I'm going just to get your catheter bag, and my catheter bag is going for a walk, if you want to come, you can come with it. I say that to male or female. But in another situation, I might say something completely different that is more guy orientated, almost more like, for a better word, you know, like a dirty joke kind of thing and get them laughing from that side, but you get them to understand the reason for that, but I certainly wouldn't say that to the woman. Depending on the woman, some I might. But just, that's part of being able to read the patients though, too.

That's where the humor comes in, like, my favorite thing is this, you know, if you [have] something I haven't seen, I don't want to see it. Like, it's as simple as that.

Humor can also be used as a means to indirectly diffuse client's fears, and as a means to break through the stoic exterior that many men feel they must project. In some cases using humor provided a vehicle for addressing an issue like pain while still allowing the client to engage in an acceptable performance of masculinity from the client's perspective. Rather than admitting he was in a lot of pain for example, which might fall outside an essentialized performance of masculinity for the client, the client might make a joke about it so as to not appear as vulnerable. The nurse may also use humor to open the door to discussion of the issue in a way that is less threatening for his client.

Eric

In Australian culture, it's a very common form of humor to be completely chauvinistic, and that gets uncomfortable fairly quickly, because it's like, some of them might see you as a gatekeeper, and if they get past you then it's open slaughter, they can suddenly do what they want. And so sometimes, the humor was misplaced. That said, you know, there are a lot of, in jokes, and a lot of medicalized kind of jokes, and fun things that I think, you know, guys are pretty good, and guys are wonderful for dismissing, you know, the fact that it hurts, and that they're pretty pissed off, and all those things, and you know they're hurting. And that's very much, it's almost that stoicism is almost a parody, you know, so there's a certain amount of humor in that, as well, for a lot of guys. And part of you not breaking with that is facilitating that humor, because stoicism is, for many of the men, is a wonderful coping mechanism. And we get concerned that we're not getting the true story, and I agree and we have chest pain, and we worry, and we do that, you know, many times it's their way of coping within it, and yeah, a lot of times, it's quite the norm, because the alternative that you see is someone who's just whimpering in the corner, and he gets labeled big time wimp very quickly, so many times I think that there's a certain humor and parody in the stiff upper lip and the staunch, because that's how you're meant to be, you know?

**Displaying acceptable essentialist masculine cues and behaviors.** Twelve situations where nurses asserted their masculinity through a display of essentialist masculine qualities or behaviors were coded to the performance of *displaying acceptable essentialist masculine cues and behaviors* from eight separate transcripts. The performance of this element had the potential to contribute to the performance sub-themes of *cautious caregiving* and *caregiving as strength*, because asserting essentialist masculinities might increase men nurses' acceptability in the role of caregiver to some clients. Presenting an acceptable masculine exterior also contributed to the image of strength, enforcer, and protector. In the following excerpt, Blaine discussed how he presented a physical performance of masculinity in order to assert his authority with certain clients or in the role of protector with women colleagues.

Blaine

So whether, yeah, I can be masculine, in ... putting my foot down with the behaviors of drug users when they're using on the unit, when we have these psychotic episodes, so yup, I might act like a tough guy, I might run to the side of a younger female nurse you know, and play that role, and probably puff myself up and don't even know it, you know, I'm sure I even lower my voice, you know, and even use different words, like tough guy words; yeah, I'm sure I do that.

In some cases, the performance of masculinity was tied to the way in which the participants dressed. In the following quote by Robert, he suggested that the high proportion of men in military nursing might be related to the military uniform, which is associated with masculinity and status.

Robert

To be honest, I think that's why we have 22 percent of the males in the military. We've migrated into a safer picture of a nurse because we get to wear a uniform, we don't wear the nursing outfit, even though we do wear whites with our rank and all that stuff on, we get to switch our uniforms around too, and I think that method of communication and we wear a uniform, it shows other people that we can do other things, so we're just not a nurse, and I think it's a safe zone for most of us

Harry also discussed how the performance of acceptable masculinity may be emphasized in a military context, and identified that nursing in a non-military context is quite different from nursing within the military. The military nursing practices described by Harry placed greater emphasis on hierarchy, authority, and orders, which was an approach more consistent with essentialized masculinities. Civilian nursing on the other hand had the potential to be more collaborative, considerate, and relational, which could be considered more consistent with essentialized femininities.

Harry

I was questioning if I was a real man, because I didn't feel to fit in this environment ... because I'm a soft-spoken person so when you're a real man, you have to get a loud voice and ... especially in the military, ... and I'd been working as a male nurse before, so I was used to you don't run the nursing unit as you run an infantry unit, you always say something, can you do that for me please, ... in the infantry unit there's no please, you give a direct order and there's no discussion, ... that creates some problem there, so to ask the opinion of a subordinate is not something that's done, and you're the officer and expected as a leader that you make the decisions, you don't ask your subordinate for decisions, so it was all those, as a real male, so it was almost in conflict with the value I have, and for me being an officer, and being a nurse, was almost, some of the value conflict showed there.

Physical characteristics like facial hair, physical size, and musculature were also discussed as a means to assert masculinity and physical presence which were frequently considered pre-requisites for the performance of *caregiving as strength*.

Edward

I think. A lot of them [men nurses] have facial hair. ... Well you know, it's an interesting - I got into weights. Now, I've kind of let myself go because of the job, but I created a larger body mass for myself through weights. ... Some of the male students, they're into bodybuilding. ... They're building up their bodies to have more of a physical presence, okay, because you have to respect a body like that. That's a man, that's quite a masculine body. Now I'm not, nowhere near that but, at all, but I've found, bulking up and putting on weight and muscle, and then I started long distance running, I liked that. And you know, I mean when I was younger, people would say, wow, he's got a physique, right, and I kind of liked that. ... Well it's hard to look masculine when you're wearing whites, but I guess, when I think about it, I did get into bodybuilding, why would I do that? I got into bodybuilding as a nursing student.

In an exchange between three Vancouver focus group participants, we also can see evidence that masculinity was asserted through the display of emotional strength and assertiveness in response to interactions with aggressive individuals. In this case the men

felt that they had been socialized to stand up to bullying, and that it was not acceptable for men to display “weakness” through emotions like crying. Displaying emotional toughness therefore not only asserted a performance of masculinity for men nurses, but also contributed to a performance of *caregiving as strength*.

#### Vancouver Focus Group Participants

- A: I think it's a gender issue, because I think ... you still grow up as a little boy in the world learning how to fight. Or that you have to stand up for yourself, somehow, somewhere along that way, whether you learn it or not, or you're the kid that gets bullied, it doesn't matter, you grow up believing that guys stand up for themselves or they fight or they put up their fists or whatever. And I think that that's in you period.
- B: You're taught not to cry.
- A: All of those things.
- B: I've watched many female nurses get lambasted and cry. You know what I mean?
- C: I need a moment and walk out of the room. I mean, I'll do this, too, from time to time, but then I'll come right back and give them shit like they wouldn't believe, ... But I think, I still believe that as a socialized thing, girls are not taught to be like that, boys are, and we still put up our dukes  
....

**Displaying an affinity for technology.** There were 12 references from eight transcripts that were coded to the performance element: *displaying an affinity for technology*. By demonstrating an affinity for technology, these participants contributed to the performance sub-theme of *technical-instrumental caregiving* in the performance of masculinity and caring.

Tom

I was kind of impressed, I remember with all the equipment and the technical stuff, so that's why I thought that I would like the ICU. ... I'm sure you'd probably find that a greater number [men nurses] are in the ICU's, a dialysis-type unit, like any specialty that requires higher technical, and it's not to say that it's because I like or I dislike dealing with patients, but it's just that the technical stuff is there, and the machines and that doesn't fizz at all, the more the better, the more pumps around the better, the more equipment the better, it's got it all.

Winnipeg Focus Group Participant

Gender wise, I love the technology, that's why I still work in ICU. I like the machines, I love ... the monitoring, I love everything about it.

Participants not only expressed an affinity for technology, they also suggested that men are expected to be more adept in the application of technology, thereby affiliating technical ability with essentialized notions of masculinity.

Tim

I think that males gravitate towards something that's more technical, faster pace, something that's more of a challenge. ... I think it's probably, well men are, you know, you'd think that men are expected to be able to you know...

Vancouver Focus Group Participant

I think another area ... is the technical aspect, I think that it's assumed that men are more adept at technical issues. So if let's say there's something wrong with the pump, or something like that, then they come get you. I think it's plugged, would you come and fix it. With the computers now, I find that some of the female nurses are going, can you help me. And I said, no. First answer, like, you know. You're asking me to do that, just read here. And not that they're stupid by any means, but they're scared they're going to break something if they don't understand it, and if you show any competency in those ways, it's like you're, you're in.



**Choice of practice setting.** The participants overwhelmingly stated that men in nursing preferred to work in critical care settings (intensive care unit [ICU], Emergency room [ER]) and psychiatry, and 27 references from 20 transcripts were coded to the performance element: *choice of practice setting*. It became apparent during data analysis that the choice of practice setting was significantly influenced by the performance of masculinity and caring by men in nursing; therefore, *choice of practice setting* is related to all three performance sub-themes: *cautious caregiving*, *caregiving as strength*, and *technical-instrumental caregiving*.

The chosen practice setting was related to *cautious caregiving* because some practice settings involved less intimate care or care of acutely ill clients who are less likely to object to nursing care from a man.

Boyd

... there is a tendency that men go to areas that are more technical. Some of the readings and research that I was doing was saying that a lot of men will go into areas where they have less patient contact, and/or if they have patient contact, it's often more immediate physical need type thing as opposed to long-term, soft, touchy-feely kind of areas.

The choice of critical care practice settings was also related to *technical-instrumental caregiving*, since critical care areas provided an opportunity to utilize technology in abundance, and the nature of nursing care in these settings is frequently focused on instrumental tasks. Participants also identified that critical care areas appealed to them because they allowed the nurse to work with more autonomy. They were also considered high status areas to practice in. The choice of some practice settings may be linked to some men's affinity for certain essentialized masculinities.

## Vancouver Focus Group Participant

But I think that, that if you look at the numbers of where men are in nursing, it tends to go towards the technical areas and, and, you know, in . . . probably if I find that, the, that another. . . Maybe another reason why there's men in those areas is because . . . when I do go to work, there's probably about four or five, six males working that particular shift and I don't feel as such a freak.

## Mark

I'd say, you know, it seems to me that a lot of men gravitate towards intensive care or emergency room work, sometimes the O.R., but more intensive care and emergency, and I would say that probably, from my own experience, it has to do with the license of autonomy that you're given in those fields, because you're responsible for one patient, and your total care, and your attention is given to that one individual, and you feel less influenced by the need for team involvement from your peers.

## Edward

I think men in nursing gravitate to certain areas. Because they're more prestigious, they're more, perceived as less feminine, perhaps, in a stereotypical way, so, very rare that you'll have a man do medical/surgical nursing, for all his life. You'll find him gravitating towards ICU, CCU, ER, those are all high status niches within the profession, and men are there. In increasing numbers.

The choice to work in a mental health practice setting was related to *caregiving as strength*, since men have historically been encouraged to practice in mental health given the potential to intervene with clients who may act aggressively. Another setting which frequently required physical intervention with aggressive or violent clients was the emergency room. This may also be a contributing factor to some men's choice to practice in this setting.

Peter

... males are always in demand within the mental health field. ... Because of the nature of the aggressive behaviors, there's still a perception that, when in doubt, you bring in the muscle, as opposed to using other types of interventions first. So that one I can knowingly speak of, there being a greater demand within the mental health field.

It was also suggested by some participants that men may gravitate to settings which already have a lot of men working in them, because it normalizes their participation in the nursing profession. In addition, it provides them an opportunity to socialize with other men in nursing

Richard

... there's areas where men feel more comfortable, I know there's like a higher percentage that work in psychiatry, and men seem to gravitate toward the more technical aspects of nursing, places where there's more machines, like the ICU's and more of the high prestige-type jobs, like down in the emergency room, or they'll do unusual things with their degrees like occupational health and safety for large companies, or, you know, aim at flight nursing or oil rigs, all sorts of things like that that may be a more traditionally-minded nurse wouldn't see as a practice setting. ... I'd say with psychiatric nursing, because there's so many men there, they probably feel more comfortable in not being the only guy. And they're perceived I think in that setting as needed due to their strength. I've never been too sure about you know the validity of that kind of thing.

### **External Context Sub-theme Elements**

The performance of masculinity and caring is socially constructed and is therefore significantly influenced by the context in which the performance occurs. *External context* refers to the factors external to the individual nurse that may have influenced his performance of masculinity and caring. Although these factors were external to the nurse, it should be acknowledged that external factors may have also influenced the sub-

theme of *internal-individual context* if the nurse internalized elements of the external context into his personal belief or value systems.

Figure 4.3 (p.131) displays a visual representation of the thematic map for the sub-theme *external context*. Three main contextual thematic elements will be discussed related to *external context* including: *societal norms influenced by gender essentialism*,

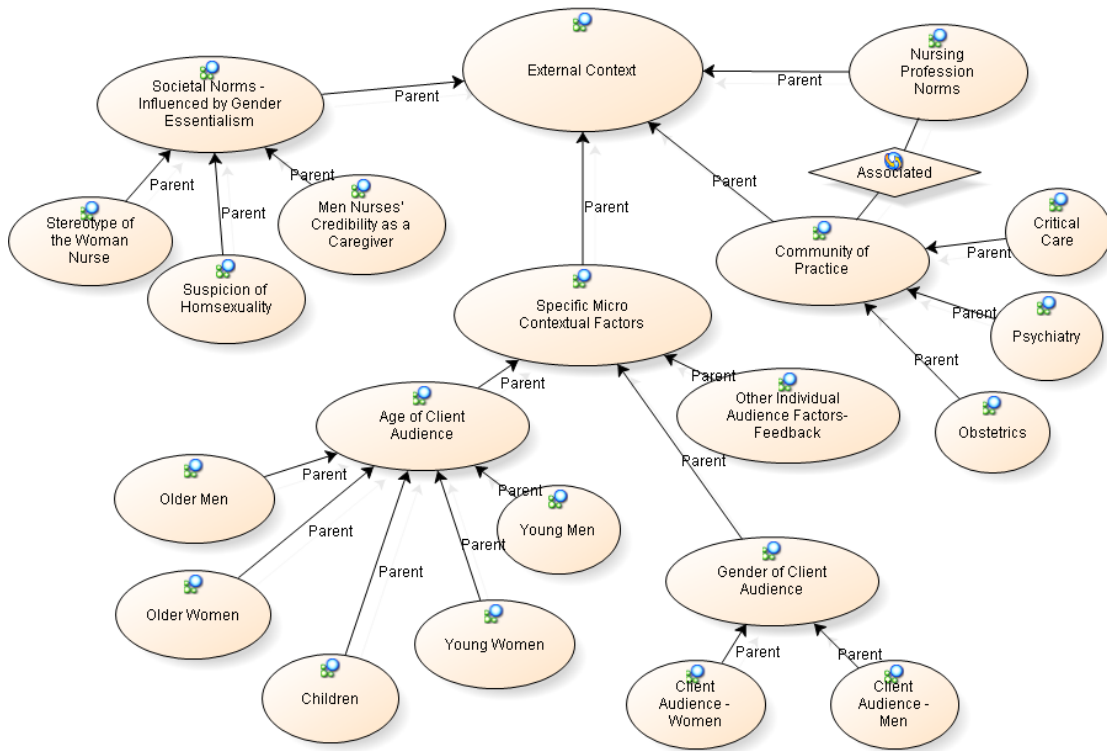


Figure 4.3. Thematic Map for the Sub-theme External Context Including: External Contextual Elements and Related Sub-elements, which Potentially Influence the Performance of Masculinity and Caring.

*nursing professional norms*, and *specific micro-contextual factors related to individual client interactions*. The sub-elements evident in the detailed thematic map are briefly

explored during discussion of these external contextual elements to provide a comprehensive and cohesive description of each element.

**Societal norms – influenced by gender essentialism.** When examining the context that affects the performance of masculinity and caring, it is essential to consider societal norms around gender. These norms will influence both the performance of masculinity by men in nursing, and the interpretation of this performance by their client audience. During data analysis, three sub-elements spoke to society's common attitudes and opinions around men in nursing including: *men nurses' credibility as a caregiver* (23 coded references from 13 transcripts), *suspicion of homosexuality* (48 coded reference from 22 transcripts), and the *stereotype of the woman nurse* (35 coded reference from 20 transcripts). These three sub-elements exerted a profound influence on the performance of masculinity and caring by men nurses because men had to navigate these common conceptualizations about gender and nursing in the course of their practice.

***Men nurses' credibility as a caregiver.*** The participants frequently identified that they had to overcome a common perspective that men have less capacity to be caring than women. These men attempted to overcome this perspective by establishing a therapeutic relationship with their clients that provided them with an opportunity to gain the client's trust and demonstrate that they were credible caregivers.

Chris

... men are not usually seen as a caregiver. I mean, society is sort of changing now, in my eyes, I see society changing, I mean, more fathers are taking the paternity leave, cause the wife makes more money than them or something, but I mean, classically, stereotypically, the man would be the bread-winner, the woman would be the one who took care of the kids, and I guess they're, sort of have more

of a care giving stereotype attached to them, whereas men are more towards the, go to work, and get the money, and come home and have a beer sort of stereotype.

Boyd

When men go into nursing, we have to prove that we care. When women go into nursing, they have to prove that they have the technology and the knowledge base to know what they're doing. They're expected to care.

Vancouver Focus Group Participant

I found that I had to. . .prove myself a lot more, like I think when you're put into a situation in . . . nursing school because everybody's trying to prove themselves. But, but then you get put in that group of all females, and it's just assumed that a woman is, is altruistic, that the woman is caring, compassionate. Whereas I felt that I had to be very, very careful . . . because I had to prove that I was all of those things, because it wasn't assumed that I was in nursing because I was caring, compassionate, with the woman it was assumed. Well, she's a woman, plus she's in nursing, you know, she must be caring.

Blaine

. . . the older people, the older ladies will say, I had a male nurse, and he was very, he was quite good, actually. You know? It just, well, thank you. But that's all part of like, you know understanding that nurses are supposed to be women. They're supposed to be mothers who care for you, right? So there may be some credibility issues, around your capacity to be comforting and caring and all those kinds of things; you might be a great technician, but, oh, I need to talk to her, I have these things I want to talk about, you know, so it may be wanting to have that relationship with a patient . . . You might have to work a little harder maybe, as a guy, to build that therapeutic relationship, the intimacy in that moment. You probably do have to work a little harder, actually. I don't think guys are perceived as people who automatically come with therapeutic skills. But they probably do come with, like, fix-it skills. Like, get a guy in here for the code, you know?

Participants also discussed how their credibility in a nursing role was also occasionally questioned by their women colleagues. They identified the need to perform

their nursing care to an excellent standard because of the implications it might have for the future acceptance of men nurses by their clients.

Terry

I enjoy working in the jail so much; there's a lot of support, and no issues as far as that goes, in the hospital, there definitely were female nurses out there who thought that men shouldn't be nurses, or that women could provide better care as nurses, and yeah, and definitely, not a high amount of discrimination, but it was definitely present, yeah.

Dale

I better have the highest level of skill, education, and motor skills possible, to be a good nurse ... a male nurse ... if I screw up, then the next guy, ... who comes along, will have potentially, the fight will start, well the last experience I had was a guy, well, he couldn't put the catheter in properly, he couldn't put the I.V. in properly, ... and I didn't want that to have a lingering affect in the clients' perspective.

*Stereotype of the woman nurse.* Because nursing is feminized by society, men are often not expected to take on the role of nurse, and participants identified that this sometimes affected their client's acceptance of them in a nursing role.

Halifax Focus Group Participant

I guess for the ... man's case it was, you know, he wanted women looking after him. He didn't see a man in the right role, you know, as a nurse.

Richard

Amongst guys, usually it's not a favorable thing; most guys are taken aback by the idea. ... they think it's women's work; they have no idea why a guy would want to do that. If they've never been in a hospital and never had anybody who was ill that they were close to in the hospital, they have no idea what a nurse does, except from television, you know. I was at a party for instance, at my wife's Christmas party, and the husbands of all the women that she works with were there, and they

were completely taken aback by the idea I was a nurse. They had no idea why I would want to do that

#### Halifax Focus Group Participant

But I don't know whether it was because it, it was a . . .gender preference issue, whether or not he was homophobic, or whether or not it was just that he didn't see that men should be in that role. That men should be doctors, and women should be nurses. I don't know. I don't know whether that was the case. I know that's definitely out there.

The establishment of nursing as a woman's role may occur early in a child's socialization as was noted by the observations of one participant who worked in a pediatric setting.

#### Kirk

Oh they say, oh, well only girls are nurses. . . . I say, what about doctors? Well, only men can be doctors. So it's the whole, probably about 5 or 6 [years old]. That's what usually, you still get those questions every now and then from kids.

One francophone participant also suggested that the acceptability of a man in the nursing role might be related to culture, since he observed a greater acceptance of men nurses in Québec as compared with western Canada.

#### Harry

I had to notice the difference, it would seem to be easier to integrate with the concept of male nurse when I was in Montreal and Quebec City, they seemed to be a larger population of male nurses, then in Ottawa too, there was, but when I was in Calgary, even in Victoria I could see there were more resistance to the concept of a male nurse.



*Suspicion of homosexuality.* Perhaps the most pervasive societal stereotype related to men in nursing is the association of men nurses with homosexuality. Time and time again, the stereotype of the homosexual man in nursing was discussed in the participant interviews in relation to many issues including: the participant's personal sense of masculinity, the recruitment and retention of men in nursing, and the influence this stereotype had on men nurses' need to perform cautious care with adult men and pediatric clients of both genders.

Richard

They tend to make assumptions about you as a person based upon your choice of occupation, and some of them may even think that you're homosexual. That doesn't come up as often with women as it does with men, but it can, but it can come up, there is some suspicion.

Harry

... it was for me the first time I worked in the real army environment, so and I did have a difficult experience because of ...the fact that I was a male in [nursing], it went as far as one of the medical assistants came to me right in my face and so like, made a comment like, you're the type of guy who would like to put your finger in my ass.

Yeah, because of all the allegations [suspicion of homosexuality] ... when I came back from ...[the peacekeeping mission] I was treated for ... post-traumatic stress disorder. ... I reconsidered my decision to stay as a male nurse. I was considering to quit the profession, for the first time, as I told you earlier I was 13, I was in grade 10 when I decided to be a male nurse...

Peter

... the potential accusations that you must be gay, if you're a nurse, therefore you're going to be stereotyped,, you put on your white uniform, and you must be gay, and if you're at all insecure with your own masculinity, then that can be a real threat, and that too, would scare some males away from the field ...

Tim

There's a stereotypical reaction of society's, that, you know, you've gone into nursing, you must be gay. And so I was very cautious at the time, so I found that a little worrisome, I sort of got over it, and I think after I finished graduating, most of my colleagues in school knew my sexual orientation, and I never hid it after that, and so I did come out, and I find it doesn't really bother me.

One pediatric nurse participant identified a situation where his sexual orientation was even questioned by a young boy he was assigned to.

Kirk

I had an 11-year old boy ask me that [if I was gay] ... Yeah, he just said, he said, well, you know, because of the whole, you know, you can't be a nurse. I said, well, I am a nurse. ? I said, no. ... He said, ooh, really. I said, yeah.

Because men in nursing are often assumed to be homosexual, they may also have to address the conflation of homosexuality with pedophilia in their personal and professional lives.

Barry

My wife has had people express surprise that she's married to a nurse because, you know, most of the male nurses are gay, and there hasn't been anything too severe, but I think there's been a few people that have been surprised that I'm not gay, yes, your children are safe around me, other than that it hasn't been that significant.

**Nursing professional norms.** As practicing Registered Nurses, the participants' performance of masculinity and caring was also influenced by the largely feminized norms in the nursing profession and the collective norms that exist within their nursing community of practice. In the following text excerpt, one participant discussed how the

nursing profession is influenced by its association with femininities he identified the challenges this posed for men as they are socialized into the profession.

Vancouver Focus Group Participant

Well, one thing I've found I was being taught in school is a ... nurses' way of knowing, and it was always kind of linked toward the feminine type of intuition. And, and I don't think I've fully grasped it yet, but I think being a nurse and doing it for as long as I have, I, I feel that I've gotten better at it. I sort of see what they're saying now, or at least I've interpreted it in my own fashion. And, but I always, I always found it interesting how, how they use that, that idea of knowing and they, they're always with this, I don't know if they, sometimes it was very direct link to, to being a woman and, and what you go through as growing up as a woman, how you get this way of knowing. And, so in a way I think I've, I've developed my personality a little bit further because I work with a . . .you know, a group of, a group that's not my, my normal social group. Kind of get what I'm saying.

The perception that men entered a different world when they joined the nursing profession was also discussed by Boyd. He suggested that men must learn a new way of interacting with women nurses, or potentially face censure from the nursing community.

Boyd

... he has to learn how to live in the world of nursing, because if he doesn't, then it can be a very alone world. You, I mean, ostracize isn't the right word, but you certainly, I mean. .. That's the word, isolated. You can be, you can be if you don't learn how to adapt, or if how to adjust so that you're accepted. ... And so because of that, to be able to survive, you have to make sure you know what you're doing, you're doing it well, and that you're not doing anything that's perceived as wrong. Because you are under a microscope.

If men do not successfully navigate the transition into the feminized world of nursing, they may experience difficulty in being accepted as a nurse by the professional community. In addition, their approach may be interpreted as inappropriate by some members of the profession.

Edward

Now, I would like men to think that nursing is quite welcoming to them, but you know what ... every time there's a student issue, I say to the assistant, don't tell me the gender, let me guess, this is a male student, isn't it? How did you guess? I think if we looked at who's getting into trouble in nursing, you'll find, disproportionately, its men. Now why is that? Some of the reasons are academic, or, and the person's failing, okay fine, right? But then there's behavioral challenges, and I'm going to take a little bit of a risk here. I think that men approach caring in a different way, just like they do parenting perhaps, or maybe that's not such a good comparison, but let's let it stand. But I think there's a male model, or a male approach to providing care to patients which is, maybe along different dimensions than women. Our clinical instructors are looking for the female model of caring. The men, they kind of hit that, right? And he's a problem, he's not communicating in a way that he should be. Okay, what? What do you mean, he's not communicating in a, he's not empathic enough. What's that?

Although there are some homogenous nursing values and practices that may cross the entire nursing profession, there are still marked differences in values and practices that can be noted between the various *communities of practice* in different practice settings. Some specialties like critical care and mental health are considered to be more desirable practice settings by men. The participants associated this preference with enhanced acceptance of men in these settings and the opportunity to draw on essentialized masculine characteristics or values that men in nursing may possess. Other practice settings, such as obstetrics, are frequently viewed as the domain of women, and men nurses may find that their gender creates a barrier to their acceptance and credibility as a caregiver in these areas

Richard

I'd say with psychiatric nursing, because there's so many men there, they probably feel more comfortable in not being the only guy. And they're perceived I think in that setting as needed due to their strength.

Peter

... males are always in demand within the mental health field. ...Because of the nature of the aggressive behaviors, there's still a perception that, when in doubt, you bring in the muscle, as opposed to using other types of interventions first.

Mark

... it seems to me that a lot of men gravitate towards intensive care or emergency room work, sometimes the O.R., but more intensive care and emergency, and I would say that probably, from my own experience, it has to do with the license of autonomy that you're given in those fields, because you're responsible for one patient, and your total care, and your attention is given to that one individual, and you feel less influenced by the need for team involvement from your peers.

Vancouver Focus Group Participant

One thing I like working in the ICU is that I do have time, not so much providing this to the, the patient, but to the family. And I have that time, it's, it's allotted to me, and I think I do a very good job of it. But I think that, that if you look at the numbers of where men are in nursing, it tends to go towards the technical areas and, and . . . Maybe another reason why there's men in those areas is because ... when I do go to work, there's probably about four or five, six males working that particular shift and I don't feel as such a freak.

Ben

Well, when I went to nursing school, I really got high marks in my obstetrical rotation, loved to work with babies, at a low-risk birthing centre at Concordia Hospital. Which was just, what a great feeling. ... I talked to one of the nurses, the head nurse there, and she said, no, she would not hire a man. Blatant male [discrimination] right, and I just kind of said, well, that's kind of inappropriate. ... I've got a right to do a job here, I've got the highest mark in our whole school, in the obstetrical rotation, and she just said, no, I will not hire a male.

Edward

... as a man ... labor and delivery was a nightmare. ...I was 20, it was our first clinical rotation ... and it's pretty frightening, labor and delivery. ... And it's

like, this is a foreign land, and I'm an alien. Now, I got on the unit, it was at the city hospital. The unit manager, a nurse, said; we're not having men nurses on this unit, and said, you're not welcome here. And I'm thinking, okay remember it's 1978, and I'm thinking, what's going on, right? So I took it upon myself to contact the Human Rights Commission. And I thought, you can't tell me I can't be on your unit, like I'm a nurse and I want to be a good nurse, and anyway, so I communicated that to the Dean at the time ..., and she got me back on the unit. ... And then labor and delivery went well, and I can tell you ... up to the point where that baby is crowning and then birthed, gender wasn't an issue. But as soon as that baby was born, and I had to do post-partum care, holy God. I was so uncomfortable. And ... the other fellows weren't with me at the time, they broke us all up right, so ... there were no men nurses, and there were no men faculty in the four years, no men [in] clinical, and I thought, I need to talk to somebody, because you know what, I'm really uncomfortable doing this kind of intimate care, and I'd like to talk to somebody about it, and say, is this normal, that I should feel uncomfortable, and will it, will I stop feeling uncomfortable at some point ...

One thing that was clear from the discourse of the study participants was that men's experience during their initiation to the nursing profession, and in the course of their practice as nurses, undoubtedly created a context that shaped their future interactions and practice behaviors. As a result, one can safely conclude that professional and community of practice norms likely influence the performance of masculinity and caring by men in nursing.

**Specific micro-contextual factors.** During the review of the interview transcripts, it became clear that the context of a discrete interaction between a nurse and his client had a profound influence on that nurse's performance of masculinity and caring in that particular case. Thirty-two text excerpts were coded to the external contextual element *specific micro-contextual factors*, representing seventeen different transcripts. Among the significant micro-contextual factors that influenced a nurse's performance of

masculinity and caring were: client gender, client age, and other individual audience factors/feedback.

*Nursing care of children.* Regardless of client gender, some participants identified that the provision of nursing care to children presented challenges. Even when participants identified a preference for working in pediatrics, their motivation for wanting to work with children was often questioned. The result was often a heightened sense of caution when providing nursing care to this client population.

Edgar

There's a lot of negative stereotypes when it comes to gay men; molestation, you know, men and boys and things like that. That still sits in the back of my mind as far as, what does, how does the public perceive me? Because there's ... been a lot ... of exposure, I don't know, negative or whatever, in the media, as far as you know, whether it's a gay man or whether it's a man and a young boy, that type of thing. That really bothers me. And it's probably the one thing in my profession, in my life, that I have to try to just accept, that I'm not there, and that, it's a little bit tough, because I don't, I feel that, you feel like you're painted with one brush when the media gets a hold of this, and whatnot, and so you wonder, if you go into a room, whether the parents are looking at you, like, what's his story, you know, why does he, why is he working here? Why does he want to work with kids?

Eric

I remember, when I first went into peds ... I was the only guy that worked there, and they couldn't work out why a 24 year old bloke would want to work with kids ... there's a lot of doubting kind of notions about what would attract you ... the pediatric team was just curious why a guy would be doing it. What interest other than pedophilia could I have, in working with children?

Vancouver Focus Group Participant

Touching kids. There, there's always that stigma and it's one reason why, like even myself, when I was applying for all these jobs when I got out of nursing school, a lot of my colleagues and a lot of my friends were going into pediatrics and I, I really enjoyed that part of my rotation. I applied on both sides, different

wards at Children's Hospital here, and all my [female] colleagues were getting jobs but I wasn't. And . . . I had a hard time understanding why because, it was something that I was interested [in], and I didn't even get to the interview stage. . .

*Nursing care of men.* The receptivity of men clients to nursing care by men was mixed, and was frequently influenced by the client's perspectives on the general acceptability of men in a nursing role. If a homophobic man client associated men in nursing with homosexuality, then he may object to intimate care by men. Some men may have also looked less favorably on the nurse based on a perception that he was enacting a subordinate or lesser form of masculinity. In other cases, some clients embraced the opportunity to receive intimate care from another man because of the potential embarrassment of receiving intimate care from a member of the opposite sex.

Edward

I found I was more nervous around men, because I felt that they . . . [were] quicker to reject me or challenge me or question me. . . . Might be gay, right, or I'm less than a man in this profession, like, what are you doing in here? And it didn't happen often, but as I think about it now, I think it happened more so with the male patients than the female patients. . . . Yeah. They [older men] were uncomfortable, some of them. Now, context is important. When they needed their Foley's adjusted or changed, they were quite alright, you know?

It was clear that the participants were initially cautious in their approach to caring for most men until they knew how they would be received. Several participants indicated that they were particularly cautious when providing care to young men because they perceived these clients would be less comfortable with touch in general.

Eric



I had them, had one young fellow ... who refused to be washed by me; he was [in] orthopedics, that was very early in my career, he would have been like the same age as me. I understood that. ... Yeah, yeah, because I think it was pretty clear that it wasn't around like a gay issue ... it was just ... a discomfort with being washed by me, you know? And I accept that, ... this is the only time it ever happened.

Tim

I think from the experiences I have, I think the younger the person is, I think there's a little bit more discomfort, but no more so than, I think, if a young female nurse would look the same patient, like a male patient, I think they get very embarrassed, and at that time, they'd rather have a man looking after them.

Richard

... we get these young guys with skiing accidents, rugby accidents, skateboarding, that type of thing. They're shy - 16, 17 year old men are shy, and they're not comfortable with a woman looking after them, and they're probably more uncomfortable with me looking after them. Especially if they're unable to void after surgery and you have to cath [catheterize] them, none of us like to do it, none of us like to do it, because it just, they're just so shy about the whole thing.

There were inconsistent opinions as to whether older men would consider nursing care by men acceptable. Some participants stated that it was easier to interact with older men, and that some older men like veterans were more accepting of men in a caregiving role. Other participants suggested that some older men had a more essentialized view of masculinity that positioned caring in the domain of women and this contributed to these men having a difficult time accepting men as caregivers.

Edgar

I certainly don't go touch a guy that's my age, unless I'm patting him on the back, or he's having a lot of pain, and I'll [say] you know, it's okay, it's okay, ... I could hold any female's hand if they were in pain and needed someone, not a problem, not an issue, whatever age. When it comes to men, probably okay for me, or it is okay for me, as long as they're older men, once you start to get my

age, younger, it's difficult to do. ...So yeah, so teenagers for sure, male or female, men, younger men, whether they are effeminate or very masculine, it's harder to do that, it's harder to touch their shoulder, hold their hand; I just don't. It's never happened. I don't think they'd be comfortable with it.

Robert

I was working on the floor and there were these two old gentleman in there, and I walked in and said hi, I'm [Rob], I'm your nurse, and they said, you're my what, and I said, I'm your nurse today, and then I could feel their eyes on me for the first 10 minutes. ... And then when I showed them that I could do the job, then the stigma, the anxiety level came down in the room, you didn't feel that anymore; but at first, you could cut it like a knife, and that was pretty much my first month on the nursing floor, and then after that, things started getting easier.

Richard

I find it's quite common with the veterans, especially if they've seen combat and they're experienced with medics, or they may have been in the forces their entire life, it's very normal for them, because there are male nurses in the military, and they seem to prefer it, they're more comfortable with that. There wasn't a lot of women around, especially if they're these bachelors, these old bachelor-types, you know.

When men were acutely ill, it was felt that they may have been more receptive to touch by a man, but even in these situations, touch may have been used sparingly so that the interaction between nurse and client represented an acceptable performance of masculinity for both parties.

Edgar

I probably have been in those situations [when a man is extremely sick], because ... usually my style is to touch, grab the shoulder, and grab the arm. Not necessarily the hand, but just grab the arm and grab the shoulder and talk to them, because you know, that's how I will talk to them, and I don't think anyone's found that threatening, certainly when people are in an acute illness, that's not, I don't think that's an issue for them. I think it's extremely therapeutic, yeah.

*Nursing care of women.* The participants frequently discussed that they approached the nursing care of women with caution and an awareness that the women might be uncomfortable having a man perform intimate nursing care. In most cases, the participants were very understanding of this perspective and they wanted to respect the woman's wishes to promote a positive and therapeutic relationship with the client.

Jacob

I remember my very first clinical experience, it was very funny, I walked in, and ... I had a female patient, she was about 90 years plus. I walked into the room, and said, I'm your nurse; the covers came up to her nose, and she said, there's no way you're touching me; I thought, okay, so that was my very first experience. But it's generally not an issue.

Vancouver Focus Group Participant

When I was a nursing student one of my very first patients in a care home, we started there when we first started just sitting around talking with the patients and then playing cards with them and developing a relationship, interviewing them, and then when we started doing personal care, I had this sweet 90-something year old lady who had been my person that I'd been paired with and I went to her room that morning, I said, you know, we're going to be doing personal care this morning, I'm supposed to take you for a, for a bath this morning, are you comfortable with that. And she looked at me and she said, very caringly, and said, you know, X, I think you're great and I think you're going to be a wonderful nurse, but in all my 90 some years, the only, only two men have seen me naked and that was my father and my husband and that's not about to change today. And fine. I was very comfortable with that, I thought that was great, I went and told my instructor, she was more uncomfortable with it than I was. Because she said, well, you need to get this experience. I'm like, well, I'm sure there's someone who will give me that experience, it doesn't need to be this person.

Ben

I think I may have traded off, maybe one female in the last year. Just because she says, and she was very apologetic, she was very shy, so I don't think it was just because of the, she was just very shy, she was from a personal care home, very prim and proper, hair done, beautiful looking lady, but she just wanted a female to help her. And that was fine, that's not a problem, I didn't push the issue. And that was the only time.

Intimate care with younger women was specifically identified as an uncomfortable situation for both the client and the nurse by several participants; however, if the woman was significantly older than the nurse then it was perceived to be easier for men to provide intimate care.

Edgar

I'll just understand that ... it's all about the patient, really, and it's just more comfortable for the patient; I can understand that. And I don't take offence if someone, [says no] ... I'll ask, usually a female, it's funny, because I will catheterize elderly females or middle-aged females, but when they start to get younger, start to get your age, you question it more, and I'm not really sure why, but ... I'm not even going to go there, but I'll catheterize an older lady, you know.

A couple of participants also discussed situations where men in nursing even go as far as to be flirtatious with older women in an attempt to establish a positive connection with them. These participants did not directly discuss why it was an acceptable strategy to engage in flirtation with older women as opposed to younger women; however, one might assume that flirtation with older women was less likely to be interpreted as a sexual advance, because older people have been desexualized by society.

Tim

... with women, in the field that I'm in, I've never had a problem ... I find that elderly women actually prefer, and it might be just me, prefer to have me around. It's more a flirtation kind of thing, ... I think it just makes them feel good, makes them young, because they like to flirt with me for whatever reason. And I don't take it the wrong way, I don't see it as sexual overture or anything like that ... it's just a little bit about the bantering that goes on. ... Oh, definitely. I think if I wasn't having fun, or flirting with them a little bit too, I always wait, if that's what they want then I'll go there with them, but other than that, no. And it's more, in terms of endearment, it's not like real flirting, it's like, you know, calling them dear, or honey, or something like that, or just looking at them a little bit

more, I don't know, like doting on them, kind of thing, getting them the extra blanket, or whatever they want and it's not a problem. It's just, yeah, more doting on them, I think.

Albert

Now, at times I am conscious of the, of the male-female thing. I could be this person's son, or there may be a little bit of flirtation sometimes, you know, that some patients may sort of, you know, be chatty, or overly chatty, or whatever. And that may be a reaction of gender. I think I'm conscious of it, which is ... a good thing, because I think it's good to be aware of the boundaries in relationships or whatever. And that may be how. And sometimes I can use that, like, you know, you can sort of, you know, get someone to open up or whatever, by just using those skills.

*Influence of other audience members.* The primary client is only one potential witness to the performance of masculinity and caring in a specific client interaction.

Other audience members might include spouses, other family members, the client's friends, or even other health care professionals. In the following text excerpt, one such audience member, the husband in this case, had a profound influence on the interaction between this nurse and his obstetrical client.

Dale

One was when I was in training. I was in obstetrics ... my patient was ... a nursing student ... and we were getting along just hunky-dorey. ... at that time, her husband had shown up. So I left for my lunch, came back from lunch ... At this point that I returned, all the nurses came out, [Dale] , [Dale], ... and I thought, oh my god, what have I done wrong, like I've done something, and they hustled me off the floor as quickly as possible into the back where the nursery was, and the delivery room, and said they don't want me to go out there, the husband is really upset, and I was like, what do you mean the husband is really upset? The husband doesn't like the idea of you being intimately involved with his wife.

All nurses strive to provide holistic nursing care based on their client's unique characteristics and preferences, but men must also clearly attend to issues related to their

gender and the way in which their touch will be interpreted by their clients of all ages and genders. Since each client interaction is contextually unique, each individual performance of masculinity and caring by men in nursing can be considered a command performance based on the unique caring context as it exists at that point in time.

### **Internal – Individual Context Sub-theme Elements**

*Internal-individual context* refers to the internalized personal beliefs and values that may influence how a man in nursing will perform masculinity and caring in the course of his nursing practice. A man's beliefs and values are the product of the internalization of societal norms, socialization, and experiential factors. Like all socially constructed concepts, these beliefs and values are constantly under revision. The currently held beliefs and values of a man in nursing subsequently provided the *internal-individual context* that influenced the choices he made about nursing care; therefore, these beliefs and values constituted a significant part of the context that informed his performance of masculinity and caring. Analysis of the participant interviews identified two related groups of contextual elements under the contextual sub-theme of *internal-individual context: socialization and internalized values (upbringing-socialization, professional socialization, and men nurses reified values)*, and the *influence of experience and maturity (experiential factors, security-insecurity in personal masculinity)*. Figure 4.4 (p. 150) provides a visual representation of the thematic map for the sub-theme *internal-individual context* and the contextual elements and sub-elements of this sub-theme will be explored in greater detail in the following sections.

**Socialization and internalized values.** Participants discussed the influence that their upbringing and socialization as men had on their personal perspective at several points in the interview transcripts. These men identified that they had been socialized to perform masculinity in accordance with essentialized conceptualizations of gender, and that they had not had significant opportunities to engage in physical care, or a maternal and nurturing approach, prior to entering nursing. There was also some acknowledgement that their performance of masculinity was not necessarily acceptable within a feminized social context like nursing.

Blaine

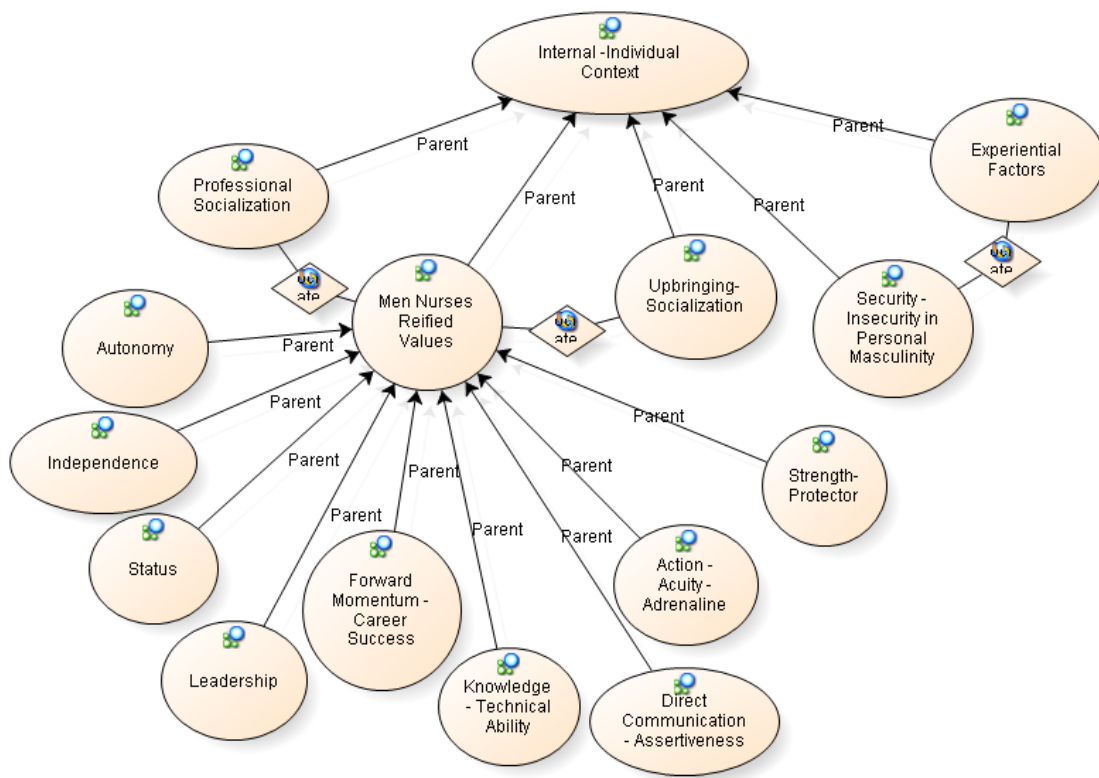
... palliative care is like the essence of nourishing, and the touchy-feely, and the mothering, and the caring stuff, and men are good at that, but, well they're not the best at it. I don't think a lot of men necessarily, are socialized or raised, to have that kind of maternal role. But if you choose to go into nursing, there's something there that is at the core of your essence in terms of compassion and caring for others, you know, the primacy of caring and all that kind of stuff.

Vancouver Focus Group Participant

... we did not grow up with dolls in our arms, and you know, stroking dolls and feeding them and all those things, you know. And it's a male socialized thing.

Vancouver Focus Group Participant

I was born and raised, you know, with masculinity in mind, and I was very masculine in my ideas, and ... that doesn't mix in a group of females.



*Figure 4.4.* Thematic Map for the Sub-theme Internal - Individual Context Including: Internal-Individual Contextual Elements and Sub-elements. Note: A diamond shape on the lines that link contextual elements together indicates an identified relationship between the elements.

One participant reported being exposed to primarily feminine perspectives in nursing school, and reported that it was initially very challenging for him to understand this way of looking at the world.

Vancouver Focus Group Participant

Well, one thing I've found I was being taught in school is a way, nurses' way of knowing, and it was always kind of linked toward the feminine type of intuition.



And, and I don't think I've fully grasped it yet, but I think being a [nurse] and doing it for as long as I have, I, I feel that I've gotten better at it.

It was acknowledged that being exposed to feminine approaches to caregiving was a positive learning experience for some participants, because it exposed them to ways of approaching care that they may not have considered or experienced before.

Vancouver Focus Group Participant

I do remember once learning a tremendous amount from female nurses in palliative care. When I starting in hospice and palliative care, and I remember watching. And there was, ... the primary maternal occupation, this thing that women have of talking to like kids, babies, or at the other end of life, the alpha and the omega thing, at the end. And I remember watching that tenderness, watching the way that they interacted with someone in a coma, and learning a tremendous amount from that. And there was something there that was unique and given to me from female nurses. And that wasn't something I think that men are necessarily socialized to give it or to do. I think, well, if you become a dad, I think you learn it. To hold the kid tenderly and to have all of those things. But if you don't grow up to have a, kids in your life necessarily, or you have that connection. . .It's an assumption, I'm just trying to imagine that, then I'm not so sure that you do that as well or whatever. You can demonstrate it. And I do remember that that was something that female nurses gave, in that context. . .There were seasoned nurses who really, really knew the art of caring in that particular context, that was special.

One participant also recounted a situation where he received some guidance regarding the role of a man in nursing through the support and mentorship of some more experienced men in his nursing program.

Vancouver Focus Group Participant

I had actually one of the female nursing instructors pull me aside and said, I think you should go to lunch with some of the male nursing students in the years above me, and they kind of gave me the lay of the land. And I felt really lucky, it was almost like being initiated into this male part of nursing, where they, for the good and the bad. And I tried, when they explained things to me, I tried to take it with a grain of salt, but also, I was really lucky, because they pointed out to me which

instructors to look out for, because they will go after you because you're a male. These are things you should and shouldn't do, being a male.

Several values were commonly expressed by the study participants in their discourse that indicated they held fairly traditional and essentialized perspectives on masculinity. Among the value themes that were reified in the interview transcripts were: *autonomy* (20 coded references from 14 transcripts), *independence* (10 coded reference from 8 transcripts), *status* (20 coded referenced from 11 transcripts), *leadership* (17 coded references from 11 transcripts), *forward momentum–career success* (17 coded reference from 12 transcripts), *strength-protector* (17 coded references from 10 transcripts), *knowledge-technical ability* (10 coded references from 9 transcripts), *direct communication-assertiveness* (23 coded references from 11 transcripts), and *action–acuity–adrenaline* (4 coded references from 3 transcripts). The following series of quotations provides some examples of these values as expressed in the participant's own words.

Robert

We all have to answer for what we do, but I think it's that autonomy and the more skills you learn, the more autonomy you have, and of course, you have to answer for what you do, but then you have principles behind it all, and all that stuff anyway, so I think that's what attracted me to the ICU and the Emerg departments.

Richard

But what I didn't understand at the time, and learned ... about myself, I'm a loner, and I had a great deal of difficulty in adapting to the fact that they cooperate, they talk to each other, they socialize together, it became apparent, they don't even leave work alone, like people will wait for them to get their jacket on and get their purse, and they'll both get on the elevator, or all six of them will get on the

elevator, they'll all wait for each other to have a pee at the end of the shift, and leave together. I mean, these are all things I know now, but I didn't know in the first few months. I came to work by myself, I left work by myself. These were my patients, I will help with the other patients, but these are my patients, and I was very proprietarial about my patients, and I was under the false assumption that I was assigned these, this assignment and if I didn't do each of the things that were involved in caring with those patients, that I wasn't doing my job, and that's not how it works, but that's how I thought it worked at the time. And it took, I mean that conversation I had with the nurse educator, she said, well I can see that that's not what's really going on, and I said, I'm a lifelong loner, it's going to take me a little while to adjust.

Richard

They [women nursing colleagues] also do this thing where they have to talk, like if they have an issue with me, they might talk about it with 10, 20 other people before I ever hear anything about it. I might hear it from somebody else, before I hear it from the person that's got an issue. ... I just, I find that not something that guys would do, you know.

Ben

Well I just, wait till they're [the physician] finished yelling and say this is inappropriate, you can leave, and come back when you can talk to me as a human. If you have a problem with that, you can talk to the director of medicine, [be]cause I know I will be. And I'll say it quite loudly, and I just don't put up with that bullshit. It's unacceptable. Yeah, and I'll give them my nurse manager's name and phone number and they can call her, and you know, they can deal with it, but I'm not there for their verbal abuse.

Harry

I feel that it's expected, not to be willing to stay in a clinical or a bedside [practice setting] for the rest of your life. As a male, I guess it's some informal pressure almost on you that you cannot stay a bedside nurse for the whole career, it's almost like a nonverbal expectation that you will eventually quit to go in training, or to go - because I know very few male nurses over 45 years who are doing clinical nursing - I don't know if they quit or for all the people I know, so there's still quite a few but ...

Blaine

I think men generally are still raised to figure it out for themselves, not to ask for help, not to show weakness; I still think that old, stereotypical bullshit is still very much alive and well, and I certainly see it in my male colleagues, gay and straight. ... But more so in straight.

Edgar

My thinking would be, we better damn well be able to support ourselves in the workplace. And to ask for support might be a difficult thing, I know it is for me, rather than be able to do it on my own, like I shouldn't need a lot of support, I should be able to do it on my own. That's how I feel, whether you know, and I think a lot of guys would feel that, too. You know, if I can't handle it, I'd better get out, right? And so I'm going to damn well cope with it, and I'm going to have to live, and I'm just going to do it. And you know, may not ask for help, I'm kind of like that.

John

I think there's respect for the knowledge, I think it's, in some respects, an easier place for everybody to work. ... But I think, as you're able to demonstrate more knowledge and more abilities to perform under some duress you get a lot of respect, and I think that tends to be wherever you've worked, but I think ICU is an area where you're allowed to express, that.

Robert

I think that's where it comes in and we compete to get to the leadership role, we formulate the high profile at that level, but we have to go on the same competition ladder as everybody else, so we probably push, if we ... accede good, if we don't well then we'll push next year. I think that's what a lot of the men are striving for, is to get to those leadership roles, but I think it's just innate.

Robert

I think we like the high profile ones, most men, I would say Med/Surg ... doesn't fulfill our need to help people, and we want the, I guess more dangerous jobs or the higher profile ones, or ones where we get to play with machines even though you're looking after patients, but I think we need that little extra addition to it instead of just in the Med/Surg floors.

Blaine

But just his physical presence itself, is this huge, I think, comfort, or security blanket. I feel it. Oh my god, thank god X is here. Even if it's like the most objective thing, like in a moment of escalation, you just have to walk in the room, the people who are doing the yelling would stop. That kind of persona, presence, it's hard for a woman to do that.

Chris

I've had quite good results with people that are being, acting out, or being physically aggressive to, me just being in the room, even, and standing at the end of the bed while the nurse does something, I've had positive reactions to that, as far as the nurse being able to accomplish what they went in there to do.

The valuing of essentialized masculine qualities amongst the participants undoubtedly had a significant influence on the personal context that informed the performance of masculinity and caring by these nurses. It was particularly interesting that these essentialized masculine values were still so prominent in the perspectives of these men. Despite being immersed in a professional culture that was so influenced by women, the participants were still very affected by their ongoing socialization as men and essentialized societal norms concerning masculinity and femininity.

**The influence of experience and maturity.** Values and beliefs are social constructions that are constantly being revised, and there was evidence of the effect that maturity and nursing practice experience had on the perspectives of the participants. Eleven references were coded to the theme *experiential factors* from five different transcripts, and three references to participants' sense of *security-insecurity in their personal masculinity* were coded from two interview transcripts. In the following text excerpts, the participants discussed how practice experience and growing older had

contributed to greater confidence in their role of nurse and the ongoing development of their practice.

Robert

And then when I showed them that I could do the job, then the stigma, the anxiety level came down in the room, you didn't feel that anymore; but at first, you could cut it like a knife, and that was pretty much my first month on the nursing floor, and then after that, things started getting easier.

and I think at that time, I'd become a little more mature, because I was getting a little older then, been around the Medical side since 17, one way or the other, and it was understanding that if I didn't want somebody looking at me, I'd probably say something too, so it didn't hurt me. But that was the first opportunity as a nurse that somebody had demanded a female nurse.

now I'm happy with what I can do; I'm happy in my skin, I'm happy with my knowledge, and we can all gain more knowledge as time goes on, and more confidence, and I think the more confidence I get as a nurse, the easier it is for me to say that I'm a nurse. ... Where before, maybe it was the lack of confidence that I was not reassured of telling people that I was a nurse, I'm not sure if they work synonymously with each other or not, but I would think that that's maybe why I felt the stigma a little stronger than probably I should have at the time.

Eric

I guess, you know, it does, it changes, it changes with age, it so changes with age, and it changes for each of the different spots, what nursing was for me at the beginning, was the floor, and then I was teaching, and now it's teaching in med-surg [medical/surgical], and it's like, it kind of changes all the way along ....

Vancouver Focus Group Participant

It's a genuine humanity kind of quality that comes out, you know. And whether you can do it or not is fine, I mean, it can, it can frighten a student terribly: I'll never be able to talk to somebody in that caring way, I'll never, I can barely go into the room and say hello, I'm so scared. You know, especially for like the first year, second year kind of students. But when you, it's just, it's just so special to see somebody who knows how to develop that kind of communication. Yeah, you develop it over time, but there's somebody inside of them, that uniquely makes them able to do that.

Maturity and experience also meant that the opinions of others had less influence on some participant's performance of masculinity and nursing care. As the man matured both personally and professionally, his focus potentially shifted and he may have gained increased understanding and perspective on his place in the world and his practice as a nurse. In other words, a man's performance of masculinity and caring was likely to change over time based on the influence maturity and experience had on their internal-individual context.

Albert

So now I know that one of the things that I've learned a lot about myself, and one of the things I realize is I don't really care that much about what other people think. And that's part of the personal integrity, you know. I don't really care. It doesn't matter what other people think. Maybe when I was younger, I did care about what other people thought about me, and that influenced me quite a great deal. You know, whereas now, I think, no ... I don't need this. I'm pretty ... sure of myself. You know. And, and it doesn't matter what any individual or thinks about me, you know, ... I feel it's very important I've been through things that have sort of strengthened my character in that regard, you know.

Edward

When I was younger and I would get rejected by patients, I would take it personally. They don't like me. They think I'm less professional. And now, I'm a much more sophisticated person, and I try to incorporate the aesthetics and ethics of nursing, and trying to be respectful of patients. And if a patient says, I'm uncomfortable; the right thing to do is to remove yourself then, from that care. When I was a student, I thought, they should have me, right, it's about me, so and in some ways, I think, this is part of a gender thing too, being a man in nursing, initially, you're really focused on yourself as a man in the profession, and I think as you get older, it kind of falls away a little bit, it's not as central. ... And maybe it's a maturational thing, too. But I find all of that huff and puff about, even now, huff and puff about being a man in nursing, it's lessening as I get older. And I think that's a good thing. But it's a real trial and tribulation I think, for younger men, and men who are struggling with who they are as men. It's a struggle for younger men, and I think, like us old goats, we work through a lot of stuff. And I, as I said, like, it's less of an issue now. And also I'm a much more

sophisticated, mature person than I was at 20. I'd like to think that, at any rate. And I see the world as a much more complicated place. And I think I'm much more accommodating as a person, and much more understanding, and less polemic, like around issues, and I think now if I, if someone, I went onto a unit, and said, you can't be on this unit, you know, you're, this is for delivering babies, and, I'd say, well help me understand why that's an, like I'd approach it a whole different way.

One participant also discussed his feelings of insecurity when comparing his performance of masculinity to the performance of other men, which he perceived to be more consistent with hegemonic masculinities. If a man in nursing felt insecure about his own performance of masculinity in the presence of some audience members, these feelings may have had the potential to affect the resultant performance of masculinity and caring that occurred in the presence of that audience. Therefore, the degree of security that a nurse had in his own presentation of masculinity had an influence on his internal-individual context and ultimately his performance of masculinity and caring.

Blaine

I just bark at them. I bark at them. I'm probably, if I was out on the street, I'd probably get beaten, but I'm safe there, because of my confidence in my knowledge base and in how I believe people should be treated. And so, but I also try, the teacher in me also spends a lot of time trying to teach these guys how to talk. So I will, like bark at them, and then I'll make an effort to go back later, or find them, and just say, listen, this is why I said that, and here is the part you might want to consider, or whatever. It's usually, like they just look at me like I'm some sort of idiot, but I'm pretty committed in that way. I have to admit to being nervous in those moments; no matter how confident I am in my work, there's a part of me inside that is, okay, you are not mister macho, stud guy, you know, you're the guy who wears the orange uniform ... So that I, in those moments, I don't feel like as masculine maybe, as they might be. Maybe I'm that little queer fairy who runs around making everybody laugh. So that is weird, and I guess gay men do have to deal with that, you know, depending how macho you are in the world or whatever, that's the thing that you have to think about. And that's really the only group that makes me nervous, is the security guy, because they are the stinking epitome of masculinity and tough guy and stuff like that



## Summary of Findings and Conclusions

In this chapter, evidence from the study findings was presented to support the identification of *the contextual performance of masculinity and caring* as the core “overarching” theme that described the performance of nursing care by the men study participants. This core theme was supported by three performance sub themes (*cautious caregiving, caregiving as strength, and technical-instrumental caregiving*), along with two contextual sub-themes (*external context and internal-individual context*).

Eight performance elements were identified that contributed to the three performance sub-themes including: *cautious touch, humor as a tool to establish a therapeutic connection, trading off nursing tasks, use of women as chaperones, identification of marital status, displaying acceptable essentialist masculine cues and behaviors, choice of practice setting, and displaying an affinity for technology*. The sub-theme *cautious caregiving* was undergirded by several performance elements including: *cautious touch, humor as a tool to establish a therapeutic connection, trading off nursing tasks, use of women as chaperones, identification of marital status, displaying acceptable essentialist masculine cues and behaviors, and choice of practice setting*. *Caregiving as strength* was undergirded by the performance elements of *displaying acceptable essentialist masculine cues and behaviors, and choice of practice setting*. Finally, the sub-theme *technical-instrumental caregiving* was comprised of the following performance elements: *choice of practice setting and displaying an affinity for technology*.

The participant's performance of masculinity and caring was informed by the contextual sub-themes of *external context* and *internal-individual context* for each nurse-client interaction. *External context* consisted of significant external contextual elements including *societal norms – influenced by gender essentialism, nursing professional norms*, and the *specific micro-contextual factors* for each caring interaction. *Internal-individual context* consisted of the contextual elements that were internal to the participant, including *socialization and internalized values (upbringing-socialization, professional socialization, and men nurses' reified values)*, and the *influence of experience and maturity (experiential factors, security-insecurity in personal masculinity)*.

The ultimate goal for the study participants was to facilitate an effective, comfortable, caring, and therapeutic relationship with their clients, while also attending to their own need to present an acceptable performance of masculinity and protect themselves from allegations of misconduct. The contextual performance of masculinity and caring provided the means for the participants to achieve this goal, through the appropriate adjustment of their performance of masculinity and caring in accordance with the holistic context of a specific nursing interaction.

The context of societal and professional norms around masculinity and appropriate nursing practice contributed to the internalized beliefs and values held by the men nurse participants, and established norms around acceptable performances of masculinity and caring. Additional context was also provided through consideration of the unique characteristics of each client, and the micro-context in which the interaction

with the client took place. The participants subsequently strategized to determine the most ideal approach to performing of masculinity and caring with the intent of navigating the unique internal-individual and external context for each client interaction. The resultant performance of masculinity and caring represented a command performance based on the unique context of each interaction, and included a number of the identified performance sub-themes and elements. These performance sub-themes and elements were not presented as comprehensive list of strategies that explained every participant's performance of masculinity and caring; however, they represented common patterns of the performance among the study participants.

The presented thematic map (Figure 4.1 on p. 91), clearly demonstrated the potential complexity that underlies each caring interaction for men in nursing, and illuminated the contradictions and tensions that men nurses must confront in their caring practice. While it must be acknowledged that the provision of holistic nursing care is fraught with complexity for nurses of both genders, men in nursing are also faced with additional challenges related to the performance of masculinity, which is frequently not associated with the performance of caregiving.

## **Chapter 5**

### **Discussion of Findings**

The findings of the current study make a substantial contribution to the understanding of men nurses and caring by adding to research that acknowledges the complex relationship between the performance of masculinity and nursing care. This study also validates and extends the findings of nursing scholars who have sought to reposition the discourse about men in nursing beyond essentialist gender differences (Evans, 2001, 2002, 2004a; Evans & Frank, 2003; Evans, et al., 2007; Fisher, 2009; Harding, 2005, 2008; Harding, et al., 2008). In this chapter, the study findings are discussed as framed by the study's purpose and research question, and in relation to existing literature that examines men in nursing and their caring practices. Findings are also compared to common nursing theoretical perspectives on caring to determine the extent to which participants' understanding and practice of caring were consistent with conceptualizations of caring within the discipline of nursing. In addition, masculinity theory is affirmed as an effective and useful theoretical framework for the exploration of the lives of men in nursing (Connell, 1995, 2000; Connell & Messerschmidt, 2005). Finally, recommendations are made surrounding future research opportunities and the potential for practical application of these findings in nursing education and practice.

#### **Reflecting on the Study Purpose and Research Question**

The purpose of this study was to explore men nurses' performance of masculinity and caring, while acknowledging the existence of multiple masculinities and femininities and the potential impact of contextual factors on reported caring behaviors. In pursuit of

this goal, the following research question was explored during the study: *How is men nurses' caring conceptualized and expressed in their discourse?* The transcripts of 21 individual interviews and three focus groups with experienced Canadian men nurses underwent rigorous qualitative thematic analysis. The resultant core theme, sub-themes, and elements were organized into a detailed thematic map (See Figure 5.1, p. 165) that described the combined and contextual performance of masculinity and caring amongst these men nurses. This thematic map provided the answer to this research question by identifying the influence of various internal-individual and external contextual factors on the actual performance of masculinity and caring enacted by the study participants. In the following sections, the various components of the thematic map will be further explored in relation to existing literature to provide the reader with a more thorough understanding of the study findings.

### **Comparison of Study Findings with Existing Literature**

**Discussion of participants' demographic characteristics.** The mean age of study participants was 43.3 years ( $\sigma=7.37$  years), which is comparable to the mean age of Canadian nurses in 2007 of 45.1 years (Canadian Nurses Association, 2009a). Although this mean age suggests the study participants have a similar age distribution to the general Canadian nursing population, it is difficult to know if this mean age is representative of men in nursing, since men nurse's mean age is not reported separately in Canadian nursing statistics.

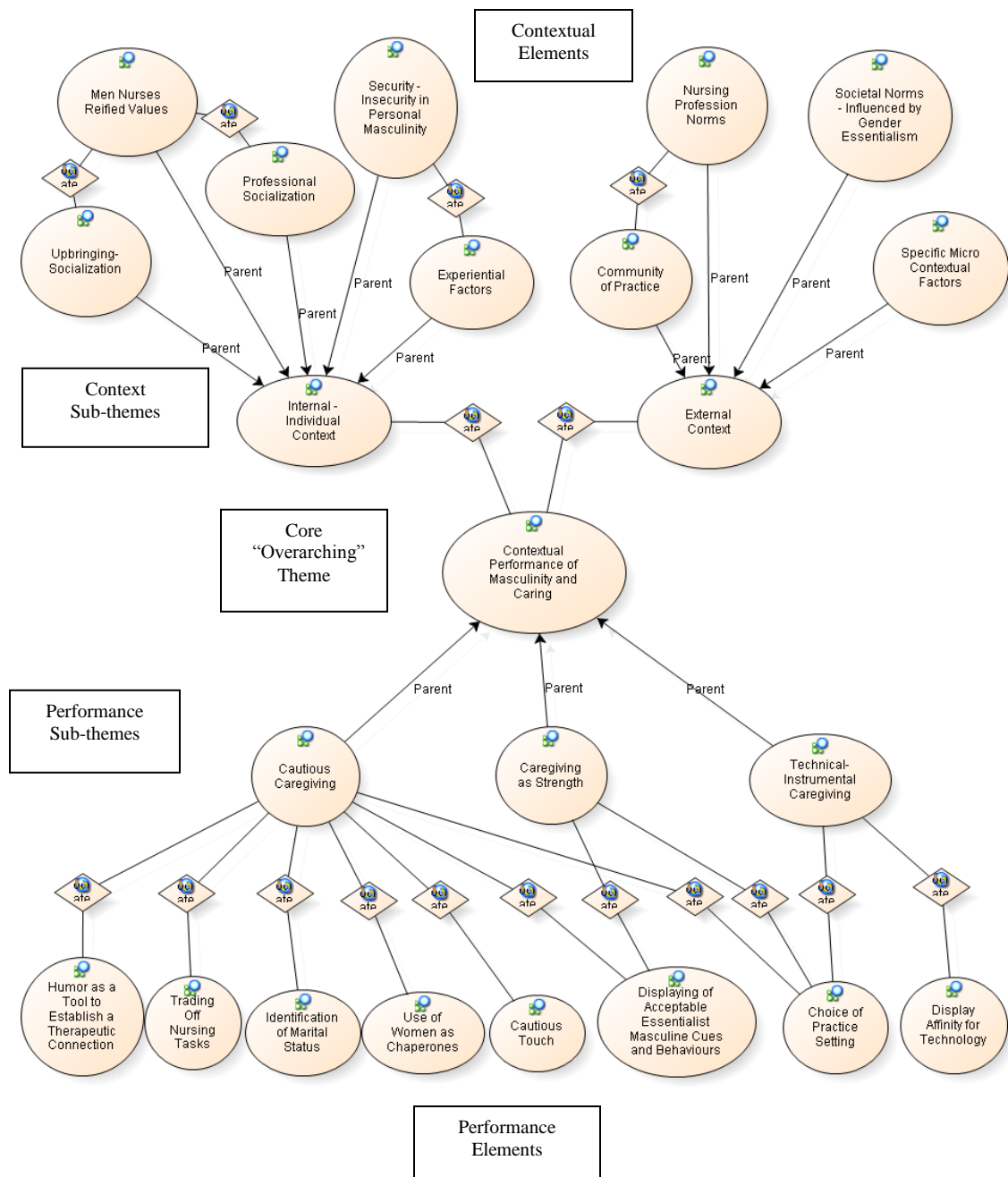


Figure 5.1. The Contextual Performance of Masculinity and Caring Among Men in Nursing. Note: Figure 5.1 was previously presented in Chapter 4 as Figure 4.1.

Participants had been practicing nursing for an average of 16.9 years ( $\sigma=8.37$  years), which suggests that they were experienced nurses. Comparable statistics were not located for the Canadian nursing population to determine if this pattern of practice experience was representative of men nurses in general.

The nursing education level held by study participants was as follows: nursing diploma 52.3% (11/21), baccalaureate degree 23.8% (5/21), master's degree 14%, and doctoral degree 9.5% (2/21). In 2007, 61.7% of Canadian nurses held a nursing diploma, 35.5% held a baccalaureate degree, 2.6% held a master's degree, and only 0.2% held a doctoral degree (Canadian Nurses Association, 2009a). Although the proportion of participants holding a Registered Nursing diploma and baccalaureate degree was reasonably comparable to the Canadian nursing population as a whole, there was a disproportionately high representation of men with graduate level education. Perhaps this disparity was related to increased interest in research participation among men nurses with a master's or doctoral degree.

The proportion of married participants was 47.6% (10/21) as compared with 42.9% (9/21) who reported being single. None of the participants reported being in a common law relationship or were divorced. It is unclear if this distribution of marital status is representative of Canadian men nurses in general since no comparable statistics were available for this population.

The distribution of the study participants' reported sexual orientation was interesting since 23.8% (5/21) self-identified as being gay, while 71.4% (15/21) reported

being heterosexual. No statistics were located related to the reported sexual orientation of Canadian nurses and no definitive statistics were located for the sexual orientation of Canadians as a whole, since any reported statistic for sexual orientation will be subject to significant reporting error. The proportion of homosexual participants was large at 23.8%; however, it is difficult to say if this proportion is significantly higher than should be expected in light of the absence of conclusive statistics related to sexual orientation in nursing or the wider Canadian population. However, the large proportion of heterosexual participants certainly challenged the homosexual stereotype for the majority of the men nurse participants.

The most common practice setting for study participants was nursing education at 19% (4/21), followed by critical care 14.9% (3/21), emergency room [ER]/trauma 9.5% (2/21), medical settings 9.5% (2/21). Tied at 4.8% (1/21) were surgical settings, mental health, occupational health, gerontology, administration, and a number of other specialties. Since men represented 5.8% of Canadian Registered nurses in 2007, disproportionately high representation by men was noted in the following Canadian practice settings during 2007: mental health 14.32%, ER 10.7%, and critical care 7.6% (Canadian Nurses Association, 2009a, 2009b). The larger numbers of participants drawn from critical care and emergency room settings was not unexpected given the tendency for men to practice in these settings; however, the large proportion of nursing education participants may be an artifact associated with an increased likelihood of nursing educators participating in nursing research studies.



It is also important to note that 71.4% (15/21) of the study participants stated that they would choose nursing again as a career, suggesting that the majority of participants were satisfied being nurses. Only 9.5% (2/21) stated they would pursue a different career; however, another 19% (4/21) were either uncertain that they would choose nursing again, or their answer was unknown.

Participants were from three locations in Canada (Halifax, Winnipeg, and Vancouver), which lends support to the conclusion that these study findings are likely representative of a wide geographical range of Canadian perspectives. Ultimately, all qualitative studies acknowledge the subjective and contextual nature of their findings, but that does not mean that such findings fail to have any applicability beyond the study participants. The demographic profile of the participants in the current study represented a diverse cross section of Canadian men in nursing, so it is possible that the findings may have some transferability to the wider Canadian context (Lincoln & Guba, 1985; Sandelowski, 1986).

**The contextual performance of masculinity and caring (core “overarching theme).** The contextual performance of masculinity and caring by men in nursing has been previously identified in the nursing literature, although it has not always been described using the same terminology. Harding (2005) discussed the notion of “caring as ‘contextual’” in his qualitative discourse analysis of interviews with 18 men nurses in New Zealand (p. 275). Harding identified that several of his participants emphasized the importance of good communication and establishing a relationship with their patients to overcome essentialist gender beliefs that can create barriers to men’s acceptability in a

caregiving role. Because men are not automatically accepted in the role of caregiver, Harding's participants had to initially invest more time to establish a trusting relationship with their patients in order to attend to the holistic or contextual needs of these patients. In other words, addressing the patient's individual context was essential to establishing an effective caring relationship that enabled the nurse to be a successful caregiver (Harding, 2005). The idea of attending to the individual needs and beliefs of clients is certainly not limited to the practice of men nurses, since providing holistic care is a pervasive theme in the nursing profession. However, men nurses may need to invest additional time to overcome essentialized perspectives that position them as unlikely caregivers and nurses in order to establish an effective caring relationship with their clients. Several researchers have noted how client characteristics such as age, gender, identified health problem, and the type of nursing procedure that must be carried out, play a significant part in men nurses' decision making around their selection of caring interventions (Evans, 2002; Fisher, 2009; Harding, 2005; Inoue, et al., 2006; Keogh & Gleeson, 2006). For example, the age and gender of the client may determine the degree of discomfort the nurse or the client feels about the caring interaction (Inoue, et al., 2006; Morin, et al., 1999). Based on his assessment of the situation, a nurse might select the most appropriate strategy from his "toolbox" that meets his need for security and protection from false allegations of impropriety, while also attending to client needs such as comfort, security, and culturally safe care. Some of the potential strategies that were commonly used by the participants in the current study are discussed further in relation to the discussion of findings around performance elements.

The socially constructed, constantly revised and contextual nature of the performance of masculinity has been well documented in the masculinities literature (Coltrane, 1994; Connell, 1995, 2000; Connell & Messerschmidt, 2005; Tillman, 2008); therefore, it was not surprising that the performance of masculinity by men in nursing was influenced by the caregiving context. Evans (2002) suggested men in nursing must address contradictory and essentialized societal perspectives on men nurses. On one hand, men nurses may be considered unlikely caregivers within the context of essentialized perspectives that fail to consider caregiving a masculine trait. This then contributes to the classification of men nurses as potential sexual aggressors (Evans, 2002). Conversely, the association of nursing and caregiving with femininity means that men nurses may be portrayed as performing a subordinate form of masculinity and this perspective contributes to the false stereotyping of all men nurses as homosexual (Evans, 2002). Evans stated both these contradictory stereotypes of men nurses contribute to the sexualization of men nurses' touch, and the result is a heightened sense of vulnerability in their nursing practice which is manifested in cautious caregiving.

Fisher (2009) further contributed to this discussion by directly linking men nurse's performance of gender to their ability to engage in intimate nursing care, which he referred to as "bodywork". Consistent with the findings of the current study, Fisher suggested men nurses constantly adjust their performance of masculinity in an attempt to present a masculine identity that will be deemed acceptable to the individual patient's ideology of what it means to be a man. One of Fisher's participants compared the changing performance of masculinity and caring behaviors by men nurses to "being a

Chameleon”. Fisher also suggested his participants developed labor processes and workplace strategies in order to overcome the influence of the gender stereotypes that can hinder their nursing work (p. 2672).

The contextual performance of masculinity and caring among men in nursing is therefore not only supported by the current study data, but is also substantially supported by other nursing scholars in the nursing literature. While this core “overarching” theme is not an entirely novel finding, the current study findings add to the body of knowledge that lends substantial support for the contextual nature of men nurses’ caring practice. What is new in the current study is the presentation of this core theme as the central component of a comprehensive thematic structure that identifies the contextual influences on the performance of masculinity and caring, and several performance sub-themes and elements that are commonly enacted as part of the contextual performance of masculinity and caring.

**The performance sub-themes.** The three performance sub-themes (*cautious caregiving, caregiving as strength, and technical-instrumental caregiving*) have all been noted to some degree in the literature on men in nursing.

*Cautious caregiving.* The cautious approach to caregiving practiced by men in nursing to promote client comfort and prevent false accusations of sexual misconduct has been extensively documented in the literature (Anthony, 2004; Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006; Keogh & O’Lynn, 2007; O’Lynn, 2004, 2007a, 2007b; Paterson, et al., 1995; Paterson, et al., 1996; Pullen, et al., 2009; Tillman, 2008). The prevalence of this theme

in the nursing literature thereby lends support to the identification of *cautious caregiving* as a performance sub-theme in the current study. The sub-theme title of *cautious caregiving* was borrowed from Evans (2002), who identified the theme of “men nurses as cautious caregivers” in her thematic analysis of interviews with eight Registered Nurses in Nova Scotia (p. 443). In the context of the current study, *cautious caregiving* is the sub-theme that captures the strategies or performance elements that are enacted by the study participants to allay their client’s discomfort with intimate care provided by men nurses, and it is also used as a strategy to decrease men nurses’ concern that their nursing care will be rejected or misinterpreted as sexual misconduct. *Cautious caregiving* is made explicit through several performance elements in the current study including: *cautious touch, trading off nursing tasks, use of women as chaperones, identification of marital status, humor as a tool to establish a therapeutic connection, and displaying acceptable essentialist masculine cues and behaviors*. All these strategies have been noted in the nursing literature previously (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006), and they will be discussed further under the section on performance elements.

***Caregiving as strength.*** The second identified sub-theme was *caregiving as strength*, and the emphasis placed on men nurses’ generally greater size, strength, and capacity for physical labor has also been well documented in the literature (Anthony, 2004; Evans, 1997a, 2001, 2004a; Harding, 2005; Hart, 2005; Kelly, et al., 1996). Participants in the current study overwhelmingly identified that they were often expected to fulfill the role of lifter with heavy patients or equipment, and were also expected to

deal with potentially violent or aggressive patients. Men's bodies have played a significant part in the roles they have traditionally fulfilled in the labor force and society, and it is evident that this is also true for the role that men have played in nursing (Connell, 1995, 2000; Evans, 2004a). From the early days of nursing, men were frequently funneled into mental health settings because of the potential for violence among some patients in these settings (Brown, et al., 2000; Evans, 2004a, 2004b). The legacy of this practice can still be noted today since the Canadian practice setting with the largest proportion of men nurses remains mental health at 14.32% and mental health is frequently presented as a preferred practice setting for men in nursing (Canadian Nurses Association, 2009b). Participants in Evans' (2001) and Harding's (2005) studies discussed the expectation that they engage in the role of lifter ("crane"), enforcer, and protector, and similar examples were provided by men in the current study.

It must be noted that although men in nursing may be expected to perform *caregiving as strength* by colleagues and society, many men nurses also embrace this role given its affiliation with essentialized perspectives on masculinity (Evans, 2004a; Forrester, 1988). Men in nursing often view this physically oriented role in nursing with ambivalence. Men in nursing want to present an acceptable performance of essentialized masculinity to counteract the societal and professional feminization of the nursing role (Evans, 2001, 2004a; Harding, 2005). Conversely, many men in nursing also recognize emphasizing essentialized masculine qualities (e.g. strength and aggression) is potentially counterproductive to establishing themselves as acceptable caregivers because essentialized gender perspectives associate caregiving with femininities (Evans, 2001,

2004a; Harding, 2005). Regardless of the position one may take on men's participation in these physically emphasized roles, it is evident that the role of strength in the performance of both masculinity and caring by men nurses remains substantial and firmly establishes *caregiving as strength* as an important performance sub-theme in the current study.

***Technical-instrumental caregiving.*** *Technical-instrumental caregiving* was the third performance sub-theme identified during the current study based on that focused on the instrumental process of nursing care rather than the affective and relational elements. In addition, many participants expressed an affinity for technology and cited this as one of the reasons that they had pursued specialties such as critical care and emergency care.

It is impossible to discuss this sub-theme without acknowledging the role of essentialized femininities on the common construction of caring within nursing, and the influence of essentialized masculinities on the performance of caring by men in nursing. Caregiving, nurturing, and outward expression of emotion and empathy (verbally and through physical touch) are strongly affiliated with essentialized conceptualizations of femininity, and have therefore become a significant part of the construction of feminized nursing caring (Forrester, 1988; Grady, 2006; Grady, et al., 2008; Harding, 2005). Essentialized masculinities, in contrast, are strongly affiliated with instrumental behaviors, assertiveness, autonomy, independence, and mechanical and technical skills (Forrester, 1988). Men in nursing, who are influenced by essentialized perspectives of masculinity, may therefore focus on the instrumental aspects of nursing care and avoid affective approaches to care that not only fall outside the performance of essentialized

masculinities, but are also rife with potential pitfalls for men in nursing. In particular, the use of touch in the course of care by men in nursing can be problematic in light of the sexualization of men's touch and societal perspectives that question men's motivation for touching (Evans, 2001, 2002; Harding, 2005; Harding, et al., 2008; Pullen, et al., 2009).

Evidence of an instrumental approach to nursing care by men was also provided by Ingle's (1988) qualitative exploration of caring among 12 baccalaureate prepared Registered Nurses in Alabama. The overriding theme identified by Ingle was "the business of caring" which identified the tendency for her participants to classify the nurse-patient relationship in terms of a business relationship. Inoue et al. (2006) also identified "controlling feelings" as a strategy that men nurses apply in the delivery of intimate nursing care to women. Inoue et al.'s participants discussed how they tried to suppress feelings of discomfort they might have in performing intimate nursing care with women, and focused on "doing their job" (p. 563). Milligan's (2001) participants also focused on the instrumental tasks of meeting their client's needs and discussed the need to manage their emotions in order to: protect themselves from the emotional impact of some of the difficult situations they must deal with; ensure that they maintain the ability to facilitate their client's needs; and, maintain societal expectations that require men to control their outward display of emotions.

Participants in Paterson et al.'s (1996) phenomenological study and Evans' (2001) qualitative thematic analysis discussed the different caring approach of men by classifying women's approach to nursing as "touchy-feely" or "warm fuzzies", which suggested they were trying to distinguish their approach to care from the affective



emphasis that they saw in their women colleagues. Men nurse participants of numerous studies have suggested that men have a different approach to caring that is not well recognized within the nursing profession (Anthony, 2004; Evans, 2001, 2002; Harding, 2005; Ingle, 1988; Milligan, 2001; O'Lynn, 2007b; Paterson, et al., 1996). However, caution is warranted when contemplating the nature of the difference between the caring practice of men and women in nursing. The tendency to dichotomize caring practice based on gender may lead many people to consider masculine and feminine caring as mutually exclusive and this would be problematic. This perspective would imply that all men do not value the affective components of caring, and suggests a uniform performance of gender by both men and women which has been soundly contested (Coltrane, 1994; Connell, 1995, 2000). Research evidence suggests that men nurses do demonstrate and value empathy (Harding, 2005; Ingle, 1988), and also exhibit traditional caring behaviors such as compassion, acceptance, consideration and kindness (Ingle, 1988). One of Harding's (2005) participants considered empathy as part of caring, but not the whole essence of caring. Empathy provided the motivation for the application of technical-instrumental skills in the course of providing holistic care to his client (Harding, 2005).

Although several participants in the current study made statements that could be interpreted as devaluing the affective components of nursing care, it was challenging to disentangle these statements from their performances of masculinity. Perhaps these men really did not value the affective components of caregiving? Perhaps their statements that devalued the affective components of caregiving represented their desire to deliver a

performance consistent with essentialized masculinities and did not necessarily represent an accurate picture of their perspectives on the affective domain of nursing care? Since the current study accessed secondary data, it was not possible to re-explore these participant's statements further to determine the underlying motivation for the statements that devalued the affective. However, the findings of Harding (2005) and Ingle (1988) suggest that these men may have valued the affective domain more than was evident in their statements. In addition, what could be interpreted as a rejection of the affective aspects of nursing care by these participants may have represented an attempt to establish themselves as masculine caregivers in counterpoint to the feminized perspectives on caring that surrounded them? It was also important to recognize that entering into the affective realm potentially placed these men at risk for accusations of inappropriate behavior because of the physical and emotional intimacy inherent in many commonly held affective approaches to nursing care. By emphasizing the technical and instrumental aspects and professionalism of their nursing care, these participants were therefore able to articulate their approach to caregiving in a way that avoided the potentially problematic nature of an affective approach by men. By avoiding the affective, these men nurses not only delivered a performance of masculinity more consistent with dichotomized and essentialized perspectives on gender, but also sought to minimize the sexualization and suspicion of their touch by decreasing the perceived intimacy of the interaction.

**The performance elements.** Eight performance elements were identified during the thematic analysis including: *cautious touch, trading off nursing tasks, use of women as chaperones, identification of marital status, humor as a tool to establish a therapeutic*

*connection, displaying acceptable essentialist masculine cues and behaviors, choice of practice setting and displaying affinity for technology.* Essentially, these performance elements represent strategies to manage the performance of masculinity and caregiving amongst the participants. Each of these performance elements contributes to one or more of the identified performance sub-themes. In addition, all eight of these performance elements have been identified in the men in nursing literature previously, which provides support for their validity as common strategies in the performance of masculinity and caring by men in nursing.

***Cautious touch.*** The use of *cautious touch* by men nurses has been consistently documented in the nursing literature (Anthony, 2004; Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006; O'Lynn, 2007b; Paterson, et al., 1996; Pullen, et al., 2009; Tillman, 2008). Common practices of *cautious touch* included strategies such as taking the time to get to know clients and explaining the purpose and rationale of procedures thoroughly before engaging in intimate care, maintaining as much privacy as possible, minimizing exposure of the client, engaging with the client in a formal or professional manner, and using the minimum amount of touch necessary (Evans, 2002; Fisher, 2009). There are two main reasons for cautious touch by men in nursing. First, the nurse utilizes cautious touch to increase client comfort and trust by reassuring the client that he is respecting his/her privacy as much as possible (Evans, 2002; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006). Second, cautious touch is also used to decrease men nurses' sense of vulnerability around the risk of false accusations of sexual impropriety by the client

(Evans, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006).

Incidentally, the participants of the current study and other previous studies applied cautious touch in their care of men and women of all ages because the affiliation of homosexuality with men in nursing, and the conflation of homosexuality with pedophilia, meant that men were potentially at risk of false accusations of misconduct from any client group (Evans, 2001, 2002; Fisher, 2009; Harding, et al., 2008).

***Trading off nursing tasks.*** One of the most common performance elements (strategies) used in the course of *cautious caregiving* by study participants was *trading off nursing tasks* with women colleagues. This strategy is very well established in the nursing literature as an accepted way to promote client comfort and decrease the sense of vulnerability men nurses experience in the provision of intimate nursing care to clients of both genders and all ages (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006). As noted by one of the Vancouver focus group participants, the practice of trading nursing tasks around certain procedures like catheterization of women is so well established that sometimes women colleagues will offer to do the task without being asked. Although this practice is common, it should be noted that it is not without concerns. Men's clinical competence in certain intimate nursing skills (e.g. catheterization of women) may suffer, and there is a potential that some women colleagues may resent being asked to participate in the care of women assigned to men nurses. Ironically, two common values reified by the participants in the current study were autonomy and independence, and the dependence on women colleagues to fulfill some aspects of their woman client's nursing care may be frustrating

for some men. Perhaps the sense of vulnerability around intimate care, and concerns for client comfort, outweighs the desire for autonomy in this case.

*Use of women as chaperones.* The *use of women as chaperones* to witness men nurse's care of clients in private settings, or in the case of intimate care, was also a frequently used performance element (strategy) in the participants' practice of *cautious caregiving*. The use of this strategy by men in nursing is well documented in the literature; however, it is also important to note that the use of chaperones with men nurses has historically often been mandated through institutional policy and sometimes reinforced by women nursing colleagues (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006; Pullen, et al., 2009). Another indirect form of chaperoning was asking women clients if they minded having a man nursing student or nurse provide care to them. Men from several studies have expressed frustration about this practice because it implies that there is an inherent problem in receiving nursing care from a man, and inadvertently positioned women colleagues in the role of gatekeeper/protector (Evans, 2001; Harding, 2005; Harding, et al., 2008; Paterson, et al., 1996). Although men in nursing may welcome the opportunity to have a woman act as a chaperone at times, policies that mandate chaperones for men nurses serve to reinforce the perspective that all men are potential sexual offenders. In addition, requiring a woman to act as a chaperone for men nurses reinforces essentialist notions that position men as unlikely or failed caregivers who can only deliver nursing care appropriately and professionally in the presence of a woman.

***Identification of marital status.*** Several participants in the current study purposefully identified themselves as married, or as parents, in the course of *cautious caregiving*. Self identifying as married reinforced the nurse's heterosexuality to his clients, and in combination with being a parent, established him as a safer and more credible caregiver. In addition, self-identifying as married can also be considered a performance of essentialist masculinity which had the potential to make a man nurse a more acceptable caregiver to homophobic men (Fisher, 2009). This practice has been noted previously in the literature and there is some evidence to suggest that it can be an effective strategy in *cautious caregiving* (Evans, 2002; Fisher, 2009). Participants in Morin et al.'s (1999) study which explored obstetrical clients' responses to care by men nursing students found married students and parents more acceptable as caregivers. One interesting point to note is that the participant interviews for the current study were completed in 2004 prior to the passing of legislation that legalized same-sex marriage in Canada. We cannot know from the existing dataset if identification of marital status would have the same impact in today's practice settings. Being married may no longer imply heterosexuality, and adoption of children into same-sex relationships is also increasingly more common, thus having children no longer implies heterosexuality. In other words this performance element may change over time to account for these societal changes. For example, men nurses may now specifically refer to "my wife" or "my girlfriend" if they want to emphasize their heterosexuality in the context of a marital relationship.

***Humor as a tool to establish a therapeutic connection.*** Humor was used as a tool by several participants to establish a connection with clients or deal with uncomfortable or anxiety producing situations. Humor was used during the care of both men and women; however, the tone and content of the jokes differed based on the gender of the client and the situational context. Jokes shared with women clients tended to be aimed at decreasing anxiety and making them more comfortable with nursing care provided by a man. Use of humor with men also served to establish a caring relationship with the client; however, the use of humor with men clients also served as a medium for the performance of essentialist masculinity in order establish the nurse as an acceptable man and caregiver. Jokes with men were bawdy at times or consisted of verbal sparring or teasing, which was essentially a performance of hegemonic masculinity. Similar use of humor is also noted by other men in nursing research, firmly establishing humor as a common performance element in *cautious caregiving* (Evans, 2001, 2002; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006).

***Displaying acceptable essentialist masculine cues and behaviors.*** The participants in the current study also engaged in the performance of essentialized masculinities in the course of *cautious caregiving* and *caregiving as strength*. Participants often emphasized their masculinity through the way they dressed (e.g. professionally, solid colors, traditional uniform) and the use of facial hair. The participants also tended to perform essentialized masculinities such as talking or acting tough in the presence of other men so they could counteract the feminized and homosexual image of men nurses and be deemed an acceptable caregiver to heterosexual homophobic men. Presenting a

“tough” exterior and emphasizing physical size and strength was also used in the course of enacting *caregiving as strength*, especially when dealing with violent or aggressive clients. Fisher’s (2009) Australian informants discussed how they ensured that they were identified as heterosexual by performing masculinity in accordance with culturally dominant masculinity through the use of language and mannerisms. Fisher’s informants went on to describe how they presented a “macho” exterior and talked about “blokey” things like cars and surfing, and stated that their performance might range from just “playing the man” to “acting the homophobe” (p. 2672). Even some homosexual nurses would present a similar performance of essentialized masculinity to disguise their homosexuality and increase their acceptance (Fisher, 2009).

There is some evidence to suggest men do not emphasize essentialized masculinities in all aspects of their nursing care. Men may downplay or “dial down” their “macho” image in an attempt to be viewed as an appropriate caregiver by women clients, women educators, and other nurses (Evans, 2002; Paterson, et al., 1996). This performance of a “soft masculinity” (masculinity with soft edges) has also been discussed by Fisher (2009) and Holyoake (2002) as a strategy used by men nurses to increase their acceptability to women clients and colleagues.

***Choice of practice setting.*** Participants in the current study overwhelmingly stated that men in nursing preferred to work in critical care, emergency department, or psychiatric settings. There has been considerable discussion in the literature surrounding men nurses’ choice of practice setting (Egeland & Brown, 1989; Evans, 1997a; Harding, 2005; Harding, et al., 2008; Williams, 2003). Some scholars have suggested that men



nurses' tendency to practice in areas like administration, and high status specialties like critical care and emergency, is related to the perpetuation of men's relative advantage within the context of our patriarchal society (Evans, 1997a; Williams, 2003). Egeland and Brown (1989) have suggested that men's choice of practice setting is related to their desire to create "islands of masculinity". The idea that men are actively seeking to create masculine areas in nursing may be overstating the issue; however, participants in the current study did express a desire to work in areas where other men were present so they didn't "feel like such a freak". Additional perspectives suggest men nurses' preferred practice settings follow stereotypical career trajectories for men or that they demonstrate men nurses' desire to distance themselves from the "lower status" work within nursing such as intimate personal care (Evans, 1997a; Fisher, 2009; Williams, 2003). Given the reification of values such as *forward momentum – career success, leadership, and status* among the study participants it would be inappropriate to dismiss these perspectives entirely; however, the reasons for choosing a practice setting are likely more complex than these reasons alone. *Choice of practice setting* ultimately can be considered a performance element that contributes to all three performance sub-themes: *cautious caregiving, caregiving as strength, and technical-instrumental caregiving*.

*Choice of practice setting* may support the performance of *cautious caregiving* because men may be choosing low-touch settings that minimize the challenges related to intimate nursing care and relationships (Evans, 2002). Similarly, Harding et al. (2008) suggested that men may choose certain practice settings in order to feel less vulnerable to accusations of sexual misconduct. Citing intensive care as an example, Harding stated

that this setting is safer for men because they are generally within the view of another nurse when performing intimate nursing care, and the complexity of the environment often means that the nurse will engage the assistance of one of his nursing colleagues, who can act as an informal chaperone.

The performance of *caregiving as strength* is also supported by choice of practice setting, since areas such as psychiatry and emergency frequently value the presence of men nurses given the likelihood of dealing with aggressive or violent clients in these settings. Since men nurses' physical contribution to nursing as lifter and security has been emphasized throughout the history of modern nursing, settings that value *caregiving as strength* have actively pursued the recruitment of men nurses (Brown, et al., 2000; Evans, 2004a, 2004b). This situation has therefore contributed to the higher proportions of men nurses in these practice settings

*Choice of practice setting* also clearly contributes to a performance of *technical-instrumental caregiving* since several participants in the current study stated that they were attracted to critical care and emergency settings because of the technology and machines used in these practice areas. The participants in this study clearly *displayed an affinity for technology* which will be discussed as the next performance element. Other researchers have also noted this affinity towards the high-tech amongst their participants (Evans, 2002).

***Displaying affinity for technology.*** Participants frequently expressed an affinity for the use of technology in their nursing practice, and this contributed to the performance sub-theme of *technical-instrumental caregiving* and a tendency to prefer

high-tech practice settings such as critical care. Similar findings were also noted in the work of Evans (2001) and Harding (2005). Common essentialized societal perspectives on masculinity frequently associate mechanical and technical ability with masculinity, and this was affirmed by the participants given the identification of the reified value of *knowledge-technical ability* within the dataset. One significant observation by participants was that they were expected to be more technically adept and were often sought out by their women colleagues for technical assistance. This suggests that the women colleagues of these men also contributed to the perpetuation of gender essentialization in the nursing workplace.

**Internal-individual and external contextual elements.** Each performance of masculinity and caring by the study participants was a social construction influenced by a number of external and internal-individual contextual elements. External contextual elements provided the societal, professional, and situational backdrop that informed the participant's internal-individual context (values and beliefs). Both internal and external elements interacted to create the continually changing context that influenced the participants' combined performances of masculinity and caring. The external contextual elements identified during the study included: *societal norms influenced by gender essentialism, nursing professional norms, and specific micro-contextual factors*. Internal-individual contextual elements included: *upbringing-socialization, professional socialization, men nurses' reified values, experiential factors and security-insecurity in personal masculinity*. It would be misleading to discuss these internal-individual and external contextual elements as completely independent discrete entities because there is

obvious interplay among many of these elements. External conditions have the potential to influence internalized individual values and beliefs. Conversely personal values and beliefs have the potential to influence collective external norms and conditions. Therefore, the following discussion of the contextual elements does not separate the discussion of external elements from internal-individual elements, but rather acknowledges the fact that each of these elements represents a different facet of the overall context that influences the performance of masculinity and caring.

*Societal norms influenced by gender essentialism, socialization, experience/maturity, and their influence on men nurses' internalized values.* What influences the beliefs and values held by individual men in nursing? Undoubtedly, there are numerous factors that shape the practice of an individual nurse; however, there were several contextual elements identified in this study which had the potential to influence the practice of men in nursing including: *societal norms influenced by gender essentialism, nursing profession and community of practice norms, professional and general upbringing-socialization, and the influence of experience and maturity (security-insecurity in personal masculinity and experiential factors).*

Three interrelated themes associated with common societal perceptions about men in nursing were identified in the study including: the *stereotype of the woman nurse, suspicion of homosexuality, and men nurses' credibility as a caregiver.*

*The stereotype of the woman nurse.* The consideration of nursing as a profession for women is pervasive and extremely well documented in the literature (Anthony, 2004; Bartfay, 2007; Brady & Sherrod, 2003; Ekstrom, 1999; Evans, 2001, 2004b; Fisher,

2009; Grady, 2006; Harding, 2005; Hart, 2005; Holyoake, 2002; Ingle, 1988; Inoue, et al., 2006; Jinks & Bradley, 2004; Kelly, et al., 1996; Keogh & Gleeson, 2006; Meadus, 2000; Meadus & Twomey, 2007; O'Lynn, 2004, 2007a; Okrainec, 1994; Paterson, et al., 1996; Tillman, 2008; Villeneuve, 1994). Likewise, this perspective continues to be reinforced by the reality that less than six percent of Canadian Registered Nurses are men (Canadian Nurses Association, 2009a). The public face of nursing continues to primarily be a woman's face, and this reality reinforces nursing as profession of women, tends to keep nursing off the career selection radar of many men, positions men as unlikely or possibly substandard nurses, and places men's motives for being nurses under scrutiny.

*Suspicion of homosexuality.* The stereotype that all men in nursing are homosexual has also been documented in numerous studies that have examined the perspectives of clients and both men and women nurses (Bartfay, 2007; Evans, 2001, 2002; Fisher, 2009; Harding, 2005, 2007; Harding, et al., 2008; Hart, 2005; Holyoake, 2002; Kelly, et al., 1996; Meadus, 2000; Meadus & Twomey, 2007; Tillman, 2008; Whittock & Leonard, 2003). In a similar vein, several studies have also identified how the pervasive stereotype of the homosexual man in nursing has had a profound influence on the practice of men nurses (Evans, 2001, 2002; Fisher, 2009; Harding, 2005, 2007; Harding, et al., 2008; Paterson, et al., 1996).

The common affiliation of men in nursing with homosexuality is likely rooted in essentialized perspectives that associate nursing and caring with femininities (Poole & Isaacs, 1997). The nursing role is therefore positioned outside an acceptable performance of essentialized masculinity (Fisher, 2009; Harding, 2007; Poole & Isaacs, 1997). Since

homosexuality is also frequently positioned as a more feminine or subordinate performance of masculinity from the perspective of common western hegemonic masculinities, the result is the inappropriate association of homosexuality with the performance of caregiving by men in nursing (Connell & Messerschmidt, 2005; Harding, 2007).

In actuality, it is impossible to say what proportion of men in nursing are homosexual, since reliable statistics on nurse's sexual orientation are not available. In addition, the proportion of men nurses who are gay may not always be germane to the discussion of men nurses' performance of caring. Regardless of sexual orientation, all men nurses must address the stereotype of homosexuality in the course of their practice. This stereotype has the potential to effect the establishment of an effective therapeutic relationship with clients of all ages and gender, but especially with men holding essentialized beliefs about masculinity and those harboring homophobic perspectives (Evans, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008). As a result, the stereotype of the homosexual man in nursing remains a significant contextual element to men nurses' performance of masculinity and caring.

*Men nurses' credibility as a caregiver.* It has been well established that essentialized ideas about gender have contributed to the affiliation of caring and nurturing with femininity; therefore, it was not an unexpected finding that the men study participants frequently felt that their credibility as a caregiver was in question (Poole & Isaacs, 1997). Hart (2005) reported that one of the top three hurdles that her men nurse survey respondents identified was being perceived as uncaring. A review of the men in

nursing literature illustrated that this concern is certainly not without foundation (Ekstrom, 1999; Jinks & Bradley, 2004; Okrainec, 1994).

In a 2002 survey of 100 nursing students in the United Kingdom, 21% of respondents indicated that they felt women were more affectionate and caring than men (Jinks & Bradley, 2004). Although the proportion of respondents holding this opinion was significantly lower than the 71% that agreed with this statement during a similar study by the authors in 1992, it was still indicative of the pervasiveness of stereotypical beliefs that position men as unlikely caregivers (Jinks & Bradley, 2004).

Okrainec (1994) surveyed 117 men and 121 women nursing students in Alberta, Canada, and reported that approximately 30% of respondents of both genders thought that women nurses possessed a superior natural aptitude for nursing; approximately 25% of both genders felt that women possessed a superior caring attitude; and approximately 20% of men and 25% of women rated women superior in term of empathy. In addition, over half the men and two-thirds of the women felt that women were superior to men in terms of expressing their feelings (Okrainec, 1994). Similarly, Ekstrom (1999) reported that expectations of certain nurse caring behaviors were significantly lower for men nurses from the perspective of both patients and women nurses.

Despite the pervasiveness of stereotypes that position women as natural caregivers as compared to men, there is evidence to suggest that these perspectives are frequently inaccurate (Boughn, 2001; Ekstrom, 1999; Ingle, 1988). Although Ekstrom's (1999) participants' (n=145) expectations regarding men nurses' caregiving were significantly lower, there were no statistically significant differences in the actual care

given based on nurse gender from either the nurse or patient perspective. Boughn (2001) examined the reasons why men and women baccalaureate nursing students chose nursing, and found that both men and women demonstrated comparable commitment to care for their patients. Ingle (1988) also noted in her study examining caring among 12 baccalaureate prepared men in nursing that men enter nursing with caring attitudes or feelings, and that they demonstrate empathy, compassion, acceptance, consideration and kindness.

Ultimately there is no evidence to suggest that men have less proclivity to be caring than women, or that the nursing care they provide is substandard. So why does this common stereotype persist? Perhaps what fuels this perspective is the tendency to measure men's caring against essentialized feminine standards of what caring should look like (Evans, 2002). Since nursing is numerically dominated by women, and affiliated with femininities, the definition of appropriate nursing care norms is undoubtedly influenced by the feminized nature of the profession. In particular, the association of nursing caring with touch creates dissonance for men in the profession because their touch is frequently sexualized and viewed with suspicion (Evans, 2002; Harding, et al., 2008).

There is little doubt that a man's credibility as a caregiver in a given setting was a significant contextual factor that influenced the performance of masculinity and caring among the current study participants. In order to be perceived as caring, men in nursing frequently had to overcome this stereotype and demonstrate that they were competent and acceptable caregivers. Failure to deliver an acceptable performance of masculinity and



caring in accordance with common feminized societal beliefs about what caring entails therefore potentially created a significant barrier to being deemed acceptable in the role of nurse.

*Socialization of men in general.* The socialization of men in society is clearly influenced by essentialized perspectives on gender; therefore, young men are often socialized to consider caring behaviors and touch as being outside the performance of masculinity (Coltrane, 1994; Connell, 1995, 2000). Participants in the current study discussed how they had not had much opportunity to engage in physical care or nurturing prior to entering their nursing education program. They also identified how this had contributed to some discomfort in the caregiving role initially. At least three previous studies have noted how society's socialization of young men has contributed to challenges for men in the performance of nursing care (Evans, 2002; Milligan, 2001; Paterson, et al., 1996).

Men nursing students in Paterson et al.'s (1996) phenomenological study discussed the discomfort they felt in taking on a professional role that asked them to engage in touch when this had not been part of their interaction as young men. These nursing student participants initially struggled to incorporate touch and demonstrations of emotion into their interactions with their clients because they had been socialized to avoid these behaviors in the performance of masculinity. In addition, they were also concerned that incorporation of these approaches would open them up to allegations of sexual misconduct by women or homosexuality by men clients (Paterson, et al., 1996).

Participants in Evans' (2002) study "spoke of the newness of touching with caring hands and learning to feel comfortable touching others. The need to learn to care and/or develop comfort with the expressions of caring previously not practiced" (p.445). Evans participants went on to discuss how they measured themselves against the feminine standards of caring expression in nursing; therefore, having being socialized to essentialized perspectives on appropriate interpersonal interaction in the performance of masculinity, they found themselves at a distinct disadvantage.

Participants in Milligan's (2001) ontological hermeneutic study also discussed the expectation that as men they were expected to control their emotions in their interactions with their clients and colleagues. Milligan's participants felt that women nurses might be more sensitive to client's feelings. Clearly these men had been socialized to accept the premise that men had less capacity for empathy, and had internalized beliefs that their outward expression of emotion should be suppressed as part of their performance of masculinity and caring. By holding and perpetuating these beliefs, Milligan's participants not only set the stage for their caregiving to be considered outside the feminized norm for nursing, but also positioned their capacity for empathetic caregiving as being less than that held by their women colleagues.

*Professional and community of practice norms and socialization.* Although the current study participants entered the nursing profession with beliefs and values profoundly shaped by their ongoing socialization as men and members of society in general, participation in nursing education and practice inevitably continued to shape their perspectives and approach to performing masculinity and caring. Participants

described the challenge of learning how to function effectively in their adopted world of nursing, which was closely tied to femininities or women's ways of knowing. Failure to successfully transition to this new way of interacting and thinking could contribute to isolation and difficulty being accepted as a nurse. These feelings have been noted by other authors in the past. "One male nursing student stated nursing is 'a whole new way of thinking,' meaning that not only must male nursing students learn to think like nurses, they also often have to learn to think like women to be successful" (Brady & Sherrod, 2003, p. 159). Junior men nursing students in Paterson et al.'s (1996) study felt that women faculty and nurses established an expectation that they "should care for patients like women do, by being sensitive and demonstrative" (p. 32).

Some common professional norms within nursing cross practice settings and jurisdictions, but it must also be acknowledged that different communities of practice may establish their own norms that are enforced by community social processes (Paechter, 2003). A community of practice is defined as any group of individuals that regularly engage in social or professional interaction with one another, such that the community develops some shared knowledge, beliefs, practices, or norms (Paechter, 2003). In the nursing context, a community of practice might be a large collective group such as all the health professionals working within a given facility, or it might refer to more specific communities such as the nurses who work in a given practice setting (e.g. medicine, surgery, obstetrics, etc.), or a small group of nurses working together on a given unit. Regardless of the size of the community of practice, these groups can have a profound influence on the social and professional practices of their members; therefore,

communities of practice are a potentially significant contextual element that shapes the performance of masculinity and caring by men in nursing.

Participants in the current study identified some examples of different practices and approaches to nursing between practice settings with specific differences noted among mental health, critical care/emergency, and obstetrical settings. Some practice settings such as critical care units and emergency care settings placed emphasis on technical and instrumental aspects of care and valued more traditional performances of masculinity such as the display of strength, because of the common need to lift immobile patients or deal with aggressive or violent patients. Conversely, clients and nurses in obstetrical settings were generally felt to value affective or relational interaction and demonstrated a clear preference for women caregivers (Inoue, et al., 2006; Morin, et al., 1999). Mental health settings, on the other hand, valued affective interpersonal interaction; however, they also had an established history of welcoming men nurses because of the possibility that some clients in mental health setting may require physical intervention if they became aggressive or violent (Brown, et al., 2000; Evans, 2004b).

Although the variations between practice settings represented only a fraction of all the possible permutations of communities of practice that could influence the socialization of men in nursing, the variations that were noted between these three practice areas clearly illustrated the potential influence that community of practice forces may exert on the choices and behaviors of their members (Paechter, 2003). Men, who wished to be deemed acceptable nursing caregivers within a given community of nursing practice potentially had to adjust their performance of masculinity and caring to be

congruent with the norms of the community or face censure from the group (Paechter, 2003). This censure may have been manifested in disapproval by clients and peers, or may have translated into the opinion that a man was not an acceptable nursing caregiver. Men in nursing may also be drawn to practice settings that welcome their performance of gender, or have gender compositions that make them feel comfortable. Communities of practice therefore represented a significant component of the socio-cultural context of an individual's practice and were a significant influence on men's performance of gender and nursing practice within a given context.

*Influence of experience and maturity.* Several of the participants in the current study discussed the influence that life and nursing practice experience had on their perspectives, beliefs, values, and ultimately on their approach to nursing care. There is little discussion in the literature about the effect that maturity and security in personal masculinity has on the practice of men nurses; however, logic and intuition would suggest that life and nursing practice experience would certainly influence a man's understanding of the socially constructed practices of masculinity and caring and ultimately effect changes in their gender performance of caring over time. In addition, Finfgeld-Connett's (2008) meta-synthesis of caring in nursing identified professional maturity as an antecedent to the process of nursing caring, which also lends support to the potential influence that experience and maturity may have on the performance of caring by men in nursing.

Paterson et al. (1996) provided some evidence to support the idea that professional experience and maturation could positively contribute to the effectiveness of

nursing care in their phenomenological study of 20 men nursing students. Junior nursing student participants expressed discomfort related to participating in the relatively unfamiliar caregiving role, and discussed the challenge of incorporating demonstrative caring behaviors they associated with femininity into their practice (Paterson, et al., 1996). Drawing on the practice experience acquired during their professional education, and the examples of role models of both genders, senior nursing student participants reported an amalgamated approach to their nursing care which incorporated both masculine and feminine perspectives (Paterson, et al., 1996). In other words, these men gradually incorporated new knowledge and perspectives over time, and developed strategies to enable them to fulfill the role of caregiver more effectively, while still maintaining a secure sense of their own masculine identity (Paterson, et al., 1996).

One of Harding's (2005) participants, Robert, also provides some support for the effect that maturity has on a man's nursing practice.

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 (Harding, 2005, p. 277).

In this quotation, Robert's comments suggest that experience and personal and professional maturity contributed to transformational change in his caring practice, beyond the performance of tasks alone as well as the development of communication skills that enabled him to connect better with his clients (Harding, 2005).

Ultimately, the participants of the current study were collectively an experienced group of nurses who have successfully fulfilled the role of Registered Nurse for many years; therefore, these men have navigated the contradictions and tensions that men experience in taking on the feminized caregiving role of nurse. Considering the words of Paterson et al.'s (1996) junior nursing students, it is apparent that many men do not start their nursing career with a sense of comfort about caregiving. However, over time the practice of successful men in nursing is inevitably shaped by experiences, ideas, and influential colleagues. Perhaps this more mature understanding articulated by study participants, and the confidence that comes with it, subsequently informed a more artful application of nursing caregiving that transcended the completion of step by step tasks alone. Clearly, the influence of maturity on men's caring practice is an area that warrants future research to garner clearer understandings of the degree to which maturity and security in one's masculinity, influences nursing care. Perhaps the influence of maturity on men nurse's caring could be explored retrospectively through a life history approach? Alternately, it would be particularly interesting to enlist a cohort of men entering a nursing education program in a long-term qualitative longitudinal study that followed their personal and professional growth throughout their nursing education and for several years following graduation.

*The internalized values of men in nursing.* Considering the influence of the study participants internalized values on their performance of masculinity and caring was inherently challenging because of the inevitable variation in values that could exist between individual participants. However, in an attempt to collectively consider the

influence of individual values on the performance of masculinity and caring, the values reified in the words of the study participants were coded and organized into several contextual sub-elements subsumed under the contextual element of *men nurses' reified values*. Each of these contextual sub-elements represented a reified value that was noted in the study transcripts including: *autonomy, independence, status, leadership, forward momentum - career success, strength-protector, knowledge-technical ability, direct-communication-assertiveness, and action-acuity-adrenaline*.

Interestingly, the reified values identified during the analysis were remarkably congruent with essentialized masculine qualities in society. This suggested that the participants' ongoing socialization to essentialized masculinities continued to exert a profound influence on their lives, despite their professional maturity and extensive experience in fulfilling a feminized caregiving role. "The traditional masculine sex role is characterized by instrumental and agnatic behaviors including an achievement orientation, assertiveness, autonomy, decision-making ability, dominance, endurance, strength, and power" (Bem, 1978; Forrester, 1988, p. 601).

Boughn (2001) also identified some of the same values among men nursing students in her study of why men and women choose nursing as a career. The men in Boughn's study displayed an interest in career advancement and a desire to hold a position of power that gave them some measure of control over their practice. In addition, Boughn's participants also expressed a desire to empower the profession, a willingness to be outspoken about their feelings, and a desire to help the position of men in the profession.



Abrahamsen (2004) has identified additional factors that influence men in nursing to pursue career advancement including traditional essentialized perspectives that position men as natural leaders, and the continued positioning of men as “breadwinners”. When directly questioned about the influence of salary and career possibilities on the choice of work pursued, twice as many men than women identified these factors to be extremely important (Abrahamsen, 2004).

Harding (2005) also identifies a tendency for men nurses to pursue career advancement and leadership positions to not only acquire higher income in order to take better financial care of their family, but also as a means to effect positive change within the health care environment. Harding suggested it may be inappropriate to assume that men’s primary motivation for choosing a practice setting (e.g. critical care or administration) is rooted in a need to hold onto patriarchal power and masculine status. Although power and status may motivate some men, concluding that this is the main factor in men’s career choices fails to acknowledge the caring impulse that motivated men to enter nursing in the first place (Harding, 2005). Career advancement as a means of providing better nursing care is therefore presented by Harding as an alternate interpretation of men’s common emphasis on career development.

The analysis of the values demonstrated in the words of the study participants certainly suggests that their values are significantly influenced by traditional essentialized views of masculinity. These findings are congruent with the findings of other studies that have examined the perspectives of men in nursing. Since these values certainly contribute to the script that informs the performance of masculinity and caring, they are

likely a significant contextual factor to these performances. Despite the fact that the performance of essentialized masculinities has had a role to play in the perpetuation of patriarchal dominance in society (Evans, 1997a; Williams, 2003), caution is warranted when assuming that all of these values are directed toward the perpetuation of masculine status and power. As Harding (2005) discussed, the motivation behind values such as career advancement, autonomy, leadership, status and assertiveness may also be rooted in some men's desire to influence positive change for their clients or the nursing profession.

*Specific micro-contextual factors.* When examining the *specific micro-contextual factors* that influenced a discrete interaction between a man in nursing and his client, the analysis generated three contextual sub-elements including: *gender of client audience, age of client audience, and other individual audience factors-feedback.*

*Gender of the client audience.* Participants discussed challenges associated with the care of both women and men because of societal perspectives that positioned men as unlikely caregivers and nurses. The nursing care of women was approached with particular caution and an awareness that women might feel uncomfortable with a man providing intimate care to them; however, the nursing care of men also presented difficulty for the study participants because the stereotype of the homosexual man nurse sometimes resulted in the rejection of these men as an acceptable caregiver to homophobic men clients. These findings were certainly not unique, since these experiences have been previously described by several men in nursing researchers. Inoue et al.'s (2006) participants all reported finding the experience of caring for women challenging, especially when providing intimate physical care. Likewise, the

sexualization of men's touch is presented as a barrier to the care of both men and women by several researchers (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008). The need to overcome the stereotype of homosexuality in order to be viewed as an acceptable caregiver by some men was first discussed by Evans (2001) and has been subsequently reaffirmed by the work of other researchers (Fisher, 2009; Harding, 2005; Harding, et al., 2008). Despite evidence that suggests the physical care of both genders has implications for men in nursing, most of the research to date has focused on the relationship between men nurses and women clients (Inoue, et al., 2006; Lodge, et al., 1997; Morin, et al., 1999), particularly in the obstetrical and gynecological setting. While Evans, Fisher (2009), Harding (2005), and Paterson et al. (1996) have all identified the complexities associated with men providing nursing care to other men in the context of their larger studies on men in nursing, there is definitely the potential for additional research in this area.

What can be said with a fair degree of certainty is that the gender of the client is a significant contextual factor that shapes the performance of masculinity and caring among the current study participants and that this conclusion is further supported by other men in nursing researchers.

*Age of the client audience.* The participants in the current study clearly identified client age as a significant contextual sub-element that influenced their performance of masculinity and caring. Increased caution in delivering nursing care was evident with both young women and young men, although for slightly different reasons. Participants perceived that young men would be less comfortable with touch in general, while they

identified intimate care of young women as uncomfortable for both the client and the man nurse. In addition, the participants felt more vulnerable to accusations of sexual misconduct when caring for young women. In response to this fear, these men often utilized strategies such as trading off nursing tasks or requesting women chaperones to decrease the inherent risk associated with these situations. Several researchers have identified this pattern in previous studies looking at the caring relationship between men nurses and women clients (Inoue, et al., 2006; Keogh & Gleeson, 2006), while others have also acknowledged the difficulties associated with the care of young men as well (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008). Men nurses' perception that young women may find intimate care provided by men nurses uncomfortable has received some support from a few studies (Chur-Hansen, 2002; Lodge, et al., 1997; Morin, et al., 1999). Similar research was not located to ascertain whether younger men had similar perspectives on care provided by men nurses.

Participants in the current study had inconsistent opinions as to whether older men would be more comfortable receiving nursing care from a man; however, some participants did suggest that they found it easier to provide intimate nursing care to older women and even felt safe enough to engage in flirting with older women clients as a means of establishing a therapeutic connection. Perhaps this increased comfort in providing nursing care to older clients is related to a tendency for older clients to be more willing to accept men in the role of caregiver given their maturity and life experience? Perhaps older clients have had more contact with men nurses in the past and have more comfort with them in this role? Perhaps society's tendency to desexualize individuals as

they get older has resulted in a perception that there is less potential for an inappropriate interaction between the nurse and an older client?

Providing nursing care to children of both genders was identified as a challenge by several participants who felt that their motivation for working with children was under question. The result was a heightened sense of caution in their interactions with children. Society's increased awareness of child sexual abuse, the questioning of men's credibility in the role of caregiver, the sexualization of men's touch, the stereotype that all men in nursing are homosexual, and the conflation of homosexuality with pedophilia, have contributed to a situation where men's motivation for nursing children is frequently met with suspicion (Evans, 2001, 2002). This phenomenon has been discussed previously by a couple of researchers (Evans, 2001, 2002; Harding, 2005), and although these perspectives are not usually rooted in fact, they never-the-less exert a significant effect on the practice of men nurses in the care of children.

The age of a client is clearly a significant contextual factor that has the potential to influence the performance of masculinity and caring by men. Although not a hard and fast rule, caring for younger clients of both genders appeared to contribute to a heightened sense of caution among the study participants, and sometimes increased discomfort among the clients themselves.

*Other individual audience factors-feedback.* Since the performances of masculinity and caring are socially constructed and each performance has an audience that will give feedback to the performance, it stands to reason that men nurses' performances may be adjusted in response to audience feedback or anticipated feedback.

One example of audience feedback discussed by one of the study participants was a case where the husband of an obstetrical client refused to allow a man (nursing student) to be involved in the intimate care of his wife. It should be noted that this occurrence was likely not entirely unexpected since Morin et al.'s (1999) study identified a partner's viewpoint as a significant influence on the willingness of a woman to accept nursing care from a man; it also illustrates the potential influence that audience members might have on the performance of masculinity and caring by men in nursing.

It is very likely that experienced men in nursing will adjust their performance of masculinity and approach to nursing care in response to the specific micro-contextual factors of a given client interaction. In addition to the consideration of client gender and age, men nurses may also potentially consider the gender of audience members, their relationship to the client, their role in the health care interaction (e.g. Does the audience include nursing colleagues or nursing instructors evaluating the man's performance of caring?). When considering all the possible factors that may influence the performance of masculinity and caring, the potential complexity of each performance is revealed and it becomes obvious that each nursing interaction is a command performance. There is no formula or procedure that can define the ideal approach to nursing care by men in nursing, and the ability to read these factors and apply them to the performance of masculinity and caring will likely develop in response to reflective social and professional interaction and a growing understanding of personal and societal perspectives on gender.

*The ever-changing socio-cultural context.* The current study has shed light on several contextual factors that have the potential to influence the performance of masculinity and caring by the men nurse participants; however, it must be acknowledged that these contextual factors are not presented as an exhaustive or static list of all the possible contextual influences on the practice of men in nursing. The socio-cultural landscape, which provides the backdrop to any nursing interaction, is constantly changing in response to evolving historical, political, social, cultural, geographical, and professional influences. Therefore, the contextual themes indentified in the current study are merely presented as a snapshot of the possible influences on the performance of masculinity and caring among this small group of men in nursing. As society's understanding of gender and caring changes in response to greater social and political forces in the coming decades, it would be interesting to revisit an exploration of these factors to see how wider socio-cultural changes will influence the practice of men in nursing.

### **Comparison of Thematic Model with Nursing Models of Caring**

How congruent is the generated thematic map, describing the contextual performance of masculinity and caring (See Figure 5.1 on page 165), with the commonly held understanding of caring within the nursing profession? Since a unified understanding of caring within nursing remains elusive, and nursing caring is a socially constructed concept which is probably constantly being remodeled, this is an inherently challenging exercise.

Morse at al. (1990) performed a content analysis of 35 nursing author's

definitions of caring and the main characteristics of their perspectives. The result of this analysis was the identification of five perspectives on the nature of caring including: caring as a human trait, caring as a moral imperative or ideal, caring as an affect, caring as the nurse-patient interpersonal relationship, and caring as a therapeutic intervention (Morse, et al., 1990). Although completed in 1990, Morse et al.'s content analysis draws on the perspectives of 35 of the major nursing caring theorists and authors up to that point, and continues to be one of the most comprehensive and clear descriptions of the concept of nursing caring available. In addition, much of the literature that Morse et al. accessed for their content analysis continues to be cited by researchers seeking to define caring (Bailey, 2009), and all five of their perspectives of caring are evident in the work of more recent content and meta-analyses (Brilowski & Wendler, 2005; Finfgeld-Connett, 2008). As a result, Morse et al.'s findings remain an excellent framework for the comparison of the current thematic model to the perspectives of caring held by the wider nursing community.

Caring as a human trait acknowledges the perspective that caring is an inherent component of human nature and that all human beings have the potential to care (Morse, et al., 1990). This perspective draws on the work of several authors including Benner and Wrubel (1989), who suggest that "caring is primary because it sets up the possibility of giving help and receiving help" (p. 4). Certainly an underlying assumption of the presented thematic model is that men nurses are fundamentally caring individuals who are motivated to provide quality and holistic nursing care to their clients. Indeed the assumption that men possess pre-existing caring attributes comparable to women has



already been established in the discussion that addressed men nurses credibility as a caregiver (Boughn, 2001; Ekstrom, 1999; Ingle, 1988).

Caring as a moral imperative suggests that caring is a fundamental value in nursing that provides the underpinning for all nursing actions, and draws on the perspectives of authors such as Watson and Gadow (Gadow, 1985; Morse, et al., 1991; Morse, et al., 1990; Watson, 1985, 2005). In addition, Finfgeld-Connett's (2008) presentation of "moral foundations" as an antecedent to caring also refers to the need for nurses to act benevolently, ethically, and conscientiously. The current study certainly supports the idea that men in nursing are motivated by an underlying desire to provide excellent nursing care that considers client comfort and security. If men were not fundamentally caring in their orientation, they would not be as concerned with adjusting their performance of masculinity and caring to address societal, professional and micro-contextual factors that influence caring interactions with their clients.

Caring as affect acknowledges the perspective that caring is an extension of empathy or emotional investment in a client or their experiences, and this perspective draws on the ideas of writers such as Bevis, Fanslow, Forrest, Gendron, and McFarlane (Morse, et al., 1991; Morse, et al., 1990). There is certainly evidence to suggest that men in nursing exhibit the qualities of empathy, compassion, acceptance, consideration, and kindness (Ingle, 1988). Boughn (2001) also states that both men and women demonstrated comparable commitment to care for their patients. Men in nursing therefore likely possess empathy and emotional investment in their clients and their experiences. However, the current study has also shown that the demonstration of this empathy and

emotional investment may be significantly influenced by men's socialization to essentialized perspectives on masculinity, which suggest men should control the outward expression of emotion (Milligan, 2001).

During her presentation of "interpersonal sensitivity" as the key to the caring process, Finfgeld-Connett (2008) also states that nurses demonstrate their sensitivity through use of touch and suggests that mechanical or instrumental nursing practice is the antithesis of "interpersonal sensitivity". Unfortunately, societal perspectives which position men as unlikely providers of touch in a caring context have contributed to the sexualization of men's touch; therefore, men nurses may be reluctant to demonstrate caring and compassion through touch. As presented in the findings of the current study, the result of these realities for men in nursing is the performance of *cautious caregiving* and an emphasis on *technical-instrumental caregiving*. Is men nurses' caring fundamentally different from that of their women colleagues? The findings of the current study would suggest that this is not the case, but men may outwardly demonstrate this caring in a different way because of their need to present an acceptable gender performance to all parties. The affective component of men's caring performance is therefore at significant risk of misinterpretation by some observers if the influence of gender performance is not considered in the interpretation of men nurses' caring practice.

Caring as an interpersonal relationship acknowledges the common perspective that the nurse-patient relationship establishes the foundation for caring or the medium through which it is expressed, and this perspective draws on the work of Benner and Wrubel, Horner, Knowlden, and Weiss (Morse, et al., 1991; Morse, et al., 1990). The

importance of establishing a trusting and intimate relationship with the client is also presented as the foundation of nursing by Brilowski and Wendler (2005), and as a major attribute in the caring process described by Finfgeld-Connett (2008). Benner and Wrubel (1989) state “we must consider the caring context because the nature of the caring relationship is central to most nursing interventions. The flexibility and diversity of expert practice depend on the nurse’s involvement in the situation” (pp. 4-5). Likewise, “variability”, or the ability to adjust nursing care to the client context, was presented as the fifth attribute of caring by Brilowski and Wendler. Finfgeld-Connett also discussed the need for nurses to personalize their care for each person and situation in her presentation of “interpersonal sensitivity” as an attribute of the caring process. Essentially the presented thematic map articulates how men in nursing consider the context of the caring interaction and subsequently adjust their performance of masculinity and caring to facilitate the establishment of an effective caring relationship with their clients. If a man cannot establish himself as an acceptable and plausible caregiver to his clients, it will be impossible for him to effectively implement nursing interventions in partnership with them. In other words, the contextual performance of masculinity and caring, as described in the thematic map, establishes the conditions that enable the formation of a caring interpersonal relationship with their clients.

Caring as therapeutic intervention emerged from perspectives that have articulated caring in terms of nursing interventions or actions aimed at creating the conditions that contribute to the establishment of a caring interaction (Morse, et al., 1990). Some of the authors examined by Morse et al. (1990) outlined specific caring

actions which nurses should employ, while others suggested that all nursing interventions aimed at assisting clients are caring in nature. Among the writers who supported this perspective on caring are Brown, Gaut, Larson, Orem, Swanson-Kauffman, and Wolf (Morse, et al., 1991). In a similar vein, Brilowski and Wendler (2005) presented “action”, or the provision of nursing care, as their second attribute of caring, which incorporated touch, presence, and competence. Finfgeld-Connett (2008) also identified the application of “expert nursing practice” as a critical attribute of the caring process. In considering the thematic map in the context of this perspective, the contextual performance of masculinity can be considered a nursing intervention enacted by men nurses to assist in the establishment of an effective caring relationship. In addition, the contextual performance of masculinity and caring is incorporated into the delivery of all nursing interventions. For example, men in nursing may focus on the technical and instrumental aspects of nursing care to maintain an acceptable performance of masculinity in one situation. In another case, a man may enact cautious caregiving in the context of providing intimate care such as bathing a client. In addition, the performance of caregiving as strength when caring for a bariatric client provides yet another example of how the contextual performance of masculinity and caring is applied in the course of therapeutic intervention. The idea that there are specific caring interventions that all nurses should employ is potentially problematic for men in nursing. If this list of caring interventions does not consider the unique challenges that members of the masculine minority must consider in the delivery of care then a performance of masculinity and caring may be considered inappropriate by the larger community. There is consequently

a need to acknowledge gender performance in the assessment of nursing practice at all levels.

It is apparent that the presented thematic model describing the performance of masculinity and caring by men nurses acknowledges the socially constructed nature of the concept of caring and is fundamentally congruent with existing theoretical perspectives on caring within the nursing profession. However, there are several common elements in the collective understanding of caring within nursing which are potentially problematic for men, such as use of touch and intimacy in caring interactions. None of the previous attempts to describe the collective understanding of caring in nursing (Brilowski & Wendler, 2005; Finfgeld-Connett, 2008; Morse, et al., 1991; Morse, et al., 1990) have acknowledged the role that caregiver qualities such as gender performance may have on the enactment of caring. The findings drawn from the current study add to this body of knowledge by providing some evidence to demonstrate that the performance of gender plays a part in the outward performance of caring. In addition, these findings underline the fact that creating a list of “one-size fits all” acceptable or appropriate approaches to nursing care is problematic, since there are so many contextual factors that can influence the determination of the best approach to delivering care. As a result, future efforts to explore caring in nursing need to consider the potential diversity of the nursing workforce, and avoid the presentation of nurses as a homogenous group.

### **Utility of the Chosen Theoretical Framework**

Masculinity theory proved to be an ideal theoretical framework to explore the performance of masculinity in the context of caregiving among the men nurse

participants (Coltrane, 1994; Connell, 1995, 2000; Connell & Messerschmidt, 2005).

The central difference between men and women in the nursing profession is their performance of gender. The socially constructed nature of this performance is inevitably an integral part of all other performances involving social interaction including the performance of caring by nurses.

Socially constructed concepts like gender and caring are not static and homogeneous entities; therefore, it would be inappropriate to consider men nurses' caring as a clearly defined and consistent concept applicable to all caring situations. Multiple masculinities and caring approaches exist and evolve in response to the diverse and fluid socio-political contexts that influence their construction (Connell, 1995; Connell & Messerschmidt, 2005). By examining the combined performance of masculinity and caring from this theoretical standpoint, it became clear that it would be inappropriate to discuss the caring practice of men in nursing without acknowledging the uniqueness of each performance.

Although each performance of masculinity can be considered unique, masculinity theory has documented the existence of common patterns of masculinity (collective masculinities), which may be defined collectively in a given culture or sustained in institutions (e.g. the nursing profession, a workplace, or a given community of practice) (Connell, 2000; Connell & Messerschmidt, 2005). Likewise collective patterns of caring performance may be established within nursing communities; however, this poses an interesting question for consideration because the social collective that contributes to the construction of nurse caring is overwhelmingly made up of women (Canadian Nurses

Association, 2009a). Society is still significantly influenced by essentialized perspectives on gender (Coltrane, 1994) that affiliate caring and nurturing with femininities (Poole & Isaacs, 1997). It therefore stands to reason that the participants may have had to overcome this perspective, which may have been held by some of their clients and women colleagues. If the social construction of caring is affiliated with essentialized femininity, would a performance of caring that also involved the performance of essentialized masculinities be considered acceptable by members of the collective? If the men nurse participants in this study had to overcome this barrier, how did they adjust their performance of masculinity and caring to be considered acceptable caregivers? Masculinity theory therefore created the context for the consideration of the factors that might influence a man's performance of masculinity and caring, and provided a framework to explain why the identified performance sub-themes and elements emerged.

Masculinity theory also provided a means to consider the inherent political nature of gender performance within our patriarchal society. The hegemonic oppression of femininities (women) and subordinate masculinities to perpetuate the socio-political dominance of patriarchy is a significant influence on the value ascribed to all social processes associated with gender performance (Connell, 1995; Connell & Messerschmidt, 2005). Men in nursing are members of a feminized profession and are engaged in a societal role that has largely been associated with essentialized views on femininity. The study participants were clearly influenced by a desire to conform to essentialized perspectives of masculinity while also attempting to be successful in performing a professional role with norms influenced by essentialized femininities. In

other words, masculinity theory provided the means to explain the complex and sometimes contradictory performances of masculinity and caring exhibited by the men nurse participants in different contexts.

### **Recommendations for Future Research**

The findings of this study present some interesting observations about the contextual practice of masculinity and caring and support the findings of several other researchers of men in nursing. In addition, these findings also help to draw attention to some gaps in the research literature and opportunities for future research.

**The case for ethnography.** The majority of studies that have examined men nurses' approach to caring have depended on the participants of these studies to self-report their perspectives through quantitative survey methods (Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a) or through qualitative interviews subjected to variety of qualitative methodologies (Evans, 2001, 2002; Evans, et al., 2007; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Ingle, 1988; Inoue, et al., 2006; Kelly, et al., 1996; Keogh & Gleeson, 2006; Milligan, 2001; Paterson, et al., 1995; Paterson, et al., 1996). Other researchers have examined men nurses' care from the perspective of women clients (Chur-Hansen, 2002; Lodge, et al., 1997; Morin, et al., 1999) or nursing educators (Grady, 2006; Grady, et al., 2008). These studies have all made a significant contribution to the growing body of knowledge about men nurses' approach to caring; however, they may be open to various forms of reporting bias (Paley, 2001, 2008). When men nurses report their caring practices, they may seek to gain approval for their approaches by framing them in the context of nursing professional norms, or adjust their presentation of



information to seek the approval of the interviewer or other audience members (e.g. in a focus group). In a similar vein, the description of men nurses' caring from the perspectives of women clients and educators is subject to interpretation through the lens of their gender, values and beliefs. With the exception of Holyoakes (2002) ethnographic examination of men nurses' practice in three mental health settings, no other ethnographies were found that explore men nurses' approach to caring. Utilization of focused ethnography in future research studies exploring men nurses' caring holds particular promise in terms of adding valuable knowledge for practical application in the education and socialization of men in the nursing profession. Ethnography is an ideal methodology to document social interactions, behaviors, and perceptions among a group of men nurses and explore the professional interaction between these men and other individuals or groups (e.g. clients or other professional groups) (Reeves, Kuper, & Hodges, 2008). Using direct engagement through approaches like participant observation, an ethnographer can richly describe the cultural patterns, perspectives, and practices of a group of men in nursing and utilize this first hand data to explore the motivation and meaning behind the socially constructed performances of masculinity and caring by these men (Reeves, et al., 2008). In addition, participant observation provides researchers with an opportunity to gather empirical insights into the social practices of men nurses, which cannot be achieved through methodologies that require individuals to self-report their practices (Reeves, et al., 2008). Through ethnographic studies, the approaches that men are applying in their nursing practice can be illuminated and the effectiveness of these strategies can be explored within different contexts. Since men in

the nursing profession often struggle to learn how to navigate the role of caregiver, and many fail to complete their education or leave the profession early in their career, being able to articulate effective caring strategies could have a definite positive impact on the experience of men in nursing. Perhaps this would ultimately translate into greater retention of men in the profession.

**Exploring the effectiveness of men nurse's communication approaches.** One of the commonly articulated deficiencies in nursing education presented within the men in nursing literature is the lack of education related to engaging in emotionally and physically intimate care with clients and navigating the politics of physical touch (Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; O'Lynn, 2004, 2007a, 2007b). In the case of men nurses, this deficiency is particularly problematic since essentialized perspectives on masculinities and societal norms position them as questionable caregivers and sexualize their touch (Evans, 2002; Harding, 2005; Harding, et al., 2008). One possible avenue for future research could be the application of content analysis to examine how experienced and successful men in nursing communicate with clients in order to facilitate the establishment of a trusting therapeutic relationship with clients of all ages and genders. By identifying potentially effective approaches to interacting with clients, educators will be able to share these successful approaches with men nursing students who are still learning to navigate the role of caregiver.

**Interaction between men clients and men nurses.** The majority of research examining the interaction between men nurses and their clients has examined the woman client-man nurse dynamic (Inoue, et al., 2006; Lodge, et al., 1997; Morin, et al., 1999).

The findings of the current study and the work of several prominent nursing researchers who have explored the topic of men in nursing (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008) have provided significant evidence to suggest that the interaction between men nurses and men clients also represents an area of challenge. As a result, there is value in exploring the interplay between the performance of masculinity and caring by men in nursing and the performance of masculinity amongst their men clients. This area not only holds promise in terms of identifying effective approaches to caring interaction between men nurses and their men clients, but may also serve to illuminate the complexity of masculinity performances between men performing a feminized professional caregiving role and men in the vulnerable position of having compromised health and possibly being dependent on the help of another person. Neither of these roles fall within traditional essentialized performances of masculinity, therefore examining masculinities in this context has the potential to provide a glimpse behind the usual façade of essentialized masculinities.

**Exploring the performance of masculinity and caring by men in nursing who are also visible minorities.** The current study has clearly articulated the potential complexity that the performance of masculinity has for men in nursing in terms of their acceptability in the role of caregiver. What if a man in nursing is also a visible minority? Would skin color, ethnic background, and the possibility of an accent, positively or negatively affect the establishment of a therapeutic relationship with clients? Would the commonly expected or stereotyped patterns of masculinity performance within a particular ethnic group influence a nurse's ability to deliver an acceptable performance of

masculinity and nursing care in the eyes of clients and colleagues? Masculinity and caring are social performances that are clearly affected by numerous contextual factors. It seems likely that underlying societal influences such as racism, discrimination, and stereotyping would add additional complexity to the performance of masculinity and caring and the reception of this performance by clients and other members of the audience. Exploring the performance of masculinity and caring by men nurses, who are also visible minorities, therefore presents an excellent opportunity to contribute to the body of research on masculinities and the performance of masculinity in a nursing context.

**Researching the reasons for attrition among men in nursing.** The literature review and findings for this study have clearly identified a number of challenges that men in nursing must navigate in the course of their education and practice. In addition, anecdotal information strongly suggests that the attrition of men from nursing programs and during the first few years of practice exceeds that experienced by women in nursing (Bartfay, 2007; Brady & Sherrod, 2003; Sochalski, 2002; Tosh-Kennedy, 2007; Villeneuve, 1994). It is difficult to know how significant the issue of men's attrition from nursing education programs is in Canada, because gender is not currently being tracked by the Canadian Nurses Association [CNA] and the Canadian Association of Schools of Nursing [CASN] survey, and there is no consistent tracking of the reasons for attrition from Canadian nursing programs in general (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2008). Failing to track gender in nursing education is a significant omission by the CNA and CASN and this oversight is

incongruous with efforts by other professional groups that are actively seeking to address the issue of gender equity and are achieving success in this endeavor. In the absence of reliable data tracking gender in Canada's nursing education programs, it is challenging to identify and address gender related issues in nursing education. All Canadian nursing statistics and surveys should include gender as an element and additional research needs to be invested in exploring the reasons for attrition from nursing educational programs and professional practice to determine if there are any causes that are open to intervention.

### **Recommendations for Nursing Education and Practice**

The current study findings provide valuable insights that have the potential to inform nursing educators and practicing nurses in all settings. It is clear from the study findings that the performance of masculinities plays a significant role in the practice of men nurses at all levels of their development. Dissemination of these findings has the potential to create supportive education and practice environments for men nurses.

**Addressing the influence of gender on the nursing practice of men and women.** There have been numerous calls within the men in nursing literature for nursing education programs to consider the influence of gender performance and the challenges surrounding provision of intimate nursing care by men in nursing (Evans, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Keogh & Gleeson, 2006; Keogh & O'Lynn, 2007; O'Lynn, 2007b). Certainly, the findings of the current study also serve to underline the urgent need to consider the influence of gender on the performance of caregiving by men nurses and the evaluation of this performance by nursing educators and practice

administrators. In addition, although the focus of the current study has been men in nursing, there are likely some comparable practice challenges related to the performance of femininities and the delivery of intimate physical care amongst women nurses as well. Consequently, nursing education programs should incorporate material into nursing curricula that explores the influence of gender performance on nursing practice. In addition, nursing education programs need to directly address the inherent challenges associated with intimate nursing care while also presenting some strategies nurses can apply in the course of delivering this care.

**Are support programs needed to assist in the retention of men in nursing?**

Since anecdotal evidence suggests that the attrition of men from nursing programs significantly exceeds the rate of attrition among their women colleagues (Bartfay, 2007; Brady & Sherrod, 2003; Halloran & Welton, 1994; Poliafico, 1998; Tosh-Kennedy, 2007; Villeneuve, 1994) and there is some evidence to suggest that men leave the nursing profession at approximately twice the rate of women in the first five years after graduation (Sochalski, 2002), it could be beneficial to consider developing some support measures or programs to assist men during their transition into the relatively feminized role of nursing. In considering this recommendation, it is important to note that the Canadian nursing landscape continues to become more diversified as the country's population becomes more ethno-culturally diverse; therefore, the recognition of the unique challenges faced by men in the profession is just one example of nursing's need to accommodate diverse perspectives and approaches to nursing care. Establishment of such support programs or measures should honor the principle of equity by acknowledging

that different groups or individuals may have unique challenges or needs, rather than taking a position of equality that treats everyone the same while ultimately disadvantaging and/or penalizing those that do not adhere to the perspectives of the dominant group. In addition, this recommendation is not suggesting that men receive special treatment or that men should be held to different standards. What is proposed is some acknowledgment that men entering the caring focused and feminized world of nursing may need some assistance or mentoring during this transition because of the influence of essentialized masculinities and femininities in society. Men entering nursing need to reflect on their own performances of masculinity, and the influence these performances may have on their acceptability as a caregiver and their relationship with women colleagues. Hopefully, facilitating this process of reflection among novice men nurses will translate into increased awareness and understanding about the influence gender performance may have on nursing practice. This increased awareness and understanding may then assist these men to incorporate the contextual performance of masculinity and caring into their nursing practice earlier in their education, and this may subsequently assist them to navigate some of the inherent challenges of being a man in nursing.

**Professional development of nursing educators and administrators to raise awareness about the influence that gender may have on nursing practice.** In addition to incorporating a discussion of gender into nursing education, there is a need to concurrently raise the consciousness of nursing educators and leaders regarding the influence of gender performance on the explicit performance of caring by men in the

profession. In particular, nurses charged with the evaluation of men's nursing care need to be aware of the potential differences in men's demonstration of caring behaviors such as touch. If men are expected to perform caring in a manner consistent with essentialized perspectives on femininity, they may run the risk of being falsely perceived as uncaring if they deliver a performance of *cautious caregiving*, *caregiving as strength*, or *technical-instrumental caregiving*, which are profoundly influenced by essentialized masculinities, the questioning of men's credibility as a caregiver, and men's fear of allegations of sexual misconduct.

When evaluating men's nursing practice, it may be necessary for assessors to consider the influence of essentialized masculinities on the man's performance of caregiving, or asking the man about his approach to care prior to evaluating his actions. The following three examples may help to illustrate the potential for disparities in the assessment of men nurses' practice.

In the initial stages of clinical practice, many men may feel very uncomfortable in the role of caregiver and in particular with the provision of intimate nursing care. As young men, some novice nurses may have been socialized to consider certain caring behaviors like physical touch as being outside the acceptable performance of masculinity, or some men may have had limited opportunity to fulfill a caregiving role as they were growing up. As a result, men in their first clinical practice rotation may seem reluctant to engage with their clients when compared with their women colleagues, or may be perceived as avoiding their clients or nursing care. What may be considered as avoidance or a lack of initiative from one perspective could also be interpreted as fear and



discomfort in the role of caregiver. If a clinical instructor takes the time to ask the student about the reasons for his actions, it will be easier to determine the root cause and develop a plan to assist him to address the identified deficiency.

The findings of the current study and the nursing literature suggest that men in nursing may feel that they have to contain emotion and display a stoic presentation in the face of emotionally charged or upsetting situations in order to present an essentialized performance of masculinity (Milligan, 2001). The implications of such beliefs around the expression of emotion may be that men nurses are more affected by a critical incident than they acknowledge. Therefore, if a supervisor asks a man how he is doing following the traumatic death of a child for example, he may outwardly present himself as managing well with the incident while in reality he may be deeply affected. In other words, the performance of masculinity may mask the reality of the underlying emotions being experienced by some men.

The thematic analysis identified that many of the participants valued independence and autonomy which are traits commonly associated with essentialized perspectives on masculinity (Bem, 1978; Forrester, 1988). Because men are often socialized to value independence and autonomy, some men may feel that demonstration of success requires them to look after all the nursing care for their clients on their own. However, if a nursing student or newly graduated Registered Nurse practices according to this perspective, he runs the risk of being perceived as arrogant or not being a team player because he is not drawing on the expertise of his more experienced colleagues. This interpretation of his actions may be perplexing to the man involved, who may be

feeling quite insecure, but feels that he must display outward confidence, demonstrate his ability to perform nursing tasks independently, and be accountable for completing all aspects of his client's care in order to be considered successful. Clearly the performance of essentialized masculinity is problematic in this case because the new nurse is not asking for help when unsure of himself, and this situation may contribute to patient safety concerns related to his practice (Gregory, Guse, Davidson-Dick, Davis, & Russell, 2009). Unfortunately, the root cause of this issue could potentially be misinterpreted if an individual evaluates the man's nursing practice without an awareness of the influence of gender performances; therefore, it is possible that the wrong intervention will be implemented to correct the behavior. By taking the time to consider the influence of gender performance, a more accurate assessment of the situation can be made.

**Taking steps to avoid the perpetuation of stereotypes based on gender essentialism in policy and practice.** Both nursing education and practice settings should examine their policies and common practices to determine if they perpetuate essentialized stereotypes about men in nursing. For example, it should not be standard practice to require chaperones for men in nursing or ask clients if they are willing to have a man fulfill the role of their nurse. Such practices reinforce the perspective that men are questionable caregivers, and can plant the seed of doubt in a client's mind about the professionalism or capability of men in the role of caregiver. The participants in the current study all supported a client's right to refuse to have a man nurse care for them if the client found it uncomfortable. However, the participants also expressed frustration about the intervention of women colleagues who made assumptions that a woman would

be uncomfortable receiving care from a man, and who policed their access to women clients. It should also be noted that this issue is not without complexity because study participants also stated that they would still like the option to trade off tasks or clients with women colleagues, or ask for a chaperone if they felt at risk of being subjected to false allegations of sexual misconduct.

### **Discussion Summary and Conclusions**

The study findings contribute to the body of research that is exploring the complex relationship between the performances of gender and caring in the nursing context. The twenty-one individual interview and three focus group transcripts that underwent thematic analysis represented a demographically diverse and relatively representative group of Canadian men in nursing which suggests that the findings likely have the potential of a fair degree of transferability to the wider context of all Canadian men in nursing. Participants had a mean age of 43.3 years ( $\sigma=7.37$ ), which was comparable to the mean age of nurses in 2007 (Canadian Nurses Association, 2009a), and were experienced nurses with a mean of 16.9 years of practice ( $\sigma=8.37$ ). The educational preparation of participants was largely comparable to the larger Canadian nursing population except for a disproportionately high representation of participants with graduate degrees. Participants were drawn from a wide variety of practice settings with the three most common settings being education (19%), critical care (14.9%) and emergency room/trauma. Additional participants demographic characteristics included: 47.6% married and 42.9% single; 23.9% self-reported as gay and 71.4% self-reported as heterosexual; and 71.4% of participants stated they would choose nursing as a career

again suggesting they were relatively satisfied in the role of Registered Nurse. In addition, participants were drawn equally from three Canadian sites: Halifax, Winnipeg, and Vancouver.

The resultant thematic map that sought to describe the contextual performance of masculinity and caring (See Figure 5.1 on p. 165) answered the research question “*How is men nurses’ caring conceptualized and expressed in their discourse?*” by identifying the influence of various internal-individual and external contextual factors on the performance of masculinity and caring as described in the discourse of the study participants.

The *contextual performance of masculinity and caring* was identified as the core “overarching” theme in the thematic structure. Although the *contextual performance of masculinity and caring* has not previously been described utilizing this specific terminology, the key elements of this theme were discussed in the work of several authors previously, providing support for its selection as the core theme. Harding (2005) discussed the idea of “caring as contextual”. Fisher (2009) linked men nurse’s performance of gender to their ability to engage in intimate care (“bodywork”). Several nursing researchers have also noted how contextual characteristics such as client age, gender, identified health problem, and the type of nursing procedure to be carried out influence men nurses approach to caregiving (Evans, 2002; Fisher, 2009; Harding, 2005; Inoue, et al., 2006; Keogh & Gleeson, 2006). The socially constructed, contextual and constantly revised nature of the performance of masculinity is also well documented in the masculinities literature, which suggests that it should not be surprising that the

caregiving context would influence the performance of masculinity by men in nursing (Coltrane, 1994; Connell, 1995, 2000; Connell & Messerschmidt, 2005; Tillman, 2008).

The three performance sub-themes *cautious caregiving*, *caregiving as strength*, and *technical-instrumental caregiving* have all been noted to some degree in the literature previously. *Cautious caregiving* was described as a theme in the nursing practice of men by Evans (2002), and there is substantial support in the literature for the cautious approach to caregiving enacted by men in nursing in order to promote client comfort and prevent false accusations of sexual misconduct (Anthony, 2004; Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006; Keogh & O'Lynn, 2007; O'Lynn, 2004, 2007a, 2007b; Paterson, et al., 1995; Paterson, et al., 1996; Pullen, et al., 2009; Tillman, 2008).

The sub-theme *Caregiving as Strength* was also significantly supported within the men in nursing literature. Several authors have addressed the tendency for men nurses' generally greater size and capacity for physical labor to be emphasized in their practice (Anthony, 2004; Evans, 2001, 2004a; Harding, 2005; Hart, 2005; Kelly, et al., 1996). Participants found they were often expected to fulfill the roles of lifter, enforcer, and protector in the course of their nursing care, which was also supported by the findings of Evans' (2004a) and Harding's (2005) studies. In addition, the literature provided evidence to show that men have often been funneled towards specialties such as mental health because of the expectation that they could use their generally larger physical size and strength in the role of protector or enforcer (Brown, et al., 2000; Evans, 2004a). Men nurses often view this emphasis on physical strength with ambivalence, because this

perspective is consistent with a performance of essentialized masculinity; however, *caregiving as strength* also has the potential to undermine the man's credibility with respect to the feminized role of caregiver (Evans, 2001, 2004a; Harding, 2005).

The third sub-theme, *technical-instrumental caregiving*, which identified men's tendency to focus on the instrumental aspects of nursing care and affinity for technology, was also noted in the nursing literature previously. Ingle (1988) identified the overriding theme of "the business of caring" in her qualitative study, suggesting that her men nursing participants viewed the nurse-patient relationship as a business contract. Participants in Inoue et al.'s (2006) and Milligan's (2001) studies discussed the suppression of feelings or emotions by men nurses, and a tendency to focus on instrumental tasks. In addition, participants in Paterson et al.'s (1996) and Evans' (2001) studies differentiated men's approach to caregiving by comparing it to the "touchy-feely" or "warm and fuzzy" approach of women. However, despite men nurses' emphasis on the instrumental, it has also been noted in the literature that they still demonstrate empathy, and other traditional caring behaviors such as compassion, acceptance, consideration, and kindness (Harding, 2005; Ingle, 1988).

The eight performance elements, which were identified during the thematic analysis, represented strategies that the study participants used to enact the performance sub-themes, and each of these performance elements was supported by the work of previous authors.

*Cautious touch* was very well documented within the literature and served as a means to increase client comfort while also decreasing men's sense of vulnerability to

accusations of impropriety in the course of caregiving (Anthony, 2004; Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006; O'Lynn, 2007b; Paterson, et al., 1996; Pullen, et al., 2009; Tillman, 2008).

*Trading off nursing tasks* also served as a strategy to enact cautious caregiving, and is well established in the literature as a means to promote client comfort and decrease men nurses' sense of vulnerability in the provision of intimate care (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006). Although a common strategy, it should be noted that trading off tasks may impact men's competence in certain nursing skills, evoke resentment from women colleagues, and decrease the functional autonomy of men nurses.

The *use of women as chaperones* was also a commonly noted strategy in the men in nursing literature; however, men nurses frequently expressed frustration if this practice was mandated in policy, since it implied that men are inappropriate caregivers or pose a sexual threat to their client (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006; Pullen, et al., 2009).

The performance element of *identifying marital status* has been described by Evans (2002) and Fisher (2009), and implies heterosexuality. This implication of heterosexuality through marriage is both a performance of essentialized masculinity and a strategy to be considered an acceptable caregiver by homophobic men or those individuals that conflate homosexuality with pedophilia.

The use of *humor as a tool to establish a therapeutic connection* with clients has been noted by several authors (Evans, 2001, 2002; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006), and this performance element served different purposes depending on the intended audience. Use of humor with women clients served as a means to decrease both parties anxiety and increase the woman's comfort with a man caregiver, while use of humor with men sought to demonstrate an acceptable performance of masculinity through bawdy jokes, verbal sparring, or teasing for the purposes of establishing the man as an acceptable caregiver.

*Displaying acceptable essentialist masculine cues and behaviors* had a potential role to play in the enactment of the performance sub-themes of *cautious caregiving* and *caregiving as strength*, by establishing an acceptable performance of masculinity through dress, appearance, and affect. This strategy was also discussed by Fisher's (2009) informants who ensured they were identified as heterosexual by performing masculinity in accordance with culturally dominant masculinity by presenting a "macho" exterior and talking about "blokey" things like cars and sports (p. 2672).

*Choice of practice setting* by men in nursing is presented as a performance element that could contribute to the performance of all three sub-themes. *Choice of practice setting* may contribute to *cautious caregiving* because choosing to practice in low-touch settings may reduce the challenges associated with the provision of intimate care (Evans, 2002), and practicing in areas such as intensive care may be considered safer by some men because they are always in the view of nursing colleagues (Harding, et al., 2008). *Caregiving as strength* may be manifested through the choice of a practice setting



which values men's physical contribution such as mental health or the emergency room (Brown, et al., 2000; Evans, 2004a, 2004b). The choice of a high-technology setting such as critical care may also contribute to the performance of *technical-instrumental caregiving*. Although the choice of high status practice settings by some men in nursing may also represent the possible manifestation of men's relative advantage within the context of a patriarchal society (Evans, 1997a; Williams, 2003) or the desire to create "islands of masculinity" (Egeland & Brown, 1989), it is suggested that the motivations behind choice of practice setting are likely more complex and multifactoral than these reasons alone.

Participants frequently *displayed an affinity for technology* in their discourse and this performance element certainly contributed to the performance of technical-instrumental caregiving and often resulted in men choosing practice settings that were associated with high technology, such as critical care (Evans, 2002; Harding, 2005).

In considering the contextual sub-themes and elements that influenced the performance of masculinity and caring, it was acknowledged that separating the discussion of external and internal-individual context would be inappropriate since each informs the other. The external context provides the societal and professional backdrop that informs the individual's values and beliefs, and each individual's perspective contributes to the formation of collective societal and professional beliefs and norms.

*Societal norms influenced by gender essentialism* such as the *stereotype of the woman nurse* (Anthony, 2004; Bartfay, 2007; Brady & Sherrod, 2003; Ekstrom, 1999; Evans, 2001, 2004b; Fisher, 2009; Grady, 2006; Harding, 2005; Hart, 2005; Holyoake,

2002; Ingle, 1988; Inoue, et al., 2006; Jinks & Bradley, 2004; Kelly, et al., 1996; Keogh & Gleeson, 2006; Meadus, 2000; Meadus & Twomey, 2007; O'Lynn, 2004, 2007b; Okrainec, 1994; Paterson, et al., 1996; Tillman, 2008; Villeneuve, 1994), the *suspicion of homosexuality* among men in nursing (Bartfay, 2007; Evans, 2001, 2002; Fisher, 2009; Harding, 2005, 2007; Harding, et al., 2008; Hart, 2005; Holyoake, 2002; Kelly, et al., 1996; Meadus, 2000; Meadus & Twomey, 2007; Tillman, 2008; Whittock & Leonard, 2003), and the questioning of *men nurses' credibility as a caregiver* (Ekstrom, 1999; Jinks & Bradley, 2004; Okrainec, 1994; Poole & Isaacs, 1997) were all very well documented in the literature.

The socialization of young men in society is profoundly influenced by gender essentialism (Coltrane, 1994; Connell, 1995, 2000), and positions caring behaviors and touch outside the performance of masculinity. Three previous studies have identified cases where the socialization of young men has contributed to challenges in the performance of nursing care (Evans, 2002; Milligan, 2001; Paterson, et al., 1996). When men enter nursing they continue their socialization to the professional nursing role, which the participants associated with femininities or women's ways of knowing. Similarly a participant in Brady and Sherrod's (2003) study felt that men had to learn to think like a woman to be successful in nursing. Junior nursing students in Paterson et al.'s (1996) study felt that women nursing faculty established an expectation that they should care for patients like they did. It was also noted in the discussion of findings that, in addition to general professional socialization, variations likely exist between different communities of nursing practice, and the norms established by some communities of practice may be

easier for men nurses to accommodate than others. Paterson et al. (1996) and Harding (2005) both provide some support for the influence that a man's personal and professional experience and maturity might have on their beliefs, values and ultimately on their performance of masculinity and caring; however, there is limited discussion of the influence of maturity and experience on men's nursing practice in the literature. Interestingly, despite the fact that the participants were experienced men in nursing, who had been socialized to the feminized workplace of nursing, they demonstrated an affiliation to essentialized perspectives on masculinity (Forrester, 1988), when their reified values were coded during the analysis. Likewise, Boughn (2001), Abrahamsen (2004), and Harding (2005) also provide some evidence in their studies that men in nursing are influenced by norms established in the context of essentialized masculinities, such as the desire to gain and exercise power, taking on leadership positions, career advancement, and fulfilling the "breadwinner" role. These findings provide evidence of the potentially profound influence that men's socialization to essentialized masculinities may ultimately have on their performance of caring, even when these men are socialized to professional norms influenced by femininities.

When considering the *micro-contextual factors* associated with a given nurse-client interaction, which may influence the ultimate performance of masculinity and caring by men in nursing, three key influencing factors were identified including: the *gender of the client audience*, the *age of the client audience*, and *other individual audience factors-feedback*. Consistent with the findings of the current study, Inoue et al.'s (2006) participants identified that caring for women was challenging, and several

researchers supported the finding that caring for men and women of all ages presented challenges because of the sexualization of men's touch (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008). In general, participants of the current study found the care of younger clients more challenging and this finding was consistent with the findings of several researchers that have looked at the caring relationship between men nurses and both young women and men clients (Evans, 2001, 2002; Fisher, 2009; Harding, 2005; Harding, et al., 2008; Inoue, et al., 2006; Keogh & Gleeson, 2006). Participants had inconsistent opinions on whether older men or women would be comfortable receiving nursing care from a man; however, there was a perception that caring for older clients entailed less risk, which may be related to society's tendency to desexualize people as they become older. Care of children of both genders was noted to be a challenge by participants and similar findings have been documented by Evans (2001, 2002) and Harding (2005). The challenges associated with caring for children are likely rooted in society's increased awareness of child sexual abuse, the questioning of men's credibility as a caregiver, the sexualization of men's touch, the stereotype of the homosexual man nurse, and the conflation of homosexuality with pedophilia (Evans, 2001, 2002). In addition, it was noted that other individual audience factors may also influence the performance of masculinity and caring in a given caring interaction, such as the perspective of a woman client's partner, and this was supported by the findings of Morin et al. (1999).

The presented thematic model was compared with existing models of caring in nursing to determine if the performance of masculinity and caring was consistent with

common perspectives on caring within the nursing profession (Benner & Wrubel, 1989; Brilowski & Wendler, 2005; Finfgeld-Connett, 2008; Morse, et al., 1991; Morse, et al., 1990). When the findings were compared to Morse et al.'s (1990) content analysis of 35 author's definitions of caring and the main characteristics of their perspectives, it was interesting to note how congruent the contextual performance of masculinity and caring was with the five perspectives on the nature of caring identified by these authors.

Findings supported the perspectives of "caring as a human trait" and "caring as a moral imperative" since the inherent nature of men as caring beings, who have a desire to provide excellent nursing care, was not in question and was documented in the literature (Boughn, 2001; Ekstrom, 1999; Ingle, 1988). In considering the perspective of "caring as affect" the presence of empathy, compassion, kindness, and emotional investment in their patients was clearly present in men nurses (Boughn, 2001; Ingle, 1988). However, men's outward expression of caring may be quite different to that of their women colleagues because of their socialization to essentialized masculinities, perspectives that suggest men should control the expression of emotion, societal perspectives that position men as unlikely caregivers, and the sexualization of men's touch. This disparity may therefore place men at risk for misinterpretation of the affective component of their nursing care. The contextual performance of masculinity and caring substantially supports the fourth perspective of "caring as an interpersonal relationship" since the adjustment of the performance of masculinity in response to different caring contexts contributes to the establishment of an effective therapeutic relationship with the client. Through this process, a nurse is able to establish a trusting interpersonal relationship with his client

that lays the foundation for more effective application of nursing interventions in partnership with the client. Likewise, the contextual performance of masculinity and caring is incorporated into the performance of all nursing interventions, thereby supporting Morse et al.'s fifth perspective of "caring as therapeutic intervention". Following this comparison, it was clear that the fundamental nature of men nurses' caring is consistent with perspectives on caring held by the nursing profession as a whole; however, what may contribute to the feeling that men's caring is different is the fact that the outward performance of caring is certainly shaped by the influence of essentialized masculinities and may look different to an observer.

Throughout the study, masculinity theory (Coltrane, 1994; Connell, 1995, 2000; Connell & Messerschmidt, 2005) proved to be an ideal theoretical framework to guide the interpretation and discussion of men nurses' caring. Not only was the performance of masculinity the central difference between men's and women's performance of nursing caring, but examining the socially constructed and ever changing performance of gender also provided insights into the socially constructed and potentially unique performances of caring that may exist in a nursing context. In addition, masculinity theory provided a means to consider the political nature of gender performance within our patriarchal society, and reflect on how the hegemonic oppression of women and subordinate masculinities plays a part in the value ascribed to different performances of masculinity and caring.

The current study has illuminated the need for additional research in a number of areas. First, there is a need to apply methods such as focused ethnography to explore the

approaches to caring that experienced men in nursing are applying in their nursing practice, to determine if these approaches can be shared to ease novice men's transition into role of nurse. Second, discourse analysis may provide the means to document effective communication strategies utilized by experienced men nurses in negotiating a trusting therapeutic relationship with their clients. Perhaps the findings of such studies can be used to provide new men in nursing with some potentially effective approaches to establishing trusting relationships with their future clients. Third, research should also be undertaken to explore the performance of masculinity and caring by men in nursing, who are also visible minorities. Given the challenges that men have faced in terms of establishing themselves in the role of nursing caregiver, it would be interesting to explore the influence that the additional factor of being a visible minority would have on the man's ability to establish himself in this role. Fourth, there is a need to further explore the interaction between men nurses and men clients, because there has been little significant research completed in this area. Finally, there is anecdotal evidence to suggest that the attrition of men from nursing education and practice is disproportionately high when compared with attrition of women; therefore, the exploration of the reasons for this attrition holds promise in increasing the numbers of men participating in nursing. For example, are the challenges associated with the performance of masculinity and caring contributing to dissonance among novice practitioners and leading to attrition?

Finally, there are several recommendations for education and practice that can be considered based on the findings of the current study. First, there is a need for nursing education programs to incorporate content into their curricula that addresses the influence

of gender on the nursing practice of men and women. Second, nursing should consider the establishment of support programs to assist the retention of men in nursing. Third, there is a need for professional development with nursing educators and administrators to raise awareness about the influence that gender performance has on nursing practice. Finally, nursing institutions should take steps to avoid the perpetuation of stereotypes based on gender essentialism in policy and practice.



## **Postscript**

### **Reflection and Reflexivity**

When I embarked on this study, I was very grateful for the opportunity to explore men nurse's caring due to my own experience as a man in nursing, and from the perspective of a nurse educator who has witnessed men's transition to the Registered Nurse role for the past seven years. At the time, I had no idea how much my perspective on gender and its influence on caregiving would change, or the effect this research study would have on my understanding of my own experience as a man in nursing.

I entered Memorial University of Newfoundland's Baccalaureate of Nursing program in 1991 and experienced many challenges during my transition to the role of caregiver and nurse. At this time, there were very few men nurses in Newfoundland and I experienced regular refusal of my care by women clients. Like many men in nursing, my greatest challenge during my nursing education was my rotation in obstetrics, and I recall vividly the sense of discomfort I felt in that setting. Despite doing very well in the theoretical component of this rotation and being very interested in obstetrics, I found the clinical portion of this rotation to be the most difficult of my education. During my clinical evaluation, my clinical instructor remarked on how awkward my interactions were with the mothers and babies. I tried to explain to her that I had never had the opportunity to hold or look after a baby previously, and that I feared being rejected as a caregiver by the women, but she did not seem to understand my perspective. In her mind, it should not matter that I was a man, and I should get over this discomfort. In addition, I did not feel welcome in the obstetrical setting because the women nurses acted

like I did not belong there and I was only allowed to participate in the care of expectant or new mothers when they agreed to have a man nursing student. I primarily got to see cesarean section births during my time in the labor and delivery unit because all but one woman refused to have me present during a vaginal delivery. The woman that agreed to have me care for her during labor was having her sixth child and did not seem to mind the fact I was a man; however, the women nurses still sent me on errands to get something every time they assessed cervical dilation or exposed the woman in any way. In the post-partum setting, it was also difficult for me to ask women if I could check their episiotomy sutures or their perineal pads to assess their post-partum bleeding, let alone assist a woman with breastfeeding. I was always concerned that my motivation for providing intimate care would be questioned, that the woman would be uncomfortable, or that the client would refuse me as a caregiver. Although obstetrics was by far the most difficult setting for me in my education, I did experience similar challenges in all practice settings. Another pattern which began during my nursing education was the use of me as “muscle” to lift heavy clients or deal with violent or unruly clients, and like most men nurses I have had to deal with this expectation throughout my career.

Following graduation with a Bachelor of Nursing degree in 1995 I initially worked in medical/surgical settings in Newfoundland and Texas, and later in an outpost setting in northern Manitoba, community health, primary health care, emergency room, program management, and most recently nursing education. One notable occurrence related to my gender happened to me when I responded to a “code white” (requesting men to respond to a violent client situation) in Texas. I ran onto the medical unit to find a

group of women nurses outside a client's room, at which point I was unceremoniously pushed into the room by the nursing supervisor without telling me what I would find. Once inside the room, I discovered a confused elderly rancher who was waving a knife in my direction as he leaned over the bed of another client. I have always been a non-violent and gentle person, and to this day I do not understand why these female colleagues felt that my gender prepared me to deal with that situation. It was only my experience in psychiatry that helped me talk to this confused client until the police arrived.

Over the years, the challenges associated with my gender have become less acute for numerous reasons. Probably the first thing that helped me become more accepted was getting married following graduation, and I was amazed how much of a difference a wedding ring made for my acceptability as a caregiver. I also became more experienced and adept at navigating the challenges of intimate care, and gained a lot of experience and confidence in my abilities as a nurse along the way. In addition, I have also migrated to nursing practice settings that do not involve as much intimate nursing care or challenges related to my gender. Over the 15 years of my practice, I believe there has also been greater acceptance of men in nursing by society, although this has not really translated into many more men in the profession.

For the last seven years, I have been a nursing educator in Manitoba and Alberta, Canada. The men students always stand out because there are not many of them, and because I have always wanted to assist them to be successful. It has been my experience that we lose many of these men during their nursing education (at least half), and I have

also noticed a tendency for these men to encounter more difficulties and experience clinical failure at a higher rate.

It is with this history, that I began my research into men nurses' caring, and my past experiences certainly influenced my initial understanding of men nurses' collective experience. When I first started the literature review on men in nursing, I found myself buying into the perspective that presented men in nursing as the victims of discrimination in the profession. Over time, I began to gain a more sophisticated understanding of the men in nursing literature as I read the perspectives of many different authors, including those that felt men experienced advantage in the profession due to patriarchal forces in society. I now have a much more balanced view on the experience of men in nursing, and recognize that although men certainly have experienced, and continue to experience, significant challenges in the role of nurse, the reasons for these challenges are multifactorial and are influenced by both men and women in nursing and society's essentialized perspectives on gender.

During the early stages of the research, I also had a fairly unsophisticated conceptualization of gender. I did recognize that there was not one form of masculinity or femininity and acknowledged the potential for multiple masculinities or femininities, but early on I understood this as each person having a different performance of gender. The turning point in my understanding of gender, and ultimately my data analysis, was the time I spent reading masculinity theory, and in particular the work of Connell. When I reflected on the masculinities literature, I started to gain a greater appreciation of the complexity of the socially constructed concept of gender, and the associated political and

power implications of gender performance. As I considered the ongoing process of gender construction and reconstruction that occurred for each individual in response to socio-political and contextual forces, I also started to realize that the performance of masculinity might change from minute to minute based on the context of the performance. If this was happening for masculinity, then I wondered if it was also occurring for the concurrent socially constructed performance of caring? This was the key epiphany that informed my ongoing data analysis and the construction of the thematic map that articulated the contextual performance of masculinity and caring.

Another key realization was that although gender research and theorists have soundly disproved gender essentialism and sex role theory as a means of understanding the complex concept of gender, the majority of individuals persist in conceptualizing gender this simplistic way. If essentialized ideas of what it means to be a man or a woman remain so pervasive, logic would suggest that these beliefs likely inform men nurses' performance of masculinity, and their client's interpretation of their performances of masculinity. This was further affirmed when the reified values expressed by the study participants proved to be so consistent with essentialized perspectives on masculinity, and when participants identified situations where men nurses were rejected because they did not deliver an acceptable performance of masculinity.

The description of the contextual performance of masculinity and caring has consequently enabled me to gain insight into my own experience as a man in nursing, and provides a framework for considering some possible strategies for navigating the gender related influences on the establishment of an effective nurse-client relationship. In

addition, exploring the influence of gender on men nurses caring has also opened the door for the consideration of how gender performance can affect other aspects of men nurses' work lives such as the relationship with women colleagues, the difficulty recruiting men into nursing, and the high attrition rates of men in nursing education programs. Over the past year, I have also had the opportunity to apply the insights I have gained through this research study to my practice as a nurse educator, and have found the thematic map of the contextual performance of masculinity and caring to be a useful framework to assist men nursing students to navigate some of the challenges they have encountered. When discussing these ideas with men nurses, I have also asked them to recognize that although essentialized perspectives on gender help to explain the difficulties that men face in nursing practice, these insights should not be used as an excuse for inappropriate interactions with clients or colleagues. It is also important for men in nursing to consider how their propagation of certain essentialized masculinities is detrimental to their acceptance in the role of caregiver, and how the perpetuation of hegemonic masculinities is harmful to both men and women in society.

Although the focus of the current study has been men nurses, the study findings have also illuminated the potential influence that the performance of essentialized femininities can have on women nurses, and the profession of nursing as a whole. Women are also undoubtedly experiencing challenges related to their performance of gender in health care environments, and would likely also benefit from reflecting on how essentialized femininities are affecting how their interactions with clients and coworkers are interpreted. Nursing must address the influence of gender in its education and

practice environments. Initiating discussions about gender performance and its influence on social interaction within nursing education and practice environments holds promise as an initial step to mitigate the effects of gender essentialism on nursing. Ultimately, the task of addressing gender essentialism in society is an almost insurmountable task, and only time and wider social forces will gradually cause a shift in the perspectives of the general public. However, there are still viable opportunities for intervention at the professional level, which may contribute to improved interactions between men and women in the profession, and provide nurses with some strategies to overcome the challenges of interacting with other individuals that still operate from the perspective of gender essentialism.

The time has come for nursing to move beyond a dialogue where nurses are presented as a homogenous group, if the profession is to make any meaningful progress in terms of increasing diversity in the profession (e.g., gender diversity). Inviting diversity without accommodating diverse perspectives in the discourse and practice of nursing ultimately dooms these efforts to failure. Nursing practices are social constructions not essentialized truths, so individuals that have different perspectives and experiences from the dominant group will be disadvantaged by a “one-size fits all” approach to nursing practice that treats everyone equally. The nursing profession needs to be willing to question the foundation of many of their beliefs and practices, recognize the influence of essentialized gender perspectives on the nursing profession, and adopt a policy of equity in both nursing education and practice environments. It is only by

recognizing the unique experience of all nurses that we will ultimately create an environment where everyone feels welcome in the profession.



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## Appendix A



Dalhousie University

OFFICE OF RESEARCH ETHICS  
ADMINISTRATION

Office of Research Services  
321 Henry Hicks Academic Administration Building  
Halifax, Nova Scotia  
Canada B3H 4H6  
Tel: (902) 494-6513  
Fax: (902) 494-1595

### Social Sciences and Humanities Human Research Ethics Board Letter of Approval -PROJECT AMENDMENT

Date: November 25,2003.

To: Joan Evans , School of Nursing

The Social Sciences and Humanities Human Research Ethics Board has examined the amendment dated November 19,2003 submitted for ethics review with respect to:

**Project #: 2003-659**

**Title :** Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female-Dominated Professions of Nursing and Elementary School Teaching

**Submitted by:** Joan Evans , School of Nursing

and found the proposed changes to the recruitment strategy to be in accordance with Dalhousie Guidelines and the Tricouncil Policy Statement on *Ethical Conduct in Research Using Human Subjects*.

Dalhousie Guidelines require that, on the anniversary of the effective date you must submit an annual report for this research project. Also, should there be any additional changes to either the research methodology, or the consent form used during the approval period, these changes must be submitted for ethics review. You must also notify the Office of Research Ethics Administration when the project is completed or terminated.

This letter is the official record of ethics approval by the Dalhousie Social Sciences and Humanities Human Research Ethics Board. You may use this letter to notify funding agencies that your project has undergone a through review and has been granted ethics approval.

Effective Date: November 21,2003.

signed: \_\_\_\_\_

James Leary (Chair SSHREB)

Copy sent to:  Graduate Studies   
Project funding ( if any)Agency - SSHRC

Research Services  
Awarded



**Social Sciences and Humanities  
Human Research Ethics Board  
ANNUAL RENEWAL Letter of Approval**

Date: May 17,2006.

To: Joan Evans, School of Nursing

The Dalhousie Social Sciences and Humanities Human Research Ethics Board has examined the annual report dated April 28,2006 for:

**Project # 2003-659**

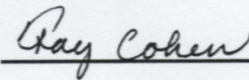
**Title:** Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female-Dominated Professions of Nursing and Elementary School Teaching

and found the proposed research involving human subjects to be in accordance with Dalhousie Guidelines and the Tricouncil Policy Statement on *Ethical Conduct in Research Using Human Subjects*. This approval will be effective until the expiring date indicated below.

1. Dalhousie Guidelines require that, prior to the anniversary of the expiry date of this approval you must submit your next annual report.
2. Should there be any significant changes to either the research methodology, or the consent form used during the approval period, these changes must be submitted for ethics review *prior to their implementation*.
3. You must also notify the Office of Research Ethics Administration when the project is completed or terminated, at which time a final report should be completed.

Expiry Date: May 16,2007.

signed:



Fay Cohen (Co-Chair SSHHREB)

Funding: SSHRC

Award No:

Copy sent to:  Research Services

## Appendix B

Interview

### RESEARCH CONSENT FORM for Interviews

**Study Title:**

Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female-Dominated Professions of Nursing and Elementary School Teaching.

**Principal Investigator:** Joan Evans, PhD, RN  
Assistant Professor  
School of Nursing  
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**Co-Investigators:** Blye Frank, PhD  
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David Gregory, PhD, RN  
Professor and Dean, School of Nursing  
University of Manitoba  
89 Curry Place  
Winnipeg, Manitoba  
Phone: (204) 474-9201  
Email: [david\\_gregory@umanitoba.ca](mailto:david_gregory@umanitoba.ca)

**Collaborators:** Kevin Davison, PhDc and Trudy Lovell, PhDc  
Address c/o Joan Evans as above

**Introduction:**

You are invited to take part in a research study at Dalhousie University. Taking part in this study is voluntary and you may withdraw from the study at any time. Your employment will not be affected by whether you participate or not. The study is described below. This description tells you about the risks, inconvenience, or discomforts which you might experience. Participating in the study might not benefit you, but things learned might benefit others. You should discuss any questions you have about this study with the researcher who explains it to you.

**Purpose of the Study:**

The purpose of this research is to explore the gendered experience of men in nursing and elementary school teaching. A particular focus of this research is the tensions and contradictions of men's lives in relation to job satisfaction, day to day work life, career choice, career mobility and the quality of relationships developed (with colleagues, patients, students). Issues related to advantages and disadvantages of being a man in nursing or elementary school teaching will be explored.

**Study Design:**

This study consists of 4 Phases:

Phase 1: Regional, provincial and national professional documents and statistical data regarding recruitment and employment patterns for nursing and elementary school teaching will be collected. A review of the literature will also be conducted.

Phase 2: In-depth one-on-one interviews with 10 men nurses and 10 men elementary school teachers will be conducted in 3 Canadian sites: Halifax, Winnipeg and Vancouver, for a total of 60 interviews. Data collected in interviews will be analyzed for emerging themes. These themes will then be explored in greater detail with participants in focus group discussions that will allow for cross-talk within and between each professional group. 3 focus groups of 8-10 participants will be conducted in each site: one with men nurses only; one with men elementary school teachers only; and, one with both men nurses and men elementary school teachers together, for a total of 9 focus groups. Those men who participate in the initial interviews will be invited to participate in focus groups. New participants will be recruited to obtain the minimum number of participants in each focus group.

Phase 3: Writing the Research Report

Phase 4: Dissemination of knowledge generated through publications, conferences, workshops and in-service sessions.

**Who Can Participate in This Study:**

You may participate in this study if you are a man who is a practicing registered nurse or elementary school teacher teaching in grades primary or kindergarten to grade 6 inclusive. A minimum of 2 years experience in nursing or elementary school teaching is required.

**Who Will Be Conducting the Research and Focus Group:**

The principal researcher is Joan Evans. She is a nurse educator at Dalhousie University, whose area of research is masculinities and men in nursing. Blye Frank is a co-investigator and professor in the Division of Medical Education in the Faculty of Medicine at Dalhousie

University. His area of research is masculinities. David Gregory is a nurse educator at the University of Manitoba whose research interests include gender and men in nursing. Kevin Davison is a doctoral candidate at the University of South Australia who has researched and published in the area of masculinities. Trudy Lovell, also a doctoral candidate at the University of South Australia, has extensive experience as an elementary school teacher and has participated in writing sexual harassment policy. One doctoral student and two masters students also comprise the research team. Interviews will be conducted by a member of the research team. Any questions about the research or interviews can be directed to Joan Evans, or a member of the research team.

**What You Will Be Asked To Do:**

You will be asked to meet once for approximately 1 to 1 ½ hours at a time and place that is convenient to you. There is no preparation required for an interview. Your contribution is your own experience as a man in nursing or elementary school teaching.

**Possible Risks and Discomforts:**

Some participants may feel discomfort related to disclosing aspects of their experience as men nurses or men elementary school teachers. At the end of the interview, the researcher can provide you with names and contact information for counseling/support services in your area.

**Possible Benefits:**

Your participation in this research may benefit nursing and elementary school teaching, and men nurses and men elementary school teachers in particular, by contributing to the knowledge of gender issues in these professions. There may also be direct personal benefits associated with having the opportunity to discuss occupational issues with other interested men in nursing and elementary school teaching. No benefits can be guaranteed.

**Compensation:**

There is no compensation involved in your participation in this study.

**Confidentiality:**

Your identity will be protected at all times. An ID number will be assigned to protect your identity. You will not be identified in any publication and presentations of the study findings. In the research report, no information will be provided that could be used to identify you, your employer, colleagues, family, or place of work. Identifying demographic features will not be described, or will be disguised to provide confidentiality. A list of the names and contact information for all participants will be stored in a secure locked location known only to the research team. This list will be destroyed at the end of the research project. All other materials collected during the study (documents, audiotapes) will be kept in locked storage, and accessible only by the research team during the study. These materials will be destroyed five years after publication of research results.

**New Information:**

You will be provided with any new information that may affect your decision to participate, or continue ongoing participation, in the study.

**Questions or Concerns:**

For more information about this research and your contribution, please call Joan Evans at (902) 494-2391 or email [joan.evans@dal.ca](mailto:joan.evans@dal.ca). In the event that you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, you may contact the Human Research Ethics/Integrity Coordinator at Dalhousie University's Office of Human Research Ethics and Integrity for assistance. The coordinator can be reached at (902) 494-1462 or by email at [patricia.lindley@dal.ca](mailto:patricia.lindley@dal.ca).

**Summary and Follow-up:**

You will receive a copy of this consent form for your records.

**Termination:**

This study might be terminated at any time for unforeseen reasons. There are no reasons anticipated for any participant being asked to withdraw from this research.

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction.

I hereby consent to take part in this study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

_____	_____	
Participant (print name)	Participant (signature)	Date

_____	_____	
Researcher (print name)	Researcher (signature)	Date

I hereby give consent to use direct quotes in any published works, with the understanding that no identifying information will be included, and that my identity will be protected.

_____	_____	
Participant (print name)	Participant (signature)	Date

_____	_____	
Researcher (print name)	Researcher (signature)	Date

## Appendix C

Focus Group

### RESEARCH CONSENT FORM for Focus Groups

**Study Title:**

Contradictions and Tensions in the Lives of Men: Exploring Masculinities in the Numerically Female-Dominated Professions of Nursing and Elementary School Teaching.

**Principal Investigator:** Joan Evans, PhD, RN  
Assistant Professor  
School of Nursing  
Dalhousie University  
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Email: [blye.frank@dal.ca](mailto:blye.frank@dal.ca)

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Professor and Dean, School of Nursing  
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89 Curry Place  
Winnipeg, Manitoba  
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Email: [david\\_gregory@umanitoba.ca](mailto:david_gregory@umanitoba.ca)

**Collaborators:** Kevin Davison, PhDc and Trudy Lovell, PhDc  
Address c/o Joan Evans as above

**Introduction:**

You are invited to take part in a research study at Dalhousie University. Taking part in this study is voluntary and you may withdraw from the study at any time. Your employment will not be affected by whether you participate or not. The study is described below. This description tells you about the risks, inconvenience, or discomforts which you might experience. Participating in the study might not benefit you, but things learned might benefit others. You should discuss any questions you have about this study with the researcher who explains it to you.

**Purpose of the Study:**

The purpose of this research is to explore the gendered experience of men in nursing and elementary school teaching. A particular focus of this research is the tensions and contradictions of men's lives in relation to job satisfaction, day to day work life, career choice, career mobility and the quality of relationships developed (with colleagues, patients, students). Issues related to advantages and disadvantages of being a man in nursing or elementary school teaching will be explored.

**Study Design:**

This study consists of 4 Phases:

Phase 1: Regional, provincial and national professional documents and statistical data regarding recruitment and employment patterns for nursing and elementary school teaching will be collected. A review of the literature will also be conducted.

Phase 2: In-depth one-on-one interviews with 10 men nurses and 10 men elementary school teachers will be conducted in 3 Canadian sites: Halifax, Winnipeg and Vancouver, for a total of 60 interviews. Data collected in interviews will be analyzed for emerging themes. These themes will then be explored in greater detail with participants in focus group discussions that will allow for cross-talk within and between each professional group. 3 focus groups of 8-10 participants will be conducted in each site: one with men nurses only; one with men elementary school teachers only; and, one with both men nurses and men elementary school teachers together, for a total of 9 focus groups. Those men who participate in the initial interviews will be invited to participate in focus groups. New participants will be recruited to obtain the minimum number of participants in each focus group.

Phase 3: Writing the Research Report

Phase 4: Dissemination of knowledge generated through publications, conferences, workshops and in-service sessions.

**Who Can Participate in This Study:**

You may participate in this study if you are a man who is a practicing registered nurse or elementary school teacher teaching in grades primary or kindergarten to grade 6 inclusive. A minimum of 2 years experience in nursing or elementary school teaching is required.

**Who Will Be Conducting the Research and Focus Group:**

The principal researcher is Joan Evans. She is a nurse educator at Dalhousie University whose area of research is masculinities and men in nursing. Blye Frank is a co-investigator and professor in the Division of Medical Education in the Faculty of Medicine at Dalhousie

University. His area of research is masculinities. David Gregory is a nurse educator at the University of Manitoba whose research interests include gender and men in nursing. Kevin Davison is a doctoral candidate at the University of South Australia who has researched and published in the area of masculinities. Trudy Lovell, also a doctoral candidate at the University of South Australia, has extensive experience as an elementary school teacher and has participated in writing sexual harassment policy. One doctoral student and two masters students also comprise the research team. Focus groups will be facilitated by one or more members of the research team. Any questions about the research or interviews can be directed to Joan Evans, or a member of the research team.

**What You Will Be Asked To Do:**

You will be asked to meet twice for approximately 1 ½ to 2 hours at a time and place that is convenient to the majority of participants. One focus group discussion will be with men in your own profession. A second focus groups will include men nurses and men elementary school teachers. There is no preparation required for a focus group. Your contribution is your own experience as a man in nursing or elementary school teaching. As a participant in a focus group you are asked to maintain the confidentiality and anonymity of all participants.

**Possible Risks and Discomforts:**

Some participants may feel discomfort related to disclosing aspects of their experience as men nurses or men elementary school teachers. At the end of the focus group the researcher can provide you with names and contact information for counseling/support services in your area.

**Possible Benefits:**

Your participation in this research may benefit nursing and elementary school teaching, and men nurses and men elementary school teachers in particular, by contributing to the knowledge of gender issues in these professions. There may also be direct personal benefits associated with having the opportunity to discuss occupational issues with other interested men in nursing and elementary school teaching. No benefits can be guaranteed.

**Compensation:**

There is no compensation involved in your participation in this study.

**Confidentiality:**

Your identity will be protected at all times. An ID number will be assigned to protect your identity. You will not be identified in any publication and presentations of the study findings. In the research report, no information will be provided that could be used to identify you, your employer, colleagues, family, or place of work. Identifying demographic features will not be described, or will be disguised to provide confidentiality. A list of the names and contact information for all participants will be stored in a secure locked location known only to the research team. This list will be destroyed at the end of the research project. All other materials collected during the study (documents, audiotapes) will be kept in locked storage, and accessible only by the research team during the study. These materials will be destroyed five years after publication of research results.



While all reasonable precautions are being taken to ensure your anonymity and the confidentiality of your statements, you should be aware that there are particular limits to confidentiality in focus group interviews. While each participant may agree to keep matters discussed by the group in confidence, there is always a risk that this agreement may not be honoured. For this reason, we suggest that you only talk about issues that you feel comfortable discussing in a group setting, or that you approach the facilitator about setting up a private interview about matters you feel cannot be shared with the group. You should also feel free to offer opinions and information on issues or subjects not raised by the facilitator that you think are relevant to this research. Individuals are free to withdraw comments at any time within one month following a focus group discussion. After this time, publications based on the research will be written and the withdrawal of comments will not be possible

**New Information:**

You will be provided with any new information that may affect your decision to participate, or continue ongoing participation, in the study.

**Questions or Concerns:**

For more information about this research and your contribution, please call Joan Evans at (902) 494-2391 or email [joan.evans@dal.ca](mailto:joan.evans@dal.ca). In the event that you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, you may contact the Human Research Ethics/Integrity Coordinator at Dalhousie University's Office of Human Research Ethics and Integrity for assistance. The coordinator can be reached at (902) 494-1462 or by email at [patricia.lindley@dal.ca](mailto:patricia.lindley@dal.ca).

**Summary and Follow-up:**

You will receive a copy of this consent form for your records.

**Termination:**

This study might be terminated at any time for unforeseen reasons. There are no reasons anticipated for any participant being asked to withdraw from this research.

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction.

I hereby consent to take part in this study. However, I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

\_\_\_\_\_  
Participant (print name)                      \_\_\_\_\_  
Participant (signature)                      Date

\_\_\_\_\_  
Researcher (print name)                      \_\_\_\_\_  
Researcher (signature)                      Date

I hereby give consent to use direct quotes in any published works, with the understanding that no identifying information will be included, and that my identity will be protected.

\_\_\_\_\_  
Participant (print name)                      \_\_\_\_\_  
Participant (signature)                      Date

\_\_\_\_\_  
Researcher (print name)                      \_\_\_\_\_  
Researcher (signature)                      Date

## Appendix D

### Memorial University's Human Investigation Committee (HIC) Letter of Ethical Approval



Faculty of Medicine

Human Investigation Committee

110B Bannockburn Ave. St. John's, NL A1B3X9

St. John's, NL A1B3X9

St. John's, NL A1B3X9

TEL: 709/722-0922 FAX: 709/722-8776

http://www.med.mun.ca/hic

September 26, 2008

#### **Reference #08.141**

Mr. P. Kellett  
C/o Dr. Robert Meadus  
School of Nursing,  
MUN

Dear Mr. Kellett:

RE: "Exploring masculine perspectives on caring within the numerically female dominated profession of nursing"

Your application was reviewed by a Sub-Committee of the Human Investigation Committee and **full approval** was granted.

This approval will lapse on **September 23, 2009**. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HIC office prior to the renewal date. *The information provided in this form must be **current to the time of submission** and submitted to the HIC **not less than 30 nor more than 45 days** of the anniversary of your approval date.* The Ethics Renewal form can be downloaded from the HIC website:

<http://www.med.mun.ca/hic/downloads/Annual%20Update%20Form.doc>

*The Human Investigation Committee advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:*

- *Your ethics approval will lapse*
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

*Lapse in ethics approval may result in interruption or termination of funding*

For a hospital-based study, it is **your responsibility to seek the necessary approval from Eastern Health and/or other hospital boards as appropriate.**

**Modifications of the protocol/consent are not permitted without prior approval from the Human Investigation Committee. Implementing changes in the protocol/consent without HIC approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HIC website) and submitted to the HIC for review.**

This research ethics board (the HIC) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Human Investigation Committee currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as per these guidelines.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,



Fern Brunger, PhD  
Co-Chair  
Human Investigation Committee

Richard S. Neuman, PhD  
Co-Chair  
Human Investigation Committee

JDH;RSN\jed

C Dr. C. Loomis, c/o Office of Research, MUN  
Mr. W. Miller, c/o Patient Research Centre, Eastern Health  
*For office use only: October 9, 2008*

## Appendix E

### University of Lethbridge's Human Subject Research Committee (HSRC) Letter of Ethical Approval

**Kellett, Peter**

---

**From:** McKeen, Margaret  
**Sent:** Thursday, November 20, 2008 2:08 PM  
**To:** Kellett, Peter  
**Subject:** Human Subject Research Approval

**Follow Up Flag:** Follow up  
**Flag Status:** Completed

Your human subject research protocol entitled, "Exploring Masculine Perspectives on Caring within the Numerically Female Dominated Profession of Nursing" has been approved on behalf of the Human Subject Research Committee, and has been assigned Protocol #813. In future, we ask that you use the current Application for Ethical Review of Human Subject Research which is available from our web site under Certification ([http://www.uleth.ca/rch/funding/online\\_forms.cfm](http://www.uleth.ca/rch/funding/online_forms.cfm)), and submit it as a stand-alone document (i.e. without cvs and manuscripts).

All the best with your research!

**Mrs. Margaret McKeen**

Research Grants & Scholarships Officer  
Office of Research Services  
D610, University Hall  
University of Lethbridge  
4401 University Drive  
Lethbridge, AB T1K 3M4  
Phone: (403) 329-2747  
Fax: (403) 382-7185

## Appendix F

The following interview guide provides insight into the range of issues that are likely to be discussed by participants. It is important to note that each participant will have the freedom to tell their own story in a manner that is acceptable to them.

### Initial Interview Guide

1. Would you tell me a little about yourself – what is important to you, your values.
2. In what nursing specialty or grade do you currently work? How long?  
Probes: What grade or specialties are easier places for men to be? Why  
What nursing specialty/grade would you prefer to work in/teach.
3. Tell me about your decision to become a nurse/elementary school teacher.  
Probes: What influenced your decision?  
Have you ever been ridiculed or shunned?  
What were the reactions of family, friends, acquaintances?  
How do you feel about telling people you are a nurse/elementary school teacher?  
Why do you think there are so few men in nursing/elementary school teaching?
4. Are men in nursing/elementary school teaching suspected of being gay?  
Probes: How has this suspicion affected how you feel about yourself as a man?  
In what way do you consider yourself masculine?  
What things do you do to appear manly?  
What things do you not do to avoid appearing feminine?
5. Are there some jobs/tasks that you do that your women colleagues do not? Why?  
Probes: Are there jobs that your women colleagues do that you do not? Why?
6. Would you tell me about your interactions with women colleagues.  
Probes: How are your interactions with women different than your interactions with men colleagues?  
How are you treated by women colleagues?  
Do you feel supported by women colleagues?  
Do women colleagues like “one type” of man better than another?  
Are women supportive of some men and not others? How?
7. Would you tell me about your interactions with men colleagues?  
Probes: Do you seek out men colleagues for support?  
How do men support one another?  
How would having more men in nursing/elementary school teaching make a difference to you?  
Is it important to have men colleagues and mentors?

Initial Interview Guide Cont'd

8. Are there situations when you feel vulnerable or unsafe?  
Probes: Do you worry about accusations of inappropriate behavior when you touch patients/children? Which patients/children?  
Can you joke around with women colleagues?  
Do you worry about being accused of sexual harassment? Do women?
  9. What are the advantages of being a man in nursing/elementary school teaching?  
Probes: Do men rise to the top more than women?  
Do men enjoy the same status within nursing/elementary school teaching?  
Do you feel that people listen to you more than they do women colleagues?
  10. What are the disadvantages of being a man in nursing/elementary school teaching?  
Probes: Do you feel pressured to advance yourself/ take on more responsibility?  
Do men take on more responsibility?
  11. Are gay men more accepted in nursing/elementary school teaching?  
Probe: Is nursing/elementary school teaching a good career choice for gay men? Why?
  12. If you could start over, would you choose nursing/elementary school teaching as a career?  
Probes: If not, what would you do instead?  
What advise would you give a man who is just beginning a career in nursing/elementary school teaching?
  13. If there were policy changes to be made regarding men nurses'/elementary school teachers' lives, what policy would you like to see?  
Probes: What are the issues that need to be addressed in policy?  
What images of men nurses and men elementary school teachers do you feel need to be promoted?
-

## Appendix G

1

### **Winnipeg and Vancouver NURSE Focus Group Guide**

Facilitators: David Gregory and Joan Evans

Participant intro: name, grades teaching now and in the past, how long in nursing

**Rare opportunity to share perspectives with men nurses who are a minority.**

**Re-Orient to the research. Focus group 1.5 - 2 hours**

**Consents: Ethics of disclosure - limits of confidentiality**

#### **General Nursing**

Men who enter nursing, choose to work with a predominantly female peer group.

- What are the challenges of working with women?
- What things do men learn from women that they don't learn from other men?
- What things do women learn from men that they don't learn from other women?

Men nurses observed that men approached things differently than women - that there was a "guy way of doing things".

- Would you describe what is meant by the "guy way".
- Does the "guy way" improve the nursing profession?

Many men nurses indicated that they have been or are currently in the upper echelons of their field, including specialties and administrative positions.

- Are men viewed as leaders and managers --- and are promotions always based on competence?

What is important in regards to being satisfied with your career as a nurse?

Leadership role? Respect? Autonomy?

What is men's contribution to nursing?

- What do men nurses bring to the profession that women do not?

#### **Safety and Caring**

Men's touch of patients is often viewed with suspicion and distrust. Why do you think this is the case?

- How do men nurses refrain from touching?
- What strategies do men nurses use to touch and nurture with less suspicion and distrust?
- How are men nurses' caring practices different from women's?
- Are married men perceived to be safer by patients?

Men nurses are expected to use physical strength to help colleagues with moving and lifting. They also expect and are expected to intervene in violent patient situations to protect patients and colleagues.

- How does the physical size and appearance of a man impact the work he does or is asked to do?
- How does the physical size and appearance of men impact how he is accepted by colleagues, patients?



While some men noted that nursing was a “gay friendly” place, others were very concerned about the presence of gay men in the profession.

- What do you think about this contradiction?
- What difficulties might gay and lesbian nurses encounter during the course of their work?

#### **Co Workers**

- How does a man nurses’ sexual orientation impact his relationships with women colleagues?
- Does a man nurses’ marital status impact his relationship with women colleagues and patients.

Men nurses observed that **physicians** would often interact with women nurses in ways that could be read as disrespectful, and that physicians would not behave the same way with men nurses.

- Is this phenomenon related to an individual nurse’s performance or is there something else “at play”?
- If the physician is a woman, how does this change the nurse-physician interaction?

WHY are more men needed in nursing? What does balance mean?

## Appendix H

### Statistical Comparison of Demographic Characteristics Between Coded Participant Transcripts and Uncoded Potential Participant Transcripts

Coded Transcript Demographic Charts	Uncoded Potential Transcripts Demographic Charts	Statistical Comparison
<p><b>Age (coded)</b></p> <p>Age of Participants GROUP: 2.00 Coded Sample Std. Dev = 7.37 Mean = 43.3 N = 18.00</p>	<p><b>Age (uncoded)</b></p> <p>Age of Participants GROUP: 1.00 Uncoded Sample Std. Dev = 6.48 Mean = 41.1 N = 20.00</p>	<p><b>Coded</b> Mean= 43.28 Sd= 7.37</p> <p><b>Uncoded</b> Mean= 41.05 Sd = 6.48</p> <p>Indep. t test t= -0.991 df=36 p= 0.328 <math>\alpha=0.05</math></p> <p>No Statistically Significant Difference</p>
<p><b>Age Cohort (coded)</b></p> <p>Age Cohort GROUP: 2.00 Coded Sample</p>	<p><b>Age Cohort (uncoded)</b></p> <p>Age Cohort GROUP: 1.00 Uncoded Sample</p>	<p><b>Coded</b> Modes = 40-44 45-49</p> <p><b>Uncoded</b> Mode = 40-44</p> <p><math>X^2= 6.077a</math> df=7 p= 0.531 <math>\alpha=0.05</math></p> <p>No Statistically Significant Difference</p>

<p align="center"><b>Years of Practice (coded)</b></p> <p align="center">Years of Practice</p> <p align="center">GROUP: 2.00 Coded Sample</p> <p align="right">Std. Dev = 8.37 Mean = 16.9 N = 20.00</p> <p align="center">Years of Practice</p>	<p align="center"><b>Years of Practice (uncoded)</b></p> <p align="center">Years of Practice</p> <p align="center">GROUP: 1.00 Uncoded Sample</p> <p align="right">Std. Dev = 7.08 Mean = 13.8 N = 17.00</p> <p align="center">Years of Practice</p>	<p align="center"><b>Coded</b></p> <p align="center">Mean= 16.90 Sd= 8.37</p> <p align="center"><b>Uncoded</b></p> <p align="center">Mean= 13.76 Sd = 7.07</p> <p align="center">Indep. t test t= - 1.218 df=35 p= 0.231 <math>\alpha=0.05</math></p> <p align="center">No Statistically Significant Difference</p>
<p align="center"><b>Year of Nursing Graduation (coded)</b></p> <p align="center">Year of Graduation</p> <p align="center">GROUP: 2.00 Coded Sample</p> <p align="right">Std. Dev = 8.37 Mean = 1987.1 N = 20.00</p> <p align="center">Year of Graduation</p>	<p align="center"><b>Year of Nursing Graduation (uncoded)</b></p> <p align="center">Year of Graduation</p> <p align="center">GROUP: 1.00 Uncoded Sample</p> <p align="right">Std. Dev = 7.08 Mean = 1990.2 N = 17.00</p> <p align="center">Year of Graduation</p>	<p align="center"><b>Coded</b></p> <p align="center">Mean= 1987.10 Sd= 8.37</p> <p align="center"><b>Uncoded</b></p> <p align="center">Mean= 1990.24 Sd = 7.08</p> <p align="center">Indep. t test t = 1.218 df = 35 p= 0.231 <math>\alpha=0.05</math></p> <p align="center">No Statistically Significant Difference</p>
<p align="center"><b>Nursing Education Level (coded)</b></p> <p align="center">Nursing Education Level of Participants</p> <p align="center">GROUP: 2.00 Coded Sample</p> <p align="center">Nursing Education Level of Participants</p>	<p align="center"><b>Nursing Education Level (uncoded)</b></p> <p align="center">Nursing Education Level of Participants</p> <p align="center">GROUP: 1.00 Uncoded Sample</p> <p align="center">Nursing Education Level of Participants</p>	<p align="center"><b>Coded</b></p> <p align="center">Mode= RN Diploma</p> <p align="center"><b>Uncoded</b></p> <p align="center">Mode= Diploma with Specialty Training</p> <p align="center"><math>X^2= 8.263a</math> df= 6 p= 0.219 <math>\alpha=0.05</math></p> <p align="center">No Statistically Significant Difference</p>

<p><b>Type of Nursing Employer (coded)</b></p> <p>Type of Nursing Employer</p> <p>GROUP: 2.00 Coded Sample</p> <table border="1"> <caption>Data for Type of Nursing Employer (coded)</caption> <thead> <tr> <th>Type of Nursing Employer</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Provincial Health Em</td> <td>13</td> </tr> <tr> <td>Canadian Military</td> <td>1</td> </tr> <tr> <td>Private Employer</td> <td>2</td> </tr> <tr> <td>Federal Government</td> <td>1</td> </tr> <tr> <td>University</td> <td>3</td> </tr> <tr> <td>College</td> <td>1</td> </tr> </tbody> </table> <p>Type of Nursing Employer</p>	Type of Nursing Employer	Count	Provincial Health Em	13	Canadian Military	1	Private Employer	2	Federal Government	1	University	3	College	1	<p><b>Type of Nursing Employer (uncoded)</b></p> <p>Type of Nursing Employer</p> <p>GROUP: 1.00 Uncoded Sample</p> <table border="1"> <caption>Data for Type of Nursing Employer (uncoded)</caption> <thead> <tr> <th>Type of Nursing Employer</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Provincial Health Em</td> <td>19</td> </tr> <tr> <td>Private Employer</td> <td>1</td> </tr> <tr> <td>College</td> <td>1</td> </tr> </tbody> </table> <p>Type of Nursing Employer</p>	Type of Nursing Employer	Count	Provincial Health Em	19	Private Employer	1	College	1	<p><b>Coded</b> Mode= Provincial Health</p> <p><b>Uncoded</b> Mode= Provincial Health</p> <p><math>X^2 = 6.458a</math> df = 5 p = 0.264 <math>\alpha = 0.05</math></p> <p>No Statistically Significant Difference</p>
Type of Nursing Employer	Count																							
Provincial Health Em	13																							
Canadian Military	1																							
Private Employer	2																							
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<p><b>Study Site (coded)</b></p> <p>Study Site</p> <p>GROUP: 2.00 Coded Sample</p> <table border="1"> <caption>Data for Study Site (coded)</caption> <thead> <tr> <th>Study Site</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Halifax</td> <td>7</td> </tr> <tr> <td>Winnipeg</td> <td>7</td> </tr> <tr> <td>Vancouver</td> <td>7</td> </tr> </tbody> </table> <p>Study Site</p>	Study Site	Count	Halifax	7	Winnipeg	7	Vancouver	7	<p><b>Study Site (uncoded)</b></p> <p>Study Site</p> <p>GROUP: 1.00 Uncoded Sample</p> <table border="1"> <caption>Data for Study Site (uncoded)</caption> <thead> <tr> <th>Study Site</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Halifax</td> <td>4</td> </tr> <tr> <td>Winnipeg</td> <td>14</td> </tr> <tr> <td>Vancouver</td> <td>3</td> </tr> </tbody> </table> <p>Study Site</p>	Study Site	Count	Halifax	4	Winnipeg	14	Vancouver	3	<p><b>Coded</b> Mode= All Sites Equal</p> <p><b>Uncoded</b> Mode= Winnipeg</p> <p><math>X^2 = 4.752</math> df = 2 p = 0.093 <math>\alpha = 0.05</math></p> <p>No Statistically Significant Difference</p>						
Study Site	Count																							
Halifax	7																							
Winnipeg	7																							
Vancouver	7																							
Study Site	Count																							
Halifax	4																							
Winnipeg	14																							
Vancouver	3																							
<p><b>Marital Status (coded)</b></p> <p>Marital Status</p> <p>GROUP: 2.00 Coded Sample</p> <table border="1"> <caption>Data for Marital Status (coded)</caption> <thead> <tr> <th>Marital Status</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Married</td> <td>10</td> </tr> <tr> <td>Single</td> <td>9</td> </tr> <tr> <td>Unknown</td> <td>2</td> </tr> </tbody> </table> <p>Marital Status</p>	Marital Status	Count	Married	10	Single	9	Unknown	2	<p><b>Marital Status (uncoded)</b></p> <p>Marital Status</p> <p>GROUP: 1.00 Uncoded Sample</p> <table border="1"> <caption>Data for Marital Status (uncoded)</caption> <thead> <tr> <th>Marital Status</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Married</td> <td>11</td> </tr> <tr> <td>Common Law</td> <td>4</td> </tr> <tr> <td>Divorced</td> <td>1</td> </tr> <tr> <td>Single</td> <td>5</td> </tr> </tbody> </table> <p>Marital Status</p>	Marital Status	Count	Married	11	Common Law	4	Divorced	1	Single	5	<p><b>Coded</b> Mode= Married</p> <p><b>Uncoded</b> Mode= Married</p> <p><math>X^2 = 8.190a</math> df = 4 p = 0.085 <math>\alpha = 0.05</math></p> <p>No Statistically Significant Difference</p>				
Marital Status	Count																							
Married	10																							
Single	9																							
Unknown	2																							
Marital Status	Count																							
Married	11																							
Common Law	4																							
Divorced	1																							
Single	5																							

<p><b>Sexual Orientation (coded)</b></p> <p>Sexual Orientation of Participants</p> <p>GROUP: 2.00 Coded Sample</p> <p>Sexual Orientation of Participants</p>	<p><b>Sexual Orientation (uncoded)</b></p> <p>Sexual Orientation of Participants</p> <p>GROUP: 1.00 Uncoded Sample</p> <p>Sexual Orientation of Participants</p>	<p><b>Coded</b> Mode= Straight</p> <p><b>Uncoded</b> Mode= Gay</p> <p><math>X^2= 1.236a</math> df = 2 p= 0.539 <math>\alpha=0.05</math></p> <p>No Statistically Significant Difference</p>
<p><b>Current Practice Setting (coded)</b></p> <p>Practice Setting</p> <p>GROUP: 2.00 Coded Sample</p> <p>Practice Setting</p>	<p><b>Current Practice Setting (uncoded)</b></p> <p>Practice Setting</p> <p>GROUP: 1.00 Uncoded Sample</p> <p>Practice Setting</p>	<p><b>Coded</b> Mode= Various Settings</p> <p><b>Uncoded</b> Mode= Various Settings</p> <p><math>X^2= 7.111a</math> df = 9 p= 0.626 <math>\alpha=0.05</math></p> <p>No Statistically Significant Difference</p>
<p><b>Would You Choose Nursing Again? (coded)</b></p> <p>Would the Participant Choose Nursing as a Career</p> <p>GROUP: 2.00 Coded Sample</p> <p>Would the Participant Choose Nursing as a Career Again?</p>	<p><b>Would You Choose Nursing Again? (uncoded)</b></p> <p>Would the Participant Choose Nursing as a Career</p> <p>GROUP: 1.00 Uncoded Sample</p> <p>Would the Participant Choose Nursing as a Career Again?</p>	<p><b>Coded</b> Mode= Yes</p> <p><b>Uncoded</b> Mode= Yes</p> <p><math>X^2= 1.619a</math> df = 3 p= 0.655 <math>\alpha=0.05</math></p> <p>No Statistically Significant Difference</p>

- a. Please note that the chi square assumption of no cells with an expected count less than 5 has been violated, therefore the reliability of the calculated chi square statistic may be affected.

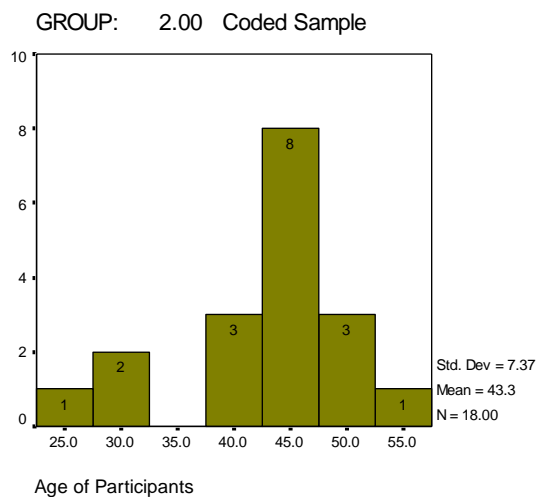
## Appendix I

### Summary of Participant Demographic Characteristics

In order to describe the current study participants, each of the demographic variables have been reviewed in greater detail for the coded sample and the overall potential study sample.

#### Age

The mean age of the coded study participants was 43.3 years ( $\sigma = 7.37$  years) while the mean age of the entire group of potential study participants was a comparable 42.1 years ( $\sigma = 6.95$  years). Please refer to Figures 1 and 2 below. The mean age of study participants is also comparable to the reported mean age for all Canadian Registered Nurses in 2007 of 45.1 years (Canadian Nurses Association, 2009a).



*Figure 1.* Histogram of Coded Participant Age Distribution.

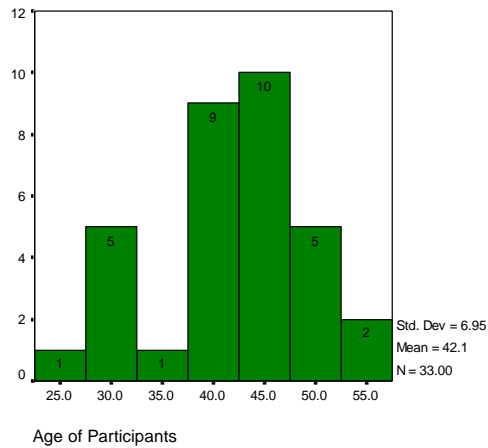


Figure 2. Histogram of the Age Distribution for All Potential Participants

### Age by Cohort

When the frequency of coded participants was charted in age cohorts of five years, it was also noted that the distribution was bimodal with 40-44 years and 45-49 years representing the most common cohorts with six study participants in each (See Figure 3). The most common age cohort in the entire group of potential participants was 40-44 years with a frequency of 13, while the second most common age cohort amongst this group was noted to be 45-49 years with a frequency of 12 (See Figure 4).

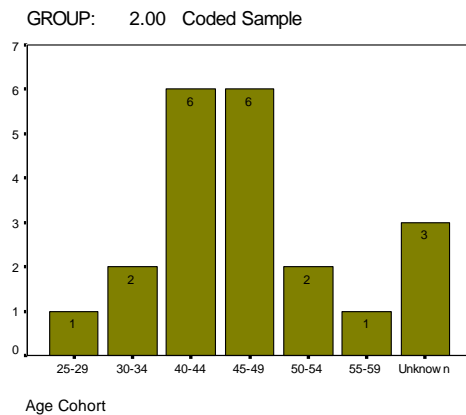


Figure 3. Frequency Distribution Chart of Coded Study Participants by Age Cohort.

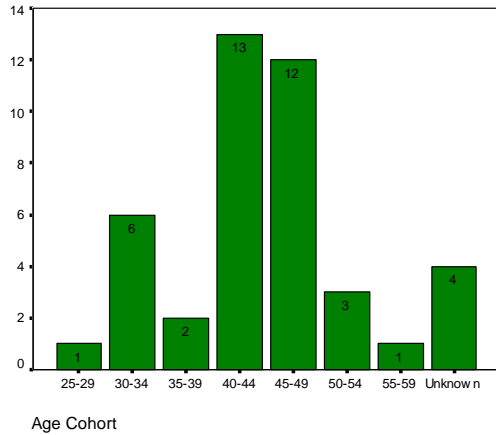


Figure 4. Frequency Distribution Chart of Potential Study Participants by Age Cohort.

### Year of Nursing Graduation

Year of nursing program graduation was recorded when participants provided this information, and the mean year of graduation for coded study participants was 1987 ( $\sigma = 8.37$  years), while the mean year of graduation for all potential study participants was 1988 ( $\sigma = 7.85$  years). See Figures 5 and 6 below.

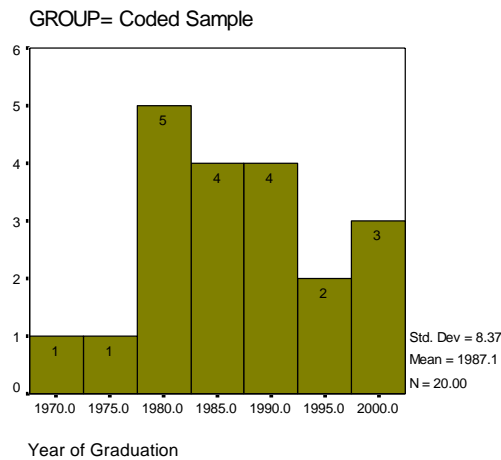


Figure 5. Histogram of “Year of Nursing Graduation” Distribution for Coded Participants.



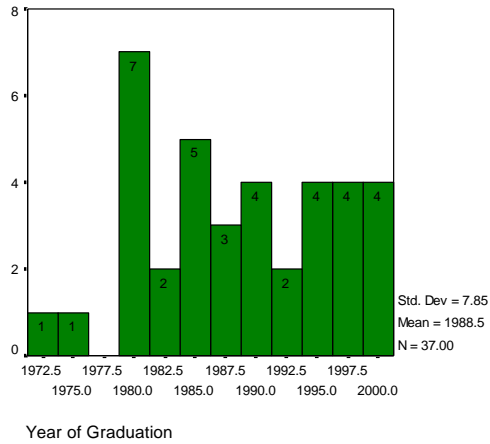


Figure 6. Histogram of “Year of Nursing Graduation” Distribution for All Potential Participants.

### Years of Practice

The mean number of years that the coded participants had been practicing nursing was 16.9 years ( $\sigma = 8.37$  years), and the mean number of years all the potential study participants have practiced nursing was 15.8 years ( $\sigma = 7.17$  years). Please refer to Figures 7 and 8. It is apparent that the study participants therefore largely present the perspectives of experienced male Registered Nurses.

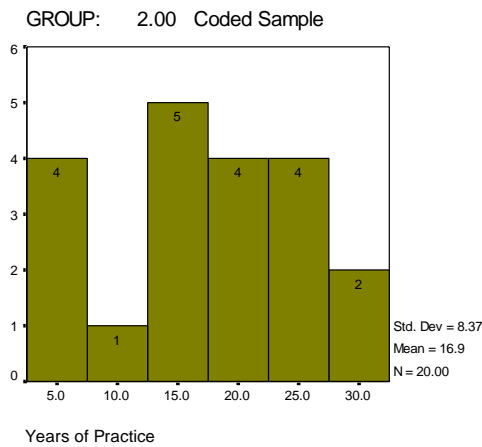
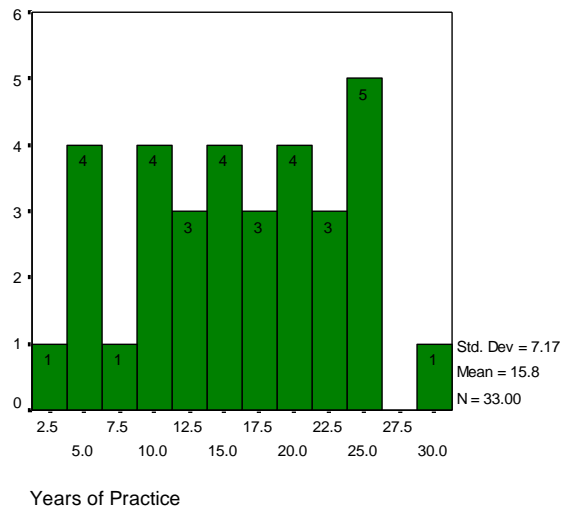


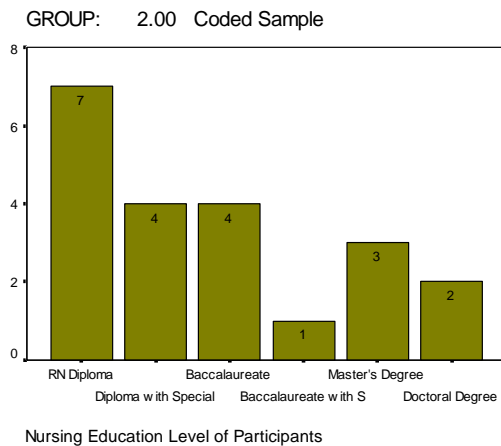
Figure 7. Histogram of “Years of Practice” Distribution for Coded Participants.



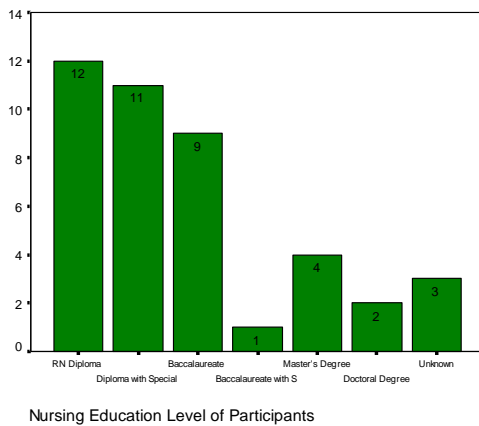
*Figure 8.* Histogram of “Years of Practice” Distribution for All Potential Participants.

### **Nursing Education Level**

Nursing education level was recorded as RN diploma (2 or 3 year program), RN diploma plus specialty training (e.g. a critical care course), baccalaureate degree in nursing, baccalaureate degree plus specialty training, master’s degree, or doctoral degree. The most common nursing educational preparation for both coded and potential participants was a RN diploma with a frequency of seven and twelve participants respectively (See Figures 9 and 10).



*Figure 9.* Frequency Distribution Chart of Nursing Education Level for Coded Study Participants.

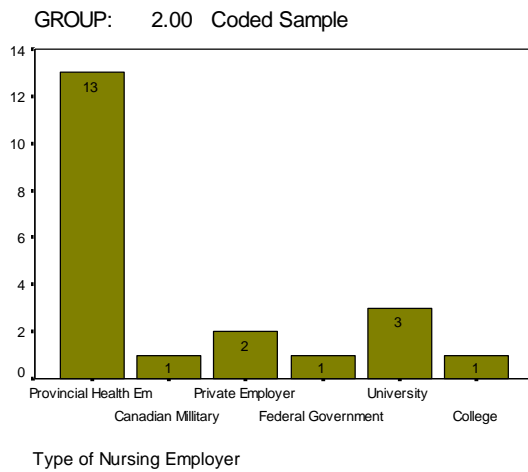


*Figure 10.* Frequency Distribution Chart of Nursing Education Level for All Potential Study Participants.

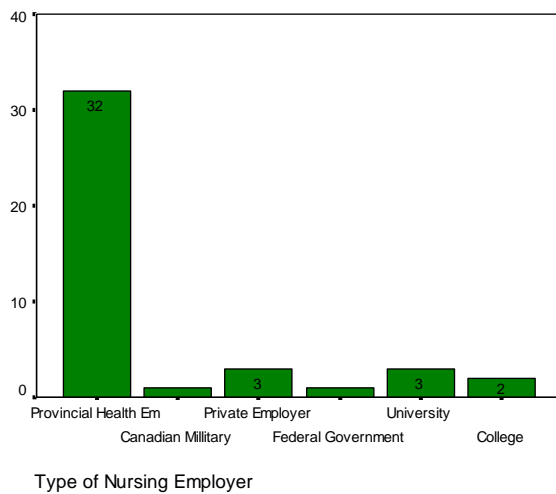
### **Type of Nursing Employer**

Study participants worked for a variety of employers including provincial health organizations, universities, colleges, private employers and federal institutions such as the civil service and the military. By far the most common employer type was provincial health organizations for both the coded and potential study participants with a frequency of 13 and 32 participants respectively. Please refer to Figures 11 and 12. This is not an

unexpected result since health care delivery is primarily a provincial responsibility in Canada.



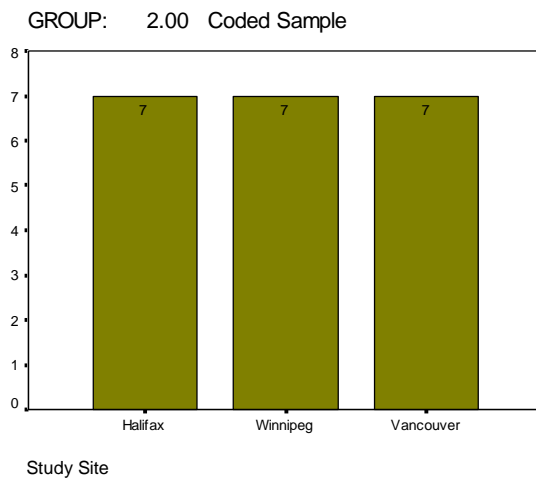
*Figure 11.* Frequency Distribution Chart of Coded Participants by Nursing Employer Type.



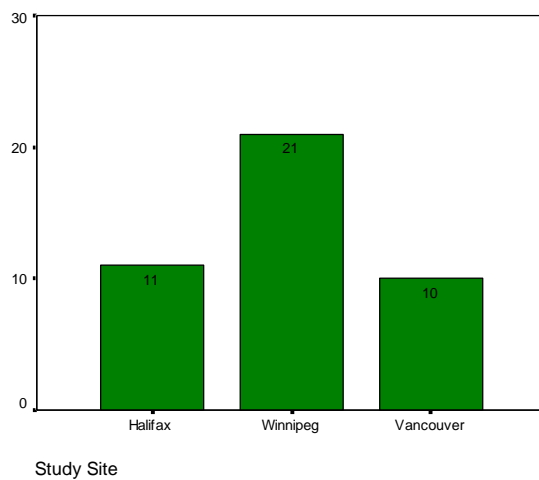
*Figure 12.* Frequency Distribution Chart of All Potential Participants by Nursing Employer Type.

## Study Site

During the primary study, individual interviews were carried out in three study sites including: Halifax (11 interviews), Winnipeg (21 interviews), and Vancouver (10 interviews); however during the current study seven interviews were line by line coded from each site (see Figures 13 and 14).



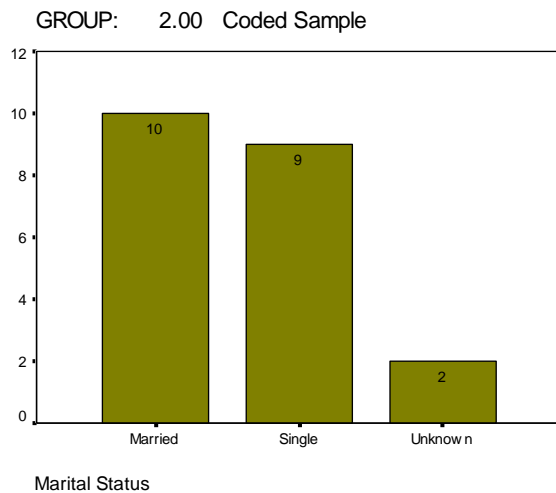
*Figure 13.* Frequency Distribution Chart of Coded Participants by Study Site.



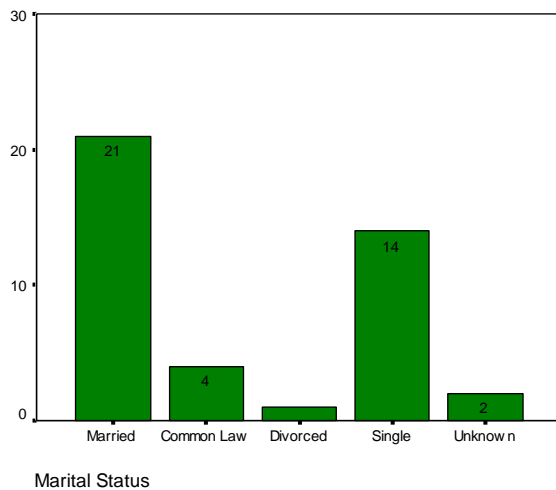
*Figure 14.* Frequency Distribution Chart of All Potential Participants by Study Site.

## Marital Status

Coded study participants and potential study participants both demonstrated married as the most common category (10 and 21 participants respectively), with single being the second most common (9 and 14 participants respectively). Please refer to Figures 15 and 16.



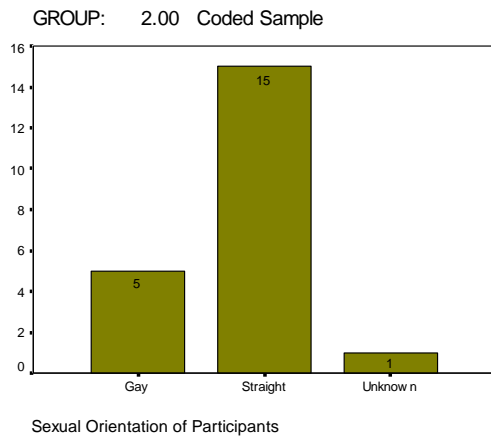
*Figure 15.* Frequency Distribution Chart of Coded Participants by Marital Status.



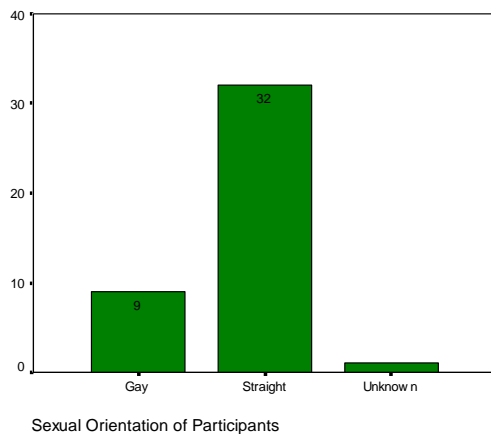
*Figure 16.* Frequency Distribution Chart of All Potential Participants by Marital Status.

## Sexual Orientation

Participants usually self-identified their sexual orientation in the course of the interview transcripts, and the most commonly identified sexual orientation was heterosexual in both the coded participants (frequency 15) and the potential participants (frequency 32). Please refer to Figures 17 and 18.



*Figure 17.* Frequency Distribution Chart of Coded Participant Reported Sexual Orientation.



*Figure 18.* Frequency Distribution Chart of All Potential Participant's Reported Sexual Orientation.

## Current Practice Setting

Initially, each participant’s practice setting was recorded as an attribute in NVIVO and

Figure 19 was generated.

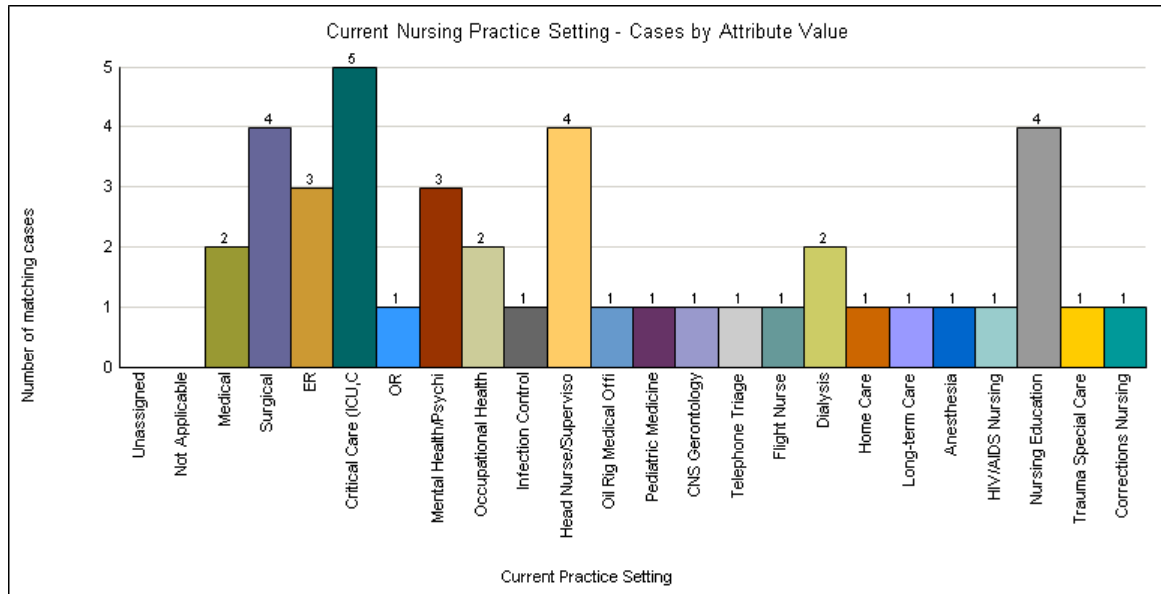


Figure 19. Current Practice Setting as Reported by all Potential Study Participants

Due to the large number of categories however, the study participant’s practice setting was subsequently assigned to a smaller number of categories including: medicine, surgery, emergency room [ER]/trauma, critical care, mental health, occupational health, gerontology, nursing education, administration, and various settings for the purposes of statistical analysis. “Various settings” was the category that captured unique practice settings that only one study participant was engaged in. Please refer to Figures 20 and 21 to see the frequency distributions for the revised practice setting categories.



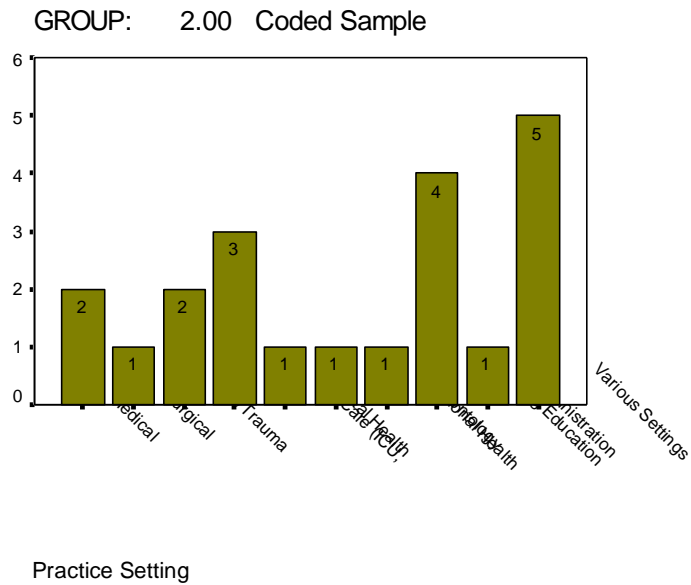


Figure 20. Frequency Distribution Chart of Coded Participant's Current Practice Setting.

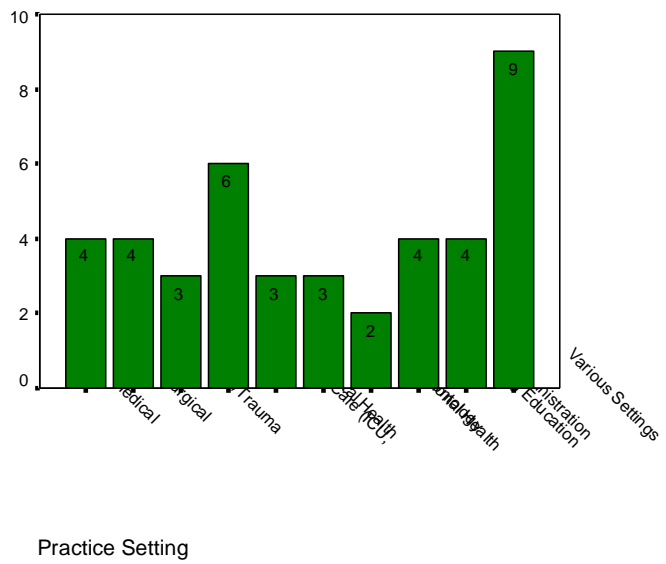
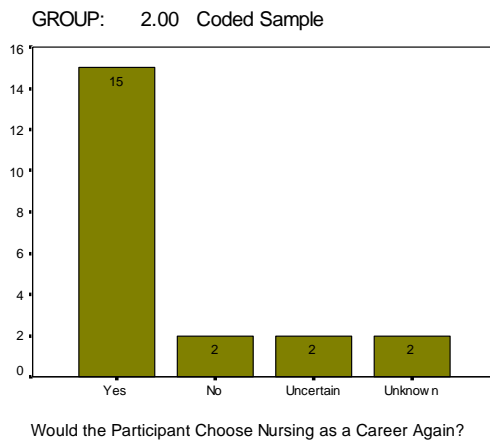


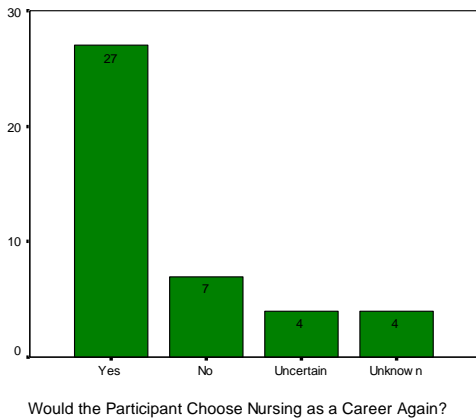
Figure 21. Frequency Distribution Chart of All Potential Participant's Current Practice Setting.

## Would They Choose Nursing Again?

During the course of the interviews in the primary study, participants were asked if they would choose nursing as a career again. Although there were some participants that said no, or were uncertain about their answer to this question, the vast majority of coded study participants (frequency 15) and potential study participants (frequency 27) identified that they would choose nursing again. Please refer to Figures 22 and 23.



*Figure 22.* Frequency Distribution Chart of Coded Participant’s Answer to the Question: “Would you choose nursing again?”.



*Figure 23.* Frequency Distribution Chart of All Potential Participant’s Answer to the Question: “Would you choose nursing again?”.