MASCU LINITIES AND MEN IN NURSING:
An Exploratory Survey and Life History Study

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

Faculty of Education and Social Work
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December, 2006
AUTHOR’S DECLARATION

This is to certify that:

I. this thesis comprises only my original work towards the Degree of Doctor of Philosophy

II. due acknowledgement has been made in the text to all other material used

III. the thesis does not exceed the word length for this degree.

IV. no part of this work has been used for the award of another degree.

V. this thesis meets the University of Sydney’s Human Research Ethics Committee (HREC) requirements for the conduct of research.

Signature(s): ____________________________

Name(s): Murray J Fisher

Date: December 1st, 2006
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ABBREVIATIONS

ADON  Assistant Director of Nursing
AIDS  Acquired Immune Deficiency Syndrome
AIHW  Australian Institute of Health and Welfare
ASRS  Australian Sex Role Inventory
BSRI  Bem Sex Role Inventory
CNC  Clinical Nurse Consultant
CNE  Clinical Nurse Educator
CNS  Clinical Nurse Specialist
DD  Developmentally Disabled
DDON  Deputy Director of Nursing
DON  Director of Nursing
HIV  Human Immunodeficiency Virus
HSM  Health Services Manager
ICU  Intensive Care Unit
IEA  Institute of Engineers Australia
NUM  Nursing Unit Manager
NM  Nurse Manager
NO  Nursing Officer - Army
NSW  New South Wales
NSWNMB or  New South Wales Nurses and Midwives Board
NSWNMB  Personality Attributes Questionnaire
PAQ  Registered Midwife
RM  Registered Nurse
RN  Research Officer
ABSTRACT

Both the experience of male nurses, and labour processes in the nursing profession, are profoundly shaped by cultural constructions of gender identity and work ideology. The purpose of this thesis is to examine social practice that configures masculinity through the lives of male nurses. By taking a pro-feminist standpoint in the examination of gender relations, multiple patterns of masculinity in the lives of male nurses are uncovered. This thesis reports the findings of two studies.

A cross-sectional survey of male nurses, female nurses and male engineers was used to examine the congruence of gender characteristics (gender norms) with work-based gender ideology. Both male engineers and female nurses constructed nursing as feminine, based on essentialist notions of gender and constructions of sex roles. The findings about self-descriptions of feminine and masculine characteristics do not support rigid gender norms. No difference was found between the three sample groups for positive masculine characteristics (instrumentality) and negative feminine characteristics. However, an occupational difference was found for the feminine characteristics associated with nursing (expressive orientation) where male nurses scored higher than male engineers.

Gender relations in the lives of male nurses were explored through life history methodology. Twenty-one participants' life stories were gathered in semi-structured interviews. Each life story underwent a structural analysis, using a four-dimension structural model of gender relations and was written as a case study. In a second phase of the analysis, the case studies were re-analyzed in groups to explore similarities and differences in the trajectories of male nurses and to understand their collective location.

Three patterns of masculinity were uncovered, each pattern having different relations with hegemony. ‘Broken masculinity’ is seen among those men who throughout their lives have struggled to maintain the advantages of hegemonic masculinity but are damaged by the struggle. They have unsatisfactory relations with women, becoming victims of women's power and agency, and become subordinate to other men.
'Complicit masculinity' is seen among those men who are rewarded by patriarchal culture and reap the rewards of hegemonic masculinities. These men engage in gender practises that structure unequal opportunities for women. A third masculinity, 'soft men', was found in some participants. These men structure gender practises that promote gender equality.

The findings of this research suggest that the experiences of male nurses are complex, contradictory and challenging, at both a personal and professional level. Compared with previous research, this study reveals a multiplicity of possibilities rather than a singular experience fitting all male nurses.
CHAPTER 1
Introduction: Structuring Gender

Introduction
This thesis sets out to explore the position of male nurses in the broader gender order. Current critical studies on men in nursing, whether theoretical or empirical, have implicitly placed men and masculinities at the centre of their examination of gender relations within nursing. In so doing, they have excluded women and femininities from their critical analyses and have failed to examine gender relations in everyday social life outside of nursing. I hope to remedy this problem by using the gender relations approach as a theoretical framework and adopting empirical approaches that allow a broader view of gender.

This thesis reports on two empirical studies. The first is a quantitative cross-sectional survey of male nurses, female nurses and male engineers, to examine differences in the self reporting of gender characteristics. The second is a life history project that explores the lived experiences of male nurses and allows for the examination of social practice, the patterning of which underpins gender relations between male nurses and others in everyday social life.

This thesis thus aims to explore male nurse subjectivities with a specific focus on how broader socio-political ideologies and the internal (re)structuring of contemporary nursing shape middle-class occupational masculinities.

Frameworks for Understanding Gender
Amy Wharton (2005), in her contemporary text, The Sociology of Gender, presents broad frameworks for the study of gender. Wharton utilizes Ridgeway and Smith-Lovin’s (1999) definition of gender to structure the research frameworks, where gender is defined as “a system of social practices, which creates and maintains gender distinctions and it organizes relations of inequality on the basis of these distinctions” (Ridgeway and Smith-Lovin 1999). Wharton (2005; 8) structures the theoretical frameworks for the study of gender “generally to where ‘sociological action’ is with respect to the social practices that produce gender”. According to Wharton, the
"individualist" approach is where social practice is associated with socialisation and where action resides in individuals in the form of characteristics: their personalities, traits, emotions etc. Gender as traits, abilities, or behavioural dispositions leads to fixed categorical definitions based on biological sex difference, and has lead to a plethora of sex difference research (both biological and psychological). Sex role theory is one such categorical notion of gender. Alternatively, the "contextual" approach is associated with gender created through social interaction and is inherently contextual in its effect. Such an approach can be used to examine individual interaction or to examine structures and practices of organizations. This is what is referred to as the gender relations approach (Connell 1987).

The concept of normative ‘sex-roles’ as a functional theory of gender was introduced in the 1940’s and developed through the work of Mirra Komarovsky and Talcott Parsons. Since then, and up to the mid 1980’s, normative role theory and deviancy was the mainstay of gender theory and research. Sex roles or gender roles are perceived to be social constructions of gender categories based on two sets of culturally specific attributes that are supposedly uniquely portrayed by the one or the other sex (masculine for males, feminine for females) (Cook 1985). Traditional female sex-role characteristics (femininity) include those characteristics considered to be desirable for females, for example sharing, nurturing and dependence. On the other hand, the male sex role includes personality characteristics such as aggression, dominance, ambition and being unemotional, which are the reverse of the feminine characteristics.

The pattern and level of masculine and feminine characteristics adopted and exhibited in some manner by an individual, is known in much of this literature as their sex-role identity (Cook 1985). Normative influence is the effect of hierarchical social structures which create expectancies about male and female behaviour, and how they affect social interaction by the reinforcement of these expectations (Eagly 1983). The obvious inference is that males are expected to take the masculine sex role identity, while females are to take the feminine sex role identity, and behave in a manner that reinforces their sex role identity. As a result sex role theory rests on the
idea of two homogenous categories, with diversity accounted for as 'deviance', from the normative roles. It is important that in role theory ‘norms’ refer to expectations and do not actually specify the reality of individuals’ lives (Carrigan et al. 1985).

By the mid 1970’s the sex role paradigm had come under considerable scrutiny, initially by feminism and to a lesser extent the gay movement, and later in interdisciplinary studies of men and masculinity. Sex role theory was criticized for being ahistorical, psychologically reductionist and apolitical (Connell 1979, Pleck 1981, Stacey and Thorne 1985, Gerson and Peiss 1985, Kimmel 1986). Role theory, and the positivist research coming out of role theory, was thought to posit a historically invariant model grounded in fixed categories into which biological males and females are forced to fit (Kimmel 1986). Even when it admits change in the role norms, role theory has no means of explaining the social processes through which such change is accomplished.

Sex role theory has led to the development of several psychological personality pencil-and-paper tests, such as Bem’s Sex Role Inventory (Bem 1974) and the Australian Sex Role Scale (Antill et al. 1981). With the arrival of such instruments in the 1970’s there has been a plethora of sex-role and sex difference research (Connell 1987). Many studies have attempted to replicate Bem’s conceptions of masculinity and femininity in order to examine the stability of sex-roles as framed in the pencil-and paper tests, but have failed to do so. Ballard-Reisch and Elton (1992) in a survey study of 265 university students in the USA failed to validate the scales of the BSRI as current social perceptions of masculinity and femininity within American culture; current at the time of the research. The difficulties in replicating factor structures of such scales may be a product of historical shifts in gender constructions, which cannot be captured as fixed categories.

In addition, sex difference research in general has failed to identify traits or behaviours that reliably distinguish men from women (West and Zimmerman 1987, Connell 1995, 2002; Wharton 2005). That is, bodily differences and social effects are not tightly linked (Connell 2002). Questions raised regarding sex difference research
include questions of the magnitude of sex difference, how different do men and women have to be in order to be different (i.e. a question of effect size), and the consistency of difference between samples or cultures, and across time periods and situations. Whilst there are studies that demonstrate statistical significance, the effect sizes are so small that no meaningful real life differences can be inferred. Conclusions made from major reviews and meta-analyses of sex difference research suggest that there are very few clear-cut psychological sex differences; rather the body of research should be referred to as sex similarity research (Connell 2002, Wharton 2005).

In my mind, the most important critique of sex-role theory, or other categorical definitions of gender constructed from sex difference, is that of the inability of such theories to explain gender inequalities in power and production, within each gender and between genders. As stated previously, sex role theory reduces gender into two homogenous categories, equal and reciprocally dependant on each other (Connell 1987). Masculinity becomes associated with those traits that imply mastery and authority, femininity with those traits that suggest passivity and subordination. As a result, sex role theory conceals and legitimizes the power of men and the overall social subordination of women (Carrigan et al 1985, Kimmel 1986, West and Zimmerman 1987, Connell 1987).

In addition, normative theory does not take into account the degree of agency in individuals. Without acknowledging individuals as able to make choices and act, there is no hope of bringing about other possibilities, other ways of being. In this sense sex roles are static and fixed. According to Connell, sex roles have no way of grasping change as a dialectic arising within gender relations themselves (1987 53).
Masculinities: The Gender Relations Approach


These critiques have been systematized into a new sociological theory of gender, gender relations, the underpinnings of which are the analysis of gender as a structure of social relations, especially a structure of power relations. Sociological concerns with subcultures and issues of marginalization, post-structuralist analysis of the making of identities in discourse, and the interplay of gender with race, sexuality, and class further inform the analysis of gender relations. Over the past two decades there has been a plethora of studies in sociology, anthropology, history and cultural studies in which researchers have examined the construction of masculinities in many different social and historical contexts. Connell (2002) calls this the “ethnographic moment” in masculinity research.

Connell (2002; 10), a leading theorist and scholar in masculinities and men’s studies, defines gender as “a structure of social relations that centres on the reproductive arena, and the set of Practices (governed by this structure) that bring reproductive
*distinctions between bodies into social processes*. Gender is an internally complex social structure, one that is reproduced in historical situations as configurations of social practice in a system of gender relations. As a result, masculinity is inherently relational and does not exist except in contrast to femininity. Masculinity is actively constructed and comes into being as people (inter)act. Since masculinity is constituted by social practice, it is vulnerable to changes in social practice. Masculinity is therefore dynamic and subject to change. Masculinity and femininity are viewed as gender projects that can be challenged, reconstructed and contested (Connell 1994, 1995, 2000).

The body is a reproductive arena through which social practice occurs. The body should not be reduced to the determinant of social practice (Connell 1995). The body is more than a location of social practice, more than a means for gender practice to occur, but is a participant in generating social practice, simultaneously as an object of social practice and as an agent in social practice (Connell and Messerschmidt 2005). The interplay between bodies and social practice has been brought into focus by research on men and masculinity. Examples are Messner’s (1992) life history study which examined the use of the body in sport as a ‘weapon’ and as a ‘machine’ by professional sportsmen, Donaldson’s (1991) investigation of the labouring work of working-class men, Dowsett’s (1996) life history study of homosexual Practices of gay men in an era of HIV and AIDS, and Messerschmidt’s (1999, 2000) life history studies that examined how the construction of masculinities in boys relates to various uses of the body in the conduct of violence.

Gender takes place in different historical and cultural contexts, and intersects other social structures, such as race, class, and sexuality. It is evident from social research that there is not one fixed or static pattern of masculinity but multiple masculinities created in historical and cultural contexts which are subject to change. The impact of ethnicity on the construction of masculinity is well documented and is exemplified in recent studies on Lebanese youth in Australia and the UK. Poynting et al.’s (2003) ethnography on Lebanese youth in south west Sydney, examines race relations that act to marginalize and subordinate individually and collectively, young Lebanese
men, leading to the construction of ‘protest masculinity’. Similarly, Archer’s (2001) study of Lebanese male youth in the UK, demonstrates how they arrange collectively an Asian identity, constructed from a specifically Muslim perspective, as a point of resistance through discursive practice against white society.

The impact of class on the construction of masculinity has been demonstrated in several studies. Walker’s (2003) ethnography examined the construction of masculinity in young Australian men engaged in the car culture, and demonstrates how marginalized working-class youth establish power through risk behaviour and the explicit exclusion of women from car culture. Messerschmidt (1999) presents the life histories of two working-class youths who engage in violence and demonstrated how differing bodily and sexual Practices impact on the construction of differing forms of masculinity – ‘subordinate and oppositional’. Donaldson (1987, 1991) presents the struggles of the working class, and examines how labouring men construct masculinity through the bodily Practices of their work. In contrast, Donaldson and Poynting’s (2004) life history study on ruling-class men demonstrate how they control their time, leisure and work, and through the use of power, construct and maintain ‘hegemonic masculinity’. Connell’s (1995) widely praised life history study “Masculinities”, clearly demonstrates the multiplicity in the construction of masculinities by outlining different configurations of masculinity in four different groups of men: affluent men, gay men, environmental men, and men on the fringe of the labour market.

The notion of hegemonic masculinity, the dominant forms of masculinity, has in recent times been the focus of criticism. The concept of hegemonic masculinity has been used in different and inconsistent ways, leading to ambiguity and overlap. Hegemonic masculinity was first proposed by Kessler et al. (1982) in an Australian study of social inequalities in schools and was further developed in studies by Connell (Connell 1982, Connell et al. 1982, Connell 1983). The concept of hegemonic masculinity, according to Connell, “was defined as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees the dominant position of men and the
subordination of women” (Connell 2001). Poststructuralists claim that the notion of hegemonic masculinity is essentialist and homogenized (Collier 1998, MacInnes 1998, Petersen 2003). They claim that the concept of hegemonic masculinity is flawed as it is reduced to a single static typology rather than a fluid reality. Connell and Messerschmidt (2005) in response point out the wealth of research that clearly articulates the multiplicity of hegemonic masculinities and the dynamic ways hegemonic masculinities not only adapt, but are able to reconfigure themselves in adapting to historical conditions.

Configurations of masculinity can be arranged in the form of a collective practice, enacted by groups, within organizations and institutions. Collective Practices structured to maintain male dominance are found in ethnographic and life history studies like Walker’s (2003) study of a car culture in Sydney. This study illustrates how a local subculture of car enthusiasts collectively construct masculinity, through the adornment of cars and driving Practices, and social Practices that objectify women or exclude them from the car culture altogether. Shaw (2002) examined the historical Practices that have maintained male dominance and the subordination of women in the Australian Surf Life Saving culture. Further evidence of collective practice is exemplified in works of organizations and management, such as Agostino’s (2003) study of the warrior identity in the Australian military and Collinson and Hearn's (1996a) edited volume: Men as Managers: Managers as Men. Agostino examined how military men discursively construct the warrior identity: a hegemonic identity articulated in a language of war, sexuality and gender, located not only in the rank and file but also in policies and legislation.

The workplace is an important site where masculinities are reproduced and maintained. Men’s gender identity, value and worth are bound up with paid work, resulting in the maintenance of gender power relations and creating a gendered segregation of labour. Men’s power, authority and status are achieved through employment as it provides the economic and symbolic benefits of wages, skills and experience (Collinson and Hearn 1996b). As multiplicity and diversity are relevant to the analysis of masculinity, different forms and locations of work provide different
sites of interaction with masculinities. The foregoing studies demonstrate how the organization of power and status are structured and maintained in different sites of work: manual labour, professional and managerial work, and traditional women's work. The literature on men in nursing will be used to explore the last of these work sites.

Exemplary Studies of Men in Work Contexts

Examining a few studies in more detail will show how some of the themes of the present study originated. Focusing particularly upon manual labour in the working class, Donaldson (1991) in his book *Time of Our Lives*, articulates how the sites of work and the family-household reproduce class-gender relations. Donaldson, drawing on a study of men working for BHP Australia, explores how young working class men associate manual labour with the social superiority of masculinity—strength, activity, hardness, danger and courage; whereas they view non-manual work as effeminate. It is from the working conditions and difficult work practices that these men symbolically construct their masculinity. For the working class it is bodily practice in manual work that is sold for a wage. Whilst it is the physicality of the work that defines masculinity, it is the nature of the work—simple, mundane, repetitive and non-skilled—that threatens their masculinity. The working class are employed to do a task and are one of a mass without autonomy, prestige or authority.

Success and failure for working class men are determined by their body and its ability to do the work required and are measured by what they earn and their ability to provide for the family. As the body fails, their ability to produce an income is threatened. Men who are unable to financially support their family are "pitied and feel like failures" (Donaldson 1991). The need to provide for the family maximizes their motivation to work and minimizes militancy Practices that might jeopardize this. Furthermore, the labouring man's power and control is maintained through household relations of production and cathexis. It is through the gender division of household labour and sexual relations that these men are able to assert power and control, sustaining their masculinity.
Like Donaldson's study, Cockburn's (1983) UK study of printers reveals how manual skills are defined and widely accepted as highly masculine. She shows how the hot-metal skills of linotype compositors have historically been protected as the exclusive domain of men. Cockburn demonstrates how technology in capitalist development, the move from hot composition to cold photocomposition and computer technology in printing, plays a key role in the struggle between capital and labour. The need to make profits and expand market share, drives technological change for greater efficiency and productiveness. For the craft compositor, capitalist technological innovation has lead to the 'dequalification' of one generation of workers. In this way technological innovation facilitated the exercise of power of the controlling class over the working class (Cockburn 1983).

In the case of printing, the technological introduction of cold composition raised questions for the men involved regarding the definition of men's work. Men found it difficult to adjust from the perceived masculine skill, the use of metal in hot compositions to the labour processes of the perceived female domain of the key board, paper and glue; work that is perceived to be more generalized and easier. The degradation of work and deskilling has lead to a fall in standing in the masculine hierarchy. In mapping the introduction of capital innovation and the subsequent changes in labour processes, Cockburn has been able to capture the change in gender relations of compositors, men who found themselves deskilled. Cockburn examined how skilled labour, the 'mental worker', was able to maintain superiority over unskilled or deskilled labour. The maintenance of separate unions and the control of technology provided skilled labour the means to maintain the intraclass order over unskilled labour.

Both Collinson and Hearn have critically examined male leadership and the Practices of male managers in organizations, questioning men's relations with power. In so doing, they explicate how masculinities shape managerial Practices as well as identifying how managerial Practices impact on the emergence of masculinities in the workplace (Collinson and Hearn 1994). Given competitive markets and corporate need for profit, there is immense pressure on managers to lower production costs,
improve efficiencies and control labour processes. Within this context, Collinson and Hearn (1996a) draw on the work of Kanter to explain how organizational processes reproduce the power of men and managers. It is through ‘homosexual reproduction’, male senior managers promoting men of a similar image (more reliable, committed and predictable) and ‘homosocial reproduction’, the processes that lead to conformity to corporate expectations and demands, that women are excluded from managerial positions. Organizational networks and asymmetrical power relations are reproduced through establishing and sustaining a masculine identity and aligning oneself to some and not others (Collinson and Hearn 1996a). Examples of how masculinity impacts on management Practices are brought out in how male managers deal with workplace discrimination (Collinson et al. 1990), sexuality and the sexual harassment of women (Hearn 1985, Collinson and Collinson 1989, Collinson and Collinson 1992) and employment Practices that exclude women (Collinson and Knights 1986).

Using two biographical case studies, Rosalyn Reed (1996) examines two forms of management, paternalism and entrepreneurialism, and their links to particular masculinities. Reed is concerned with the reproduction of male dominated entrepreneurialism. The differences in social and management practices in different times and contexts, and the similarities in terms of producing forms of hegemonic masculinity, are revealed in examining the lives of David Symes (1827-1908), the Scottish-born editor of The Age newspaper, and Rupert Murdoch, the Australian-born international multimedia entrepreneur.

Another defining feature of hegemonic business masculinities is gender relations in the domestic sphere. Success of the ‘manager’ requires the withdrawal of men from domestic labour (Donaldson 2003). Emotional labour, child care and domestic work are then the exclusive domain of women. Mulholland (1996), in an ethnographic study in the UK, examined the relations of entrepreneurs with their wives, particularly in production relations, where she found the wives provide essential input into capitalist accumulation in the form of hidden emotional and domestic labour. Comparing two forms of entrepreneurial masculinity (working-class and
middle-class), Mulholland found that despite the differences in practice, they had equally drawn upon and benefited from domestic exclusionary Practices, whilst simultaneously benefiting from the production and reproduction of a gender division of emotional and domestic labour.

The construction of middle-class professional masculinities is exemplified in Mairtin Mac An Ghaill’s (1994) ethnographic and life history study of teaching. Mac An Ghaill explored the reconstruction of masculinities in a UK 11-18 co-educational comprehensive school located within a Midlands inner-city industrial area. Mac An Ghaill, in exploring the construction of teacher masculinities, illustrates the struggles, contradictions and fractures of competing masculinities, masculinities centring on pedagogical ideologies constructed out of different historical moments: the Professionals, the Old Collectivists and the New Entrepreneurs. He provides insight to how the internal restructuring of the curriculum and the institutional power of the dominant masculinity, the New Entrepreneurs, were linked to overt forms of surveillance and control of labour processes with changes in pace, content, and form of teacher work, involving increased workloads. In this case state reform and the curriculum became a vehicle to ensure a widening gap between school management and teachers, creating a division of labour controlled by the New Entrepreneurs.

These studies demonstrate how the work of men is both a means by which masculine identity is constructed and the location where masculinities are reproduced and maintained. Specifically, these studies open up the themes of embodiment (Donaldson 1991), labour processes (Cockburn 1983), hierarchies at work (Collinson and Hearn 1994, 1996a and 1996b), and multiple professional identities (Mac An Ghaill 1994). This study will draw upon these themes and take them forward in the exploration of the lives of male nurses.
The Purpose of the Research

The purpose of this research was to expand the current understanding and appreciation of the gender relations of men who work in predominantly female occupations like nursing. The current understandings provide a fragmented picture of the experiences of male nurses and their position in the broader gender order. Current studies on men in nursing, as will be shown in chapter 2, have implicitly placed men and masculinities at the centre of their examination of gender relations within nursing. In so doing, they have excluded women and femininities from their critical analyses and have failed to examine gender relations in everyday social life outside of nursing. This research will provide greater insights into gender relations, especially the understanding of the social practices that construct masculinities in men who undertake "women's work" as an occupation.

Plan of this Study

This study was conceived out of my own experiences of being a nurse. Initially I was interested in the stereotypes of male nurses and their lived experiences of such stereotypes. After an initial examination of the literature of men in nursing, it appeared that the stereotypes of male nurses were a consequence of normative influence, the conflict of the expected male identity and the culturally constructed feminine nurse. This led me to examine gender characteristics in nurses and to examine sex differences.

A cross-sectional survey study was developed to examine both gender characteristics and culturally constructed gender stereotypes, and compare characteristics across male nurses, female nurses and male engineers. This three way comparison allowed conclusions to be drawn regarding the assumptions about gender identity in the form of gender characteristics and occupational based gender stereotypes.
The objectives of this survey were to:

- Document the self-reported gender descriptions of participating registered nurses;
- Ascertain differences in self-reported gender descriptions between male and female nurses;
- Determine if there are any differences in self-reported gender descriptions between the nurse samples and male engineers;
- Identify common perceptions and stereotypes of male nurses.

The method and results of the cross-sectional survey study are presented in Chapter 3: Research Method: Self-Reported Gender Descriptions, Chapter 4: Perceptions of Men in Nursing, and Chapter 5: Gender Self-Descriptions.

The survey study highlights the concerns for male nurses and the stereotypes that place pressure upon them. However the survey is limited, as it inhibits the ability to make conclusions regarding social practice, the construction of masculinities and gender relations. The approach taken in the survey did not illustrate social inequality and power differences in every day life, within the occupation or more broadly. For these reasons it was concluded that a different kind of method was needed to get beyond the exploration of norms and self-images. Accordingly, I undertook a life history project.

The Life History method documents a person’s life or a significant part of their life as narrative, through the telling and recording of one’s life (Plummer 2001). Life history method is used to explain an individual’s understanding of social events, movements and political causes or how individual members of groups or institutions experience and interpret events. Several key masculinity studies have used life history method (Messner 1992, Connell 1995, Dowsett 1996, Messerschmidt 2000). The personal narrative (life story) is a most helpful way to gain a perspective on and understanding of the gendered experiences of men who are nurses. In this study the life history is a vehicle to identify a person’s place in the social order of things, the processes used and social structures that influence gender relations.
The life history project was designed to address the following research questions:

- How do male nurses describe their gender relationships within the institutions of the family, work and other social networks?
- What are the social practices that construct gender relations between male nurses with others?
- What are the issues for male nurses that place their construction of masculinity under pressure?
- What strategies do male nurses employ to overcome these pressures placed on their construction of masculinity?

The method and results of the life history project are presented in Chapter 6: Methodology and method: The life history project, Chapter 7: Life history case studies, Chapter 8: Gender substructures and types of masculinities, and Chapter 9: Cautious carer: professional injury and male nurse care.
CHAPTER 2

Literature Review: Women, Men and Gender in Nursing

Introduction

The studies discussed in chapter 1 demonstrate how the work of men is both a means by which masculine identity is constructed and the location where masculinities are reproduced and maintained. The studies demonstrate how, through class struggle, the dominant masculinities maintain power and authority over lower class men and women in general. With these broad conclusions in mind, I will now turn to discuss and review the literature on men in nursing. The literature on men in nursing focuses on three themes: the male token and male privilege; men's bodies and the gendered division of nursing labour; and gender characteristics mainly seen in sex-role literature. The literature of each theme will be discussed in turn.

Tokenism and Male Privilege in Nursing

Across all western countries males in nursing remain statistically a small minority. In New South Wales, Australia, males make up 8.1% of the enrolled and registered nurse workforce (NSW Health Department 2003). Unlike the situation of female minorities in male-dominated professions, males in nursing tend to hold high status employment positions. In NSW male nurses occupy 13.5% of the nursing administration positions, 11.4% of nursing education positions and 12.2% of senior clinical positions i.e. Clinical Unit Manager and Clinical Nurse Consultant (NSW Health Department 1998). Such evidence implies that men in nursing have a structural advantage over women in their nursing careers (Williams 1989, Williams 1991, Williams 1995, Evans 1997).

Several studies have examined the status of men in nursing, drawing on the concept of tokenism developed by Kanter (1977). Kanter argues that it is a group's composition and dynamics that significantly influences career advancement. She postulates that in highly skewed groups, the numerically dominant are also socially dominant and have significant influence on the behaviour and career of the minority. According to Kanter token status is associated with three dynamics: visibility; polarization; and assimilation.
Studies in the US (Floge and Merrill 1986, Gans 1987, Williams 1989, and Heikes 1991) and the Netherlands (Ott 1989) have examined the token status of men in female dominant occupations using male nurse samples. All these studies concluded that gender, specifically the patriarchal culture that affords men a situational dominance, advantages men in nursing and places them in a privileged minority - a position that female tokens in male dominated occupations cannot attain. As a result, there is a disproportionate distribution of power and prestige in nursing favouring men. Although Kanter’s token status framework is applicable to men in nursing, the differences they experience compared to female tokens are attributed to the socio-cultural constructions of masculinity and femininity and gender based issues of status.

The privilege for men extends to having a higher mean income than women despite having lower levels of education and fewer years of experience (Gans 1984, Williams 1989, Finlayson and Nazroo 1998). This mean difference in income and career advancement, in part, is explained by the gender arrangements of families, where women who work as nurses still bear most of the responsibilities for domestic labour and child rearing (Gans 1984, Williams 1989, Finlayson and Nazroo 1998, Wittock et al. 2002). The major obstacles to career advancement for women, indirectly benefiting male nurses, are part-time work, out of hours shift work (evenings, nights and weekends), and career breaks to have children (Finlayson and Nazroo 1998, Whittock et al. 2002, Whittock and Leonard 2003). These traditional domestic arrangements that inhibit women in nursing are the same that support men and their careers. Married male nurses and their careers are supported by the inequalities in domestic labour where their wives take up the majority of the domestic work (Evans 1997, Whittock et al. 2002).

According to Williams (1995) and Evans (1997), male nurses are advantaged in hiring and promotion, in developing relationships with physicians and colleagues, and in relationships with patients. In two US studies Williams (1992, 1995) found an organizational preference for the hiring of men in female occupations. Yet this advantage does not extend to all subspecialties within nursing. Men are actively
'tracked' into practice areas considered appropriate for men and are barred or actively dissuaded from female-identified specialties such as obstetrics and gynaecology (Jenny 1975, Brown 1986, Brown 1987, Gans 1987, Williams 1992, Williams 1995, Soerlie et al. 1997, Poliafico 1998, Whittock and Leonard 2003, Wilson 2005, Cornforth and Ashurst 2006). For example, the California Fair Employment and Housing Commission in 1994 upheld a ban on male nurses from working in labour and delivery suites at San Bernardino hospital (Letizia 1994). Again in 1994, Bruce Wheatley filed complaints with the Equal Employment Opportunity Commission in Florida after two Florida hospitals refused his employment in maternity units because of his sex (Nelson and Belcher 2006). In this case the ruling was in favor of Wheatley. In addition, male nurses were actively prevented from joining the nursing division of the Canadian military (Care et al. 1996).

Evans (1997) suggests that male nurses choose areas of practice that are compatible with the male character (strength, technical prowess and autonomy) and have lower identification with the “feminine” nursing traits. Lo and Brown (1999) examined the career aspirations of Australian male and female nursing students and found that males were interested in future careers in acute care areas (intensive care, emergency and operating room), community health, mental health and nurse education. Female students were more interested in obstetrics, pediatrics and community nursing.

Men are subjected to disincentives and incentives that pull them away from the bedside and push them towards administration (Gans 1987, Porter-O’Grady 1995, Soerlie et al. 1997). Men are promoted in the process. Yet this process does not occur at all levels. Williams (1995) argued that these advantages only extend to those who exhibit conventional masculine characteristics and do not extend to men in nursing academia, nor to gay men. Soerlie et al. (1997), in a study of Norwegian male nurses, found that males experienced conflict because other people expected them to behave in stereotypically masculine ways. They were excluded from participating in caregiving activities and everyday bed-side nursing, and were expected to take up administrative roles.
Floge and Merrill (1986) examined the token status of 7 male nurses and 3 female physicians employed at one of two hospitals in the northeastern US. They used participant observation and individual interviews as data sources. They reported that female nurses, patients, and supervisors assign male status characteristics, such as authority, competence and leadership, to male nurses. Jinks (1993) in a UK survey of 100 student nurses found that male and female nursing students felt males were more independent and were better leaders. According to Floge and Merrill (1986) these positive expectation states associated with males caused male nurses to be seen as better workers. According to Evans (1997), the positive valuing of “masculine” characteristics places men in an advantaged position, which assists in the promotion of men into leadership positions. However, Jinks and Bradley (2004) in a replication of their 1992 study found student nurses disagreed with the statements that males were more independent and make better leaders. Perhaps traits such as independence are no longer seen as masculine, rather are more socially desirable for both males and females.

The “token” status of male nurses places them in a position of high visibility, which places performance pressures on them (Gans 1987, Heikes 1991, Paterson et al. 1996). Heikes (1991) conducted in-depth interviews with fifteen male nurses employed in a hospital in Austin, Texas and found that despite having an increased visibility because of their minority status, male nurses do not attempt to limit their visibility. Rather they attempt to overachieve in performance and use their increased visibility to bring their performance to the attention of others. As a result, accomplishments of male tokens are noticed (Floge and Merrill 1986, Gans 1987, Heikes 1991). In an attempt to identify the dynamics that account for differences in male and female career advancement and attainment Gans (1987) interviewed 25 male and 25 female registered nurses employed in Chicago hospitals. The male subjects in Gans’ study found the increased visibility to be advantageous despite the performance pressures. With the increased visibility their clinical performances were noticed, often admired, and they were used by female peers for clinical advice and assistance. According to Gans this assisted men to refine their clinical skills, and inadvertently to develop leadership skills. Being visible and subject to performance
pressures, move men toward leadership roles. The men in this study were socialized from early on in their careers toward administration.

The literature is less clear regarding the evidence for Kanter’s dynamic of polarization. The low number of men in nursing contributes to the social isolation of some men. Not having other men in the work environment is a source of strain for these men (Egeland and Brown 1988, Cyr 1992, Villeneuve 1994). The literature generally reports positive attitudes and acceptance of males in nursing by female nurses (Fottler 1976, Williams 1989, Lo and Brown 1999, McMillian 2006). Yet some contest this (Jenny 1975, Soerlie et al. 1997). Whilst female nurses report acceptance of male nurses into the profession, male nurses report a problem of non-acceptance (Jenny 1976, Soerlie et al. 1997). Age, marital status and working with male nurses have been identified as significant influencing factors in the attitude of female nurses towards men in nursing. McMillian et al. (2006) surveyed 105 female registered nurses from rural and urban areas from a large Midwestern state of the US, and found equal numbers of participants indicating low and high levels of acceptance of male nurses. Regression analysis indicated that the number of years worked with male nurses was the only predictive demographic. Working with males over time increased acceptance, but this only accounted for 6.8% of the variance. Age, years of registration, population of the town and number of employees in the place of employment had little effect on acceptance of male nurses (McMillian et al. 2006).

Several ethnographic studies, using different sources of data such as participant observation, in-depth interviews and focus group interviews, suggest that male nurses are excluded from interpersonal relationships and isolated from female nurse social networks (Williams 1995). Male nurses are excluded from female centered conversation and verbal interaction (Floge and Merrill 1986, Heikes 1991, Kelly et al. 1996) and from female dominated social activities (Heikes 1991). The exclusion of male nurses from female social networks, especially in networks where female nurse managers were engaged, can lead to men being excluded from participating in decision making and therefore being disadvantaged bureaucratically (Floge and Merrill 1986, Heikes 1991). Williams (1989) interviewed 21 male nurses and
surveyed 27 other male nurses predominantly from the San Francisco Bay Area in the US. She claims that males exclude themselves from female social networks as they were not interested in female discourse. By doing this, male nurses set themselves apart from female nurses, establishing a masculine identity by distancing themselves from the feminine. In a later study where she interviewed 32 male nurses from major cities across the US, Williams (1995) found that there was variability in the attendance of male nurses at informal female centered social events. In some cases she found males to be excluded from friendship networks. It is difficult to establish from these studies, the degree to which male nurses distance themselves from social networks and the degree to which they are excluded.

Gans (1987) found that some male nurses and their careers were supported and groomed by female peers. Williams (1992) found that in several instances female nurses facilitated the career of male nurses; however male nurses also reported being “shutout” of decision making. The perception that males have an advantage sometimes triggers hostility and resentment in some females which is directed towards their male peers (Gans 1987, Williams 1989, Brooks et al. 1996, Soerlie et al. 1997).

The literature suggests that male nurses have a better rapport with physicians (Segal 1962, Floge and Merrill 1986, Gans 1987, Ott 1989, Williams 1989, Williams 1995, Isaacs and Poole 1996) and that special treatment from physicians enhanced their careers (Floge and Merrill 1986, Gans 1987, Ott 1989, Williams 1989, Williams 1995). For instance doctors were more likely to listen to advice from male nurses (Williams 1989, Isaacs and Poole 1996). In addition, male nurses were likely to experience less physical and verbal abuse from doctors (Williams 1995). According to Floge and Merrill (1986), Gans (1987), Williams (1989) and Williams (1995), physician’s direct evaluations of nurses indirectly determine nursing positions, through their influence over promotion and demotion decisions.

The token dynamic of assimilation is concerned with the perceived fit of the individual’s characteristics with the existing stereotypes of the dominants (Heikes

The literature supports the view that the public perceptions of males in nursing are generally positive and accepting (Villeneuve 1994, Lo and Brown 1999). However, when the acceptability of male nurses was compared with the acceptability of female nurses or males and females from other disciplines, male nurses were not as acceptable (Hesselbart 1977, Laroche and Livneh 1983, Decker 1986, Rallis 1990).

Decker (1986) surveyed 56 university students enrolled in a lower-division management course and 56 high school students in their 10th grade from a major city in the southeast of the US. They tested the students’ ratings of three occupations, comparing males with females from nursing, teaching, computer professionals and the average person, for effectiveness, autonomy and acceptability. Male subjects perceived male nurses less favorably than female subjects did. Females rated male nurses significantly higher than the average male on all dimensions, whereas males rated them no higher than the average male. Male nurses were not rated as high as female nurses for acceptability.

These findings were consistent with earlier studies. Laroche and Livneh (1983) in a US study of 174 respondents examined the relationship of six demographic variables to the acceptance of men in nursing. They found that the acceptability of males in nursing was influenced by the sex and education of the research subject. Women and
the higher educated were more accepting of male nurses than males generally (Laroche and Livneh 1983). In a US study, Hesselbart (1977) examined the attitudes of students from a Mississippi high school towards male and female medical and nursing students. She found that male and female medical students were positively rated as competent. However, male nurses were rated negatively as being “unattractive, unrealistic, and unambitious”. Berkley and Kohler (1992) in a US study surveyed 126 male teenage high school students and found that the nursing profession and nurses of both sexes were rated positively. Yet 27% of respondents believed that only women should be nurses. Only seven of the 126 respondents stated that they were definitely considering nursing as a future career.

Lo and Brown (1999) surveyed 38 male and 117 female nursing students enrolled in a rural Australian university to identify their perceptions of the public image of men in nursing. They found that female nursing students believe male nurses are sometimes viewed by the public as being homosexual and feminine. Female nursing students suggest that society views nursing as being a women’s career, yet some discrete areas of nursing practice were acceptable for men (Lo and Brown 1999). Male nursing students were more ambiguous, suggesting that there was a generational or age effect on the perception of men in nursing. Male students believe that the public image is changing with younger men being more accepting of male nurses. But some students believed that the public views nursing as “not a man’s job” (Lo and Brown 1999). Kelly et al.’s (1996) study was less positive regarding male student’s perceptions of the public’s perception of men in nursing. Male students felt that the public view nursing as mundane; under somebody’s direction; lacking in autonomy; and subservient (Kelly et al. 1996).

To sum up this mass of research findings: whilst women are supportive and accepting of men in nursing, this appears not to be the case for men. Nursing as a career for men is not as socially acceptable as it is for women or for other disciplines, and can lead to “role traps” for men. These studies support the view that nursing is socially constructed as a feminine profession, most suitable for females. Nursing as a profession for men challenges the notion of traditional gender roles and contradicts
the ideology of the dominant forms of masculinity. Due to nursing being culturally constructed as feminine and contradicting contemporary dominant masculinities, men fail to legitimize nursing as a suitable career for men.

**Barriers to male recruitment into nursing**

Now let us look at the evidence about recruitment of men into nursing. Unlike most male dominated professions where the proportion of females has significantly increased, nursing has failed to increase the proportion of men. Over the past decade in NSW there has been a real increase in the number of men entering nursing, however the percentage of the registered nurse workforce who are male has only marginally increased: from 7.5% in 1993 to 8.1% in 2003 (NSW Health Department 2003).


Alternatively, the stereotyping of male nurses as being masculine becomes problematic, as they are perceived to contradict the feminized cultural construction of nursing (Soerlie et al. 1997). This may account for the difference in public acceptance of male and female nurses.

Galbraith (1991) in a US study found that male nurses (and men in early childhood education) are more focused on relationship-oriented components of their career (relationships with peers, clients and in general) compared to men in traditional occupations. But nurses and other men did not differ in how they rated the importance of external factors such as income, power and prestige in their career. Romem and Anson (2005) in an Israeli study found that women emphasized more than men the importance of internal rewards such as helping others. They found no gender differences in the importance of external factors such as economic security, as motivating factors for choosing nursing as a career.
Few studies have examined the socio-demographic characteristics of men who enter nursing. It appears that men in nursing are more likely to come from marginal social groups and are more likely to be from native or immigrant backgrounds. In an Israeli study, Jewish Israeli men were proportionately underrepresented in nursing and veterans who immigrated to Israel prior to 1989 were over represented (Romem and Anson 2005). Burns (1998) provides a comprehensive historical account of how apartheid, gender politics and industrial nursing in South Africa has structured nursing as a segregated discipline, where male nurses are predominantly black men. However, this situation does not appear in the United States. In the US, white males account for over 85% of the male nurse workforce (Himmelstein 1996, Wenzel and Utz 2002). In a US study of males seeking employment in female-dominant jobs, males who seek female jobs were less likely married, with lower family income and are likely to be the sole contributor to family income (Williams and Villemez 1993). The majority of men employed in female jobs did not seek employment in the area, but were diverted into it. This is what Williams and Villemez (1993) calls the “trapdoor effect”. A striking ethnic difference appears between those who sought employment in female jobs and those that were diverted; 27% of those who were diverted were from a minority race, while 0% of seekers were (Williams and Villemez 1993). Williams and Villemez (1993 70) conclude that “men who seek female jobs are in different social and structural positions than men who seek more male jobs, and may be more prone to different types of social control”. Therefore, the low levels of minority men in nursing in US society could, in part, be explained by their unwillingness to do women’s work so as to preserve their traditional masculine identity. I have found no studies that examine the class roots and socioeconomic status of men as they enter nursing.
The nursing literature has attempted to locate the position of men in the nursing profession. The literature on men in nursing involves two opposing epistemological positions. Many have used a critical feminist methodology to identify the advantages of male nurses, by examining the structures that advantage men in society. Without dispute, as a population, male nurses have an advantage in career progression and development. The limitations of these studies are grounded in their epistemological, theoretical and methodological frameworks. These studies failed to use a gender framework that examines multiplicities in masculinity and femininity. They position all men as having the same degree of advantage and women as being subordinate to all men. They also fail to examine gender relations. These studies treat male nurses as a collective, having the same ambitions, desires and practices, therefore ignoring the differences in social practice between men. Female researchers of men in nursing have neglected to analyse the impact of female nurses on gender relations with male nurses. Their analyses ignore the degree of agency women and men have in gender politics in nursing. The studies have failed to examine the advantages of women in senior nursing positions and their relations with men and other women. Groups of women in senior nursing positions may have similar structural advantages as those of men but have not been studied.

Studies of men in nursing conducted by men also have epistemological and methodological problems. In the absence of a gender framework, these studies fail to challenge hegemony and the subsequent masculine privilege awarded to male nurses. As a result, these studies concentrate on the disadvantages and difficulties male nurses face. No studies were found that examine gender relations of male nurses in contexts outside of nursing. How male nurses construct masculinity has not been explored. This thesis sets out to examine the position of male nurses within the gender order by examining gender relations from a pro-feminist standpoint.

**Men’s Bodies and the Gendered Division of Labour in Nursing**

The biological difference of men’s bodies is a major determinant of the gender division of nursing work. The sexual nature of men’s bodies, size, muscle mass, and strength contribute to the gender division of nursing labour along two lines. Firstly,
the sexual body stifles the provision of care by male nurses to female patients, creating a sex matching allocation of nursing work. Secondly, the physical strength of men leads to an informal division of labour where men disproportionately contribute to heavy manual work and providing security services. Each of these will now be examined in more detail.

Male Nursing Care

The perception of the male body as being sexual, produces difficulties for male nurse care. Despite male nurses being motivated by altruism and caring for their patients in an equally committed fashion to females (Ekstrom 1999, Boughn 2001), the sexed body becomes a determinant of the division of nursing labour and hinders the provision of male nurse care. Disproportionately allocating male nurses to the care of male patients, and giving female patients an opt-out clause from male nurse care may be seen as discriminatory (Waters 2006, Cornforth and Ashurst 2006). The allocation of patients based on sex of the nurse is predominantly an issue for male nurses and does not occur to the same extent for female nurses. This is due to the majority proportion of female nurses, where it is perceived to be acceptable for them to care for male patients (Waters 2006). There appears to be a view that male patients are more accepting of female nurse care, than female patients are of male nurse care. This is sustained by hospital policies that prevent male nurses from catheterizing female patients but do not restrict female nurses from catheterizing male patients (Waters 2006) and requiring chaperoning for male nurses when dealing with female patients (Newbold 1984, Waters 2006).

The motives of men who work with female patients are often questioned. Jane Salvage, nursing director Emap Healthcare and columnist, in an opinion piece in Nursing Times (2000) questions men’s motives for wanting to care for females in obstetrics and gynaecology, calling it “odd” and “weird” that men would want to. Salvage is “puzzled” by gynecologists and male midwives and sets them up as sexual and oppressive deviants. To make this point Salvage refers to a male nurse murder case and refers to abuses of men against women in general and attempts to transfer these onto male nurses by saying that nursing provides opportunities to repeat such
abuses. Salvage’s (2000) claims are discriminatory and may reflect the views held by some in the profession. Such statements are designed to maintain a female dominance in these areas of practice.

There is significant evidence that gender differences in patient preference for a same-sex nurse exists (Chur-Hansen 2002; Lodge, Mallett, Blake and Fryatt 1997; Brooks and Phillips 1996). In a longitudinal study by Chur-Hansen (2002), in intimate situations female patients had a significantly stronger preference for a same-sex nurse, as where males tended to have no preference. In studies investigating how male nursing students learn to care, students identified differences in the way males and females care (Patterson et al. 1998; Poole and Isaacs 1997). According to Poole and Isaacs (1997) when a nurse conducts intimate body care on those of the opposite sex, the cultural boundaries that delineate social relations are crossed, redefined and changed. Poole and Isaacs (1997) highlight that in the social construction of the nurse as female, caring is seen to be natural for women, tending and nurturing are seen as intrinsic parts of a woman’s identity, and this is not so for men. As a result there is an acceptance of female nurse/male patient interaction and little embarrassment is caused by the intimacy of the act. This is not the case for male nurses. The social construction of the nurse as feminine creates barriers for male nurses and their ability to provide care.

Gender differences were found in self-reported nurse care behaviours: male nurses were less likely to perform comforting behaviours (Greenhalgh, Vanhanen and Kyngas 1998). In Ekstrom’s (1999) study, gender differences in caring behaviours were not found. However, patient and female nurse expectations of male nurse care were less than for female nurses. Ekstrom (1999) in a study conducted in the US, examined the effect of gender on nurse and patient perceptions of nurse caring. One hundred and forty five nurse-patient dyads, in an equal distribution across four possible gender combinations (male nurse/male patient; male nurse/female patient; female nurse/male patient; female nurse/female patient), were surveyed following a work shift. In actual care delivered, no difference was found between male and female nurses. However, expectations of certain caring behaviours, such as nurturing,
were significantly lower for male nurses. Jinks (1993) found that female nursing students believed women were more affectionate and caring, and make better nurses, although this was not as strong a belief in a later study (96% of females in 1992 compared with 47% in 2004) (Jinks and Bradley 2004). These studies demonstrate that the ascribing of gender characteristics as traditional gender norms, serve to reinforce gender stereotypes, for example, men’s inability to care. Such norms are socially constructed, but can be contested. This is evidenced by the difference in expected and actual care behaviours of men in Ekstrom’s (1999) study.

In fact, the normalization of gender characteristics possibly hinders men’s access when attempting to provide care. Milligan (2001) used ontological hermeneutics to explore the concept of care in male nurse work. Male nurses reported that their sex restricted their access to patients. The participants found that patients identified them firstly as male and secondly as a nurse.

The sexuality associated with men’s bodies and its hindrance to male nurse care is brought out strongly in studies with female gynaecological and obstetric patients. Two UK studies conducted in the 1980’s found that males in midwifery were generally accepted by female patients. However, specific procedures (checking of sanitary pads, examining vaginal sutures and breast care) created concern for women (Newbold 1984, Cooper 1987). Morin et al. (1999), in a US ethnographic study using a sample of 32 women, found that women’s acceptance of male nursing students’ care was dependent on their sense of self and personal feelings, in addition to contextual factors. Psychological comfort and feelings of “embarrassment, vulnerability and distress” were given as reasons for the refusal of male care. Contextual factors that impact on a woman’s acceptance of male student care identified by Morin et al. (1999) included the student’s characteristics, establishment of relationships, nursing care activities and partner viewpoint. Women were more interactive with older, married men who had children of their own rather than with young single men. The women participants felt they could be more open and trusting of female nurses and that they could relate better with them. They also expressed a clear delineation of the activities that they would allow males to undertake. Where
the activity involved the exposure or touching of a female sexual organ, such as breast feeding or perineal toilets, males were not permitted. The partners’ comfort with a male student nurse was also found to be a factor in women’s acceptance of male nurse care.

In a survey of 91 gynaecological patients in the UK, Lodge et al. (1997) aimed to identify perceived embarrassment of female gynaecological patients with physical and psychological care from male and female nurses. Not surprisingly, a statistical difference in sex of nurse was found with high levels of perceived embarrassment associated with semi-intimate (undressing and exposing underwear) and intimate (involving exposing genitalia) male nurse care. Similar results were found with discussing sensitive or intimate topics such as patient hygiene and sexual function. Qualifying comments suggest that the age of male nurses may impact on the patient’s acceptance of their care. Views that female nurses were more able to share the patient’s experiences were used by some to justify their preference for female nurses. One comment questioned men’s motives for engaging in female care, suggesting some form of sexual deviant behavior, a view similar to that of Salvage (2000). Comments suggest that women do not hold similar levels of perceived embarrassment with male doctors. Patient preferences for male or female nurses were not correlated with patient age, religion, social standing or diagnosis. Previous patient admissions and not being in a relationship were associated with less embarrassment with male nurse care. Results indicate that women initially construct their views of male nurse care in bodily terms, and their preference for female care centres on essentialist views of gender. However, these constructions of gender become contested when female patients experience care from male nurses, and they become more accepting of their care.

In order to provide care to both male and female patients, male nurses have to combat on a daily basis both the sexual deviant and homosexual tags (Evans 2002). A phenomenological study that examined how male nursing students learn to care found that the expectations of care behaviour were ‘feminized’ manifestations, where the open display of emotions and touch were effeminate and emasculating (Paterson
et al. 1996). Male students learnt to negotiate a form of caring, different from that of female caring, 'less touchy feely' but none the less connected as a 'reciprocal friendship' (Paterson et al. 1996 36). Evans' (2002) study of Canadian male nurses confirmed that male nurse and female nurse caring were different, but did not explain how. What is evident is the problematic nature of men's touch. For male nurses the stereotypes of men as sexually aggressive and homosexual sexualize male nurses’ touch (Paterson 1996, Evans 2002). Male nurses are cautious when touching patients for fear of potential misunderstandings and accusations. To prevent these, male nurses learn when it is safe to touch and develop strategies to protect themselves (Evan’s 2002). Evans (2000) suggests that the problem of male nurse touch becomes a driving force for men to gravitate to low touch specialties. In addition, the difference in men’s construct of caring aims to further distinguish them from female care, therefore maintains their masculinity (Evans 2002).

In summary, the contradiction of male bodies and the social construction of nursing as feminine, in a context of essentialist gender ideology, creates tensions and inhibit male nurses from providing nursing care. These contentions produce different expectations of male nurse care compared to that expected of female nurses. As a result, male nurses learn to provide care in a safe and non threatening manner.

Men doing the manual work
An extensive literature search found only one study (Evans 2004) that examines the experiences of men in the division of nursing work. Several studies examining the broader experiences of men in nursing report male nurses being associated with manual handling, including doing more lifting and dealing with confused or physically threatening patients (Heikes 1991, Milligan 2001).

Heikes (1991), who interviewed men from Texas in order to examine the token status of men in nursing found that one of the role traps for male nurses was that of the ‘He-Man’. This refers to the common practice of placing male nurses in positions that involve manual work like lifting and moving. Respondents claimed that this role was expected in orthopaedics and psychiatric nursing, but outside these areas the role was
burdensome since it increased their work loads. Yet the respondents claimed that they assisted upon request.

Williams (1989) claims that the ‘He-Man’ role is constructed by male nurses to establish or prove their masculinity in an environment that brings it into question. Heikes refutes this, claiming that the role is not wanted by men. This is supported by a US phenomenological study investigating the anger experiences of men in their working situations as nurses. Brooks et al. (1996) found that being identified as a source of physical strength and called upon to do physical tasks, rather than for their nursing knowledge, was a major source of frustration and anger for their participants. The notion that female nurses value male nurses for their strength rather than their knowledge was also a major finding of Cyr (1992).

Evans (2004) interviewed eight male nurses from Nova Scotia, Canada to examine the experiences of men in nursing, and the role male nurses expect and are expected to assume by virtue of being men. Evans’ results confirmed the existence of the ‘He-Man’ role where patient allocation, and therefore the distribution of labour, was associated with male nurses’ physical strength. In addition, Evans identified the ‘Enforcer’ role – the use of physical strength to enforce safety and good behaviour. According to Evans, both roles involve advantage and disadvantage for men nurses. The advantages for male nurses are the affirmation of their masculinity and the identification of a unique contribution they make to nursing. For some participants in her study the roles of ‘He-Man’ and ‘Enforcer’ made them feel more valued, accepted and appreciated. The disadvantages are the frustration and resentment of men as they felt taken for granted in doing ‘muscle work’, along with an increase in work load. More often the participants felt the expectations to intervene in violent situations were burdensome and stressful. Such roles are often institutionally sanctioned, where meal breaks and shift assignment centre on the institution’s need of physical labour.
Gender and Sex-Role Characteristics


Despite an abundance of studies investigating psychological sex characteristics in nurses, the results reported in the nursing literature are unclear and are contradictory. Like the general literature, the results on nurses are not definitive; some studies indicating no sex differences for masculinity and femininity (Pontin 1988, Sprouse 1987, Fisher 1999) and others reporting a sex difference (McCutcheon 1996). Few studies report role strain associated with being a male nurse. The results of the studies are further blurred by methodological concerns, such as small sample sizes and validity issues of scales. I will now examine the sex difference literature on sex characteristics of nurses and attempt to unravel the methodological issues associated with the studies.

There continue to be assumptions within the nursing literature that nursing is synonymous with femininity. Occupations like nursing are considered more appropriate for females and elicit role strain in males (Egeland and Brown 1988, Fitzgerald 1995, Williams 1995). The ability of males to assume the feminine sex role identity expected of nurses, has become a point of contention. According to Evans (1997 p.226) “the incompatibility of masculine and feminine sex role identities, coupled with the fact that increasing numbers of men are now entering the nursing profession, prompts questions as to how men adapt to nursing’s
quintessential feminine sex role". Evans' (1997) stance is based on a dichotomy man-masculine vis a vis woman-feminine. The notion that male nurses are in sex role conflict and that male nurses separate their masculine sex role identity from the feminine image of nursing assumes that masculinity and femininity are at opposite ends of a simple sex role continuum. It is true, as shown earlier, that there is a symbolic link between nursing and femininity. It may still be argued, using androgyny theory and the concept of multiple masculinities, that it is possible for male nurses to possess personal attributes consistent with the 'feminine' occupational demands of nursing.

Pontin (1988) compared 25 male and 25 female UK nurses using the Bem Sex Role Inventory (BSRI) and found no significant difference between the male and female groups. Both groups displayed a tendency towards androgyny. The male group scored higher on both the masculine and androgyny indices and the female group scored higher on the feminine index. Fisher (1999) in an Australian study and Sprouse (1987) in a US study, both using the BSRI, found no statistical difference between male and female nurses in sex type. These authors too identified androgyny as the prominent sex role classification. The difficulty with the interpretation of these studies is their small sample sizes and the failure to establish statistical power. In contrast to these studies, McCutcheon (1996) gives no support to the hypothesis that male nurses possess feminine sex role characteristics. In a study comparing 66 female nurses with 56 male nurses from Florida US using the long version of the Bem Sex Role Inventory, McCutcheon (1996) found that female nurses were more likely to be androgynous or to be sex typed feminine and male nurses were more likely to be sex typed masculine or be undifferentiated.

In an attempt to determine whether nursing 'feminises' male nurses, McCutcheon (1996) compared the results of her study with a study by Culkin et al. (1987) which investigated the sex role orientation of nursing students. McCutcheon (1996) found the male nursing students from the Culkin et al. study to be more feminine in orientation, with more male students being androgynous or cross-typed, than her male sample. McCutcheon (1996) concluded cautiously that nursing does not
feminize male nurses. Sprouse (1987) compared sex role characteristics using the BSRI between male and female nursing students and male and female nurse experts. He found a significant difference between students and experts, with students categorised as feminine and experts more likely to be masculine, regardless of the sex of the individual. Even though one’s sex role identity may change during one’s life time (Cunningham and Antill 1984), sex typing occurs from an early age (Cook 1985). Rather than male nurses being feminized by nursing, one could expect nursing to attract males who have a feminine orientation.

To determine student perceptions of the ‘ideal nurse’, Minnigerode et al. (1978) using the Personal Attributes Questionnaire (PAQ) surveyed 186 US nursing students, of whom 172 were female. The ‘ideal nurse’ was described as highly feminine and highly masculine, that is, psychologically androgynous rather than sex typed. In a study of Chinese Hong Kong nurses, Holroyd et al. (2002) examined 177 pre-registration and postgraduate student nurses’ perceptions of sex role characteristics of their ‘ideal nurse’, the ‘typical Chinese nurse’ and self ratings. Holroyd et al. (2002) found in the combined sample no difference in male and female students’ ratings of gender characteristics for the ‘ideal nurse’, the ‘typical nurse’, or self ratings. As in Minnigerode et al.’s (1978) study, the androgynous nurse was described by students as the ‘ideal nurse’. Students rated the ‘typical Chinese nurse’ as being lower than the ‘ideal nurse’ in the masculine dimensions, and are consistent with the ratings for the typical Chinese female in society. In part the difference between the ‘ideal nurse’ and the ‘typical Chinese nurse’ may be accounted for by slight differences in ratings on the masculine dimensions for the ‘ideal nurse’ in male and female student sub-samples (pre-registration and postgraduate), where male students tended to have slightly higher scores. However, as a total sample no significant difference was found between male and female students for the ‘ideal nurse’, indicating they had a shared view of the ideal nurse (Holroyd et al. 2002). Similar findings were reported in a US study by Sprouse (1987).
According to some, the conflict between occupational role and gender identity often produces role strain in male nurses (Davis-Martin 1984, Egeland and Brown 1988, Fitzgerald 1995, Cummings 1995). When individuals violate the traditional sex role for their sex, they may feel personally inadequate and insecure (Pleck, 1981). O'Heron and Orlofsky (1990) in a US study found that men who were low in masculine characteristics were less well adjusted on measures of depression, anxiety, and social maladjustment. These findings are supported by an Israeli study of 154 male registered nurses (Krausz et al. 1992). Krausz et al. found that even in a female dominated profession, males with high scores of masculinity and low scores of femininity as measured by the Bem Sex Role Inventory had high levels of adjustment and well being, and expressed less distress. Masculine and androgynous typed men were more satisfied with work compared with feminine and undifferentiated typed men. In comparison, Krausz et al. (1992) did not find the same results in female nurses. This is probably due to the small number of females in their groups (Krausz et al. 1992). These findings are not surprising considering the nature of the items that construct Bem's (1974) masculine and feminine scales. This will be discussed further.

Jacobson (1985) in a US study using the BSRI, the Maferr Inventory of Feminine Values and the Zung Self-Rating Depression Scale surveyed 203 female nurses and found an association of depression with the feminine sex role and a negative correlation of depressive symptoms with masculine and androgynous traits. In a US study where the PAQ and Rotter's Locus of Control Scale were used to survey 98 female registered nurses by Napholz (1992), androgynous and cross typed masculine female nurses were associated with an internal locus of control, whilst undifferentiated and sex typed feminine females were associated with external locus of control, yet these results were not statistically significant. This again is possibly due to small sample sizes in the masculine and feminine sex typed groups (n= 19 and n= 19 respectively). These results suggest that masculine characteristics are associated with high levels of adjustment and well being (Krausz et al. 1992), lower levels of depression (Jacobson 1985) and an internal locus of control (Napholz 1992). The two later studies demonstrate that females who do not conform to traditional sex
role are more likely to be better adjusted, similarly to the men in the Krausz et al. (1992) study. The masculine items on sex role scales (eg. independent, assertive, and leadership) may be more positive, and therefore socially desirable, than feminine items. It appears that it may be the characteristics of the items that construct masculinity and femininity scales and not the lack of conformity to one’s sex specific sex type that determines role strain in male nurses.

Egeland and Brown (1988; 1989) examined role strain in 367 male registered nurses. Egeland and Brown’s (1988) descriptive study aimed to explore self perceptions of the hypothesized incongruities between their roles as men and their roles as practising nurses. Such a theoretical framework relies heavily on the assumption that masculine characteristics are in opposition to the characteristics of nurses. Not surprisingly the authors found that the participants as a group only reported mild role strain associated with being a male nurse. The major factors creating role strain in these men included: lack of pay, social isolation from other men and the performance of body care on women, yet according to the participants in this study this was easily overcome. These findings are consistent with Greenberg and Levine (1971). Egeland and Brown (1988) concluded that it is possible that nursing is not synonymous with stereotypical female characteristics, but is consistent with androgynous characteristics.

Due to the disproportionate representation of males in certain specialty areas of nursing practice, it has been hypothesized that male nurses may be less likely to suffer role strain in certain “masculine” specialised nursing positions (administration, emergency, critical care, operating room, and mental health), because of the perceived masculine role, when compared to other nursing specialties, such as midwifery or paediatric nursing (Greenberg and Levine 1971, Davis-Martin 1984, Egeland and Brown 1988, Fitzgerald 1995). However, specialty choice as a strategy to reduce role strain is not substantiated (Egeland and Brown 1988).

With most of the positivist attempts to determine difference using self-response sex role scales, there has been an inability to demonstrate sex differences within nursing.
Over the past three decades there has been a growing body of literature that questioned the construct validity of these scales. Many of the studies examining sex roles in nursing (Sprouse 1987, Pontin 1988, McCutcheon 1997, Fisher 1999) have used the Bem Sex Role Inventory (BSRI) to determine sex difference in nurses. Discrepancies have been identified in the construct validity and internal consistency of this instrument (Waters et al. 1977, Pedhazur and Tetenbaum 1979, Ratcliffe and Conley 1981, Ruch 1984, Wong et al. 1990, Brems and Johnson 1990, Ballard-Reisch and Elton 1992). Choi and Fuqua (2003) reviewed 23 factor analytic validation studies of the BSRI and found that the factor structure of the scale is more complex than the originally proposed two factor structure and the masculinity items have more factorially complex tendencies. They conclude that masculinity and femininity have not been adequately operationalized by the Bem Sex Role Inventory. Few of the sex difference studies on nurses have examined the factor structure or the internal consistency reliability of the Bem Sex Role Inventory. One study which did (Fisher 1999) explored the short version of the BSRI and found a simple two factor structure confirming the construct validity of the masculinity and femininity subscales. From the general literature on the BSRI, however, the value of the scale remains in question.

This study sets out to overcome the methodological weaknesses of the aforementioned studies. The research procedure set out in Chapter three includes the use of large sample sizes to achieve statistical power in order to prevent type two statistical errors. In addition, factor analysis was used to confirm the underlying constructs of the sex role scales and factor scores were used for analysis to decrease the amount of error variance in the measures. In achieving this, inferences regarding sex differences in gender characteristics can be made.
CHAPTER 3
Research Method: Self-Reported Gender Descriptions

Introduction
This chapter outlines the methods used in a cross-sectional survey, of which the results are presented in chapters 4 and 5. The cross-sectional survey was used to examine gender characteristics across three samples: male nurses, male engineers and female nurses. The purpose of this study was to examine gender characteristics across samples to determine if differences occur: 1) between two occupational groups, one typically predominantly male and the other predominantly female; and 2) between males and females within the nursing profession.

Male engineers were considered a suitable comparative group as engineering remains a predominantly male occupation that is seen to be traditionally masculine. The use of male engineers provides a traditional masculine group to compare with male and female nurse samples. This three way comparison allows conclusions to be drawn regarding the assumptions about gender characteristics, sex of individuals and occupations, particularly nursing.

Specifically the objectives of this part of the project were to:
1. Document the self-reported gender descriptions of participating registered nurses;
2. Ascertain differences in self-reported gender descriptions between male and female nurses;
3. Determine if there are any differences in self-reported gender descriptions between the nurse samples and male engineers;
4. Identify common perceptions and stereotypes of male nurses.

Instruments
The questionnaire consisted of 3 sections. Section A contained biographical data and occupational information. This section also contained the Kinsey (1948) scale of Homosexuality. Section B contained items from two scales, The Bern Sex Role Inventory (short version) and the Australian Sex Role Scale, that measured sex-role characteristics. Section C contained additional items to determine perceptions of males in nursing. The instrument is presented in Appendix A.
The Bern Sex Role Inventory (BSRI)
The short version of the BSRI consists of thirty items measuring personality characteristics, 10 of which were stereotypically feminine, 10 stereotypically masculine and 10 characteristics were filler items. The participants were asked to indicate on a seven point Likert scale how well each characteristic describes them. The scale ranged from 1 (never or almost never true) to 7 (always or almost always true). Each subject's femininity and masculinity score was obtained by calculating the mean score of the femininity and masculinity scales respectively. The median split method described by Bern (1976) was used to determine the sex type category for each individual.

According to Bern (1981) the BSRI is comprised of two independent unipolar constructs, masculine and feminine, rather than a single bipolar dimension. Difficulties have arisen in attempts to validate the two-factor structure of the long version of the BSRI using Principal Component and Factor analytic methods (Waters et al. 1977, Pedhazur and Tetenbaum 1979, Ratcliffe and Conley 1981, Ruch 1984, Wong et al. 1990, Brems and Johnson 1990, Ballard-Reisch and Elton 1992). The short version of the BSRI is more homogenous and provides a good fit to the two-factor model (Martin and Ramanaiah 1989, Brems and Johnson 1990, Campbell et al. 1997, Fisher 1999). For this reason the BSRI short version was used in this study.

Consistent with the attempts to confirm the factor structure of the long and short versions of the BSRI, the short version yields more reliable scores (Antill and Russell 1980, Bern 1981, Campbell et al. 1997). The reported Cronbachs Coefficient Alpha for the BSRI short version in studies by Antill and Russell (1980), Bern (1981), Campbell et al. (1997), and Fisher (1999) ranged from 0.84 to 0.89 for the feminine scale and 0.78 to 0.86 for the masculine scale. The reported test-retest reliability correlation coefficients for the feminine and masculine scales of the short BSRI ranged from 0.85-0.91 and 0.76-0.91 respectively (Bern 1981).
Australian Sex Role Scale (ASRS)

Two parallel forms of the Australian Sex Role Scales (Form A and Form B) were developed by Antill et al. (1981) in response to a need to develop an Australian scale from an Australian population. Both of the Australian Sex Role Scales (ASRS) consists of 5 sub-scales of ten items each. The sub-scales consist of 10 positive and 10 negative masculine characteristics (M+ and M-), 10 positive and 10 negative feminine characteristics (F+ and F-) and 10 other socially desirable characteristics (S). Like the BSRI, participants were asked to indicate on a seven point Likert scale how well each characteristic describes them. The scale ranges from 1 (never or almost never true) to 7 (always or almost always true). Each subject’s femininity and masculinity score was obtained by adding the scores of the femininity and masculinity items respectively.

Form A of the ASRS was used in this study. Previous studies reported the coefficient alpha of the F- subscale of Form B to be too low (Antill et al. 1981, Hong et al. 1983, Russell and Antill 1983). Furthermore, the subscale intercorrelations between the F+ and F- subscales for Form B were also low (Antill et al. 1981, Hong et al. 1983, Russell and Antill 1983). Congruence across several studies in the factor structure, coefficient alphas and subscale intercorrelations supports the use of Form A of the ASRS (Antill et al. 1981, Hong et al. 1983, Russell and Antill 1983, Farnill and Ball 1985). The reported Cronbachs coefficient alpha for Form A of the ASRS in studies by Antill et al. (1981), Hong et al. (1983), Russell and Antill (1983), and Farnill and Ball (1985) ranged from 0.67 to 0.83 for the feminine scales and 0.61 to 0.84 for the masculine scales.
Sample Selection

The field procedure set out to contact a representative sample for each of the 3 groups: male registered nurses, female registered nurses and male engineers.

List A of the Nurses Register contains the names of persons who were previously (prior to 6 November 1987) registered as a general nurses, mental retardation nurses and psychiatric nurses; and those who have completed an approved (by the NSWNRB) pre-registration education program at a university or college of advanced education, including those who have completed equivalent courses interstate or overseas as outlined by the Nurses Act 1991 – section 18. In 1998 there were 73075 registered nurses on list A of the N.S.W Nurses Register, of which 66688 (91.3%) were female and 6387 (8.7%) were male (NSW Health Department 1998).

Both the male and female nursing samples were selected using a systematic sampling technique conducted by the NSW Nurses Registration Board (NSWNRB). The sampling fraction \( (k) \) method was used where the samples were taken from list A of the NSW Nurses Register on the basis that the sampling fraction was equal to \( N/n \), where \( N \) was the total number of male or female registered nurses on list A and \( n \) was the desired sample size. List A of the Nurses Register was sorted by sex and the two samples were selected independently. Both sample frames were then sorted by date of registration in ascending order from most to least recent. Starting from the first individual every \( k \)th person was selected in the sample.

The Institute of Engineers Australia is the major professional organisation for engineers in Australia, as well as the agency authorised to assess engineer qualifications for migrant purposes. The Institute is not a registration authority, however, members are bound to adhere to a code of ethics. The Institute is comprised of 6 discipline-based colleges (Civil, Mechanical, Electrical, Chemical, Biomedical and Structural) and 27 affiliated technical societies.

The male engineer sample was obtained from a list hired from Engineers Australia Pty Ltd, publishers of the magazine of the Institute of Engineers Australia. The
engineer sample was selected from the list of members of the Institute of Engineers Australia with NSW residential addresses. Like the nursing samples, the male engineer sample frame was sorted by date of membership in ascending order from most to least recent, then the engineer sample was selected using the sampling fraction \( (k) \) method described above. This sampling method automatically randomizes the sample for engineering discipline (civil, mechanical, electrical, chemical, biomedical and structural), membership status (Graduate, Member, Senior Member, Fellow, Honorary Fellow) and technical interest areas. The sample names and addresses were provided to the researcher on adhesive labels.

**Procedure for survey administration**

The questionnaires for the male and female nurse samples were distributed by post by the NSW Nurses Registration Board. The researcher was blind to any individual’s personal details for these samples. The questionnaires for the male engineer sample were distributed by post by the researcher after obtaining contact details from the Engineers Australia database. Each participant was sent an information sheet containing an invitation to participate (Appendix B), as well as, the questionnaire (Appendices C and D). Attached was a reply paid, return addressed envelope. At the completion of the questionnaire the participants returned the questionnaires using this envelope to a post office box in a self-addressed, reply paid envelope, supplied by the researcher. A follow-up letter or subsequent questionnaire mail-out was not possible due to the researcher being blind to the contact details of the nursing samples.

**Sample Obtained**

The response rate for this project was 25.4% \( (n=254) \), 31% \( (n=310) \) and 34.4% \( (n=344) \) for the male engineer, male nurse and female nurse samples respectively. These rates are comparable with similar research that utilized a single mail out without follow-up (Senn, Desmarias, Verberg, and Wood, 2000). There is evidence to suggest that response rates are lower when the survey investigates topics of sensitive material (Dillman, Sinclair and Clark, 1993), for example in this study sexuality and gender descriptions of self were under investigation. The gender
difference in response rates in this study is consistent with general survey trends, where males are less likely to respond to surveys regardless of the topic under investigation (Green, 1996, Green and Kvidahl, 1989, Bradburn, 1988).

A probability sampling selection method was used to select subjects from a sampling frame, which should give a representative sample. However, a response bias can not be ruled out due to the sample response rates. In order to check for biases in the sample obtained, comparisons with the population data have been made. The male and female nurse samples were compared with the New South Wales nurse workforce in age, type of work and principal area of nursing practice. The male engineer sample was compared with the male NSW membership of the Institute of Engineers Australia in age and engineer discipline.

Table 1 compares the male and female nurse samples with the entire NSW Nursing workforce in age. It appears that age influenced the response rates differently for the male and female nurse samples. The female sample was younger than the NSW female nurse workforce, with mean ages of 33.8 and 42.0 respectively. The calculated mean age for the NSW female nurse workforce was compared to the female nurse sample with the use of a single sample t test, which indicated a significant difference between the two groups ($t_{(346)} = -18.99$, $p < 0.0001$). In contrast, the male sample was significantly older than the NSW male nurse workforce ($t_{(308)} = 4.91$, $p < 0.0001$), with mean ages of 42.3 and 40.4 respectively. These differences may act as covariates for other items. When comparing the differences between the samples the effects of age on other items were controlled for by using path analysis (See Chapter 5).
Table 1: Comparison of NSW Nurse Workforce with Male and Female Nurse Samples in Age Distribution.

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>NSW 1998 Females</th>
<th>NSW 1998 Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No %</td>
<td>No %</td>
<td>No %</td>
</tr>
<tr>
<td>19-24</td>
<td>1132 3.0</td>
<td>111 3.3</td>
<td>1243 3.0</td>
</tr>
<tr>
<td>25-29</td>
<td>3425 9.1</td>
<td>362 10.6</td>
<td>3787 9.2</td>
</tr>
<tr>
<td>30-34</td>
<td>4112 10.9</td>
<td>420 12.3</td>
<td>4532 11.0</td>
</tr>
<tr>
<td>35-39</td>
<td>6676 17.7</td>
<td>610 17.9</td>
<td>7286 17.7</td>
</tr>
<tr>
<td>40-44</td>
<td>7570 20.1</td>
<td>786 23.0</td>
<td>8356 20.3</td>
</tr>
<tr>
<td>45-49</td>
<td>5941 15.7</td>
<td>623 18.2</td>
<td>6564 15.9</td>
</tr>
<tr>
<td>50-54</td>
<td>4557 12.1</td>
<td>287 8.4</td>
<td>4844 11.8</td>
</tr>
<tr>
<td>55-59</td>
<td>2757 7.3</td>
<td>140 4.1</td>
<td>2897 7.0</td>
</tr>
<tr>
<td>60-64</td>
<td>1174 3.1</td>
<td>54 1.6</td>
<td>1228 3.0</td>
</tr>
<tr>
<td>65-69</td>
<td>311 0.8</td>
<td>15 0.4</td>
<td>326 0.8</td>
</tr>
<tr>
<td>70-74</td>
<td>77 0.2</td>
<td>6 0.2</td>
<td>83 0.2</td>
</tr>
<tr>
<td>75+</td>
<td>20 0.1</td>
<td>0 0.0</td>
<td>20 0.0</td>
</tr>
<tr>
<td>Total</td>
<td>37752 100.0</td>
<td>3414 100.0</td>
<td>41166 100.0</td>
</tr>
</tbody>
</table>

Notes:
1. NSW Workforce data was taken from the Profile of the Registered and Enrolled Nurse Workforce, NSW 1998, prepared by the Workforce Planning Unit, Statewide Services Development Branch, NSW Health Department.
2. For the 1998 NSW Workforce data, Age of 1445 (3.4%) survey respondents was unknown.

Table 2 compares the male and female nurse samples with the NSW nurse workforce in type of work - main job. The female sample was found to be representative of the total NSW female nurse workforce as no statistical difference was found ($\chi^2_{12, n=37985} = 17.1401, p>0.05$). In contrast, the male sample was significantly different from the NSW male nurse workforce in type of work ($\chi^2_{12, n=3625} = 89.8944, p<0.001$). The more than expected frequency in the nurse manager level 4 and other categories, and the less than expected frequency in the registered nurse/midwife category for the male sample accounts for the difference between the two groups. This may be resultant of the low expected frequency of males in several of the categories due to the relative low numbers of men in nursing and the nature of the distribution of the type of work they do. This has led to small but significant differences between the male nurse sample and the registered nurse population. However, these results are consistent with the distribution of age, that is, generally nurses in clinical positions are younger in age compared with nurses in the senior clinical and administration positions.
Table 2: Comparison of NSW Nurse Workforce with Male and Female Samples in Type of Work – Main Job.

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>Females NSW 1998</th>
<th>Females Sample %</th>
<th>Males NSW 1998</th>
<th>Males Sample %</th>
<th>Total NSW 1998</th>
<th>Total Sample %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse/ Midwife</td>
<td>26909</td>
<td>71.4</td>
<td>2035</td>
<td>61.3</td>
<td>28944</td>
<td>70.7</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>4558</td>
<td>12.1</td>
<td>460</td>
<td>13.9</td>
<td>5018</td>
<td>12.2</td>
</tr>
<tr>
<td>Clinical Nurse Consultant</td>
<td>801</td>
<td>2.1</td>
<td>113</td>
<td>3.4</td>
<td>914</td>
<td>2.2</td>
</tr>
<tr>
<td>Nursing Unit Manager</td>
<td>1774</td>
<td>4.7</td>
<td>245</td>
<td>7.4</td>
<td>2019</td>
<td>4.9</td>
</tr>
<tr>
<td>Subtotal – clinical</td>
<td>34042</td>
<td>90.4</td>
<td>2853</td>
<td>86.0</td>
<td>36895</td>
<td>90.1</td>
</tr>
<tr>
<td>NM 1 &amp; 2 (Nurse Manager)</td>
<td>768</td>
<td>2.1</td>
<td>113</td>
<td>3.4</td>
<td>881</td>
<td>2.1</td>
</tr>
<tr>
<td>NM 3</td>
<td>375</td>
<td>1.0</td>
<td>75</td>
<td>2.3</td>
<td>450</td>
<td>1.1</td>
</tr>
<tr>
<td>NM 4</td>
<td>145</td>
<td>0.4</td>
<td>15</td>
<td>0.5</td>
<td>160</td>
<td>0.4</td>
</tr>
<tr>
<td>NM 5 to 9</td>
<td>473</td>
<td>1.3</td>
<td>72</td>
<td>2.2</td>
<td>545</td>
<td>1.3</td>
</tr>
<tr>
<td>Subtotal – Admin/ Management</td>
<td>1761</td>
<td>4.8</td>
<td>275</td>
<td>8.3</td>
<td>2036</td>
<td>4.9</td>
</tr>
<tr>
<td>Clinical Nurse Educator</td>
<td>214</td>
<td>0.6</td>
<td>26</td>
<td>0.8</td>
<td>240</td>
<td>0.6</td>
</tr>
<tr>
<td>Nurse Educator</td>
<td>435</td>
<td>1.1</td>
<td>44</td>
<td>1.3</td>
<td>479</td>
<td>1.2</td>
</tr>
<tr>
<td>Nurse Academic</td>
<td>220</td>
<td>0.6</td>
<td>45</td>
<td>1.4</td>
<td>265</td>
<td>0.6</td>
</tr>
<tr>
<td>Staff Development</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>0.6</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td>869</td>
<td>2.3</td>
<td>115</td>
<td>3.5</td>
<td>984</td>
<td>2.4</td>
</tr>
<tr>
<td>Research</td>
<td>169</td>
<td>0.4</td>
<td>5</td>
<td>0.1</td>
<td>174</td>
<td>0.4</td>
</tr>
<tr>
<td>Other</td>
<td>800</td>
<td>2.1</td>
<td>70</td>
<td>2.1</td>
<td>870</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>37641</td>
<td>100.0</td>
<td>3318</td>
<td>100.0</td>
<td>40959</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Notes:
1. NSW Workforce data was taken from the Profile of the Registered and Enrolled Nurse Workforce, NSW 1998, prepared by the Workforce Planning Unit, Statewide Services Development Branch, NSW Health Department.
2. For the NSW Workforce data the type of work was unknown for 1423 respondents (1300 females, 123 males) and the non response rate was 3.3%.
3. There was 1 missing value for the male nurse sample.
A significant statistical difference was found between the female nurse sample and the NSW female nurse workforce in the principal area of practice ($\chi^2 (16, n=37181) = 94.5207, p<0.0001$) (See Table 3). This difference was the result of a lower than expected frequency of the female nurse sample in geriatric and gerontology nursing and a higher than expected frequency of the sample in the other category. When these two categories were removed from the analyses no statistically significant difference between the two groups was found ($\chi^2 (13, n=29855) = 21.1129, p>0.05$).

Table 3: Comparison of NSW Nurse Workforce with Male and Female Nurse Samples in Principal Area of Nursing Practice.

<table>
<thead>
<tr>
<th>Area of Nursing Practice</th>
<th>Females NSW 1998</th>
<th>Males NSW 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>Medicine</td>
<td>6406</td>
<td>17.4</td>
</tr>
<tr>
<td>Surgery</td>
<td>3971</td>
<td>10.8</td>
</tr>
<tr>
<td>Mixed Medical Surgical</td>
<td>2077</td>
<td>5.6</td>
</tr>
<tr>
<td>Operating Theatre / Recovery</td>
<td>2663</td>
<td>7.2</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>2195</td>
<td>5.9</td>
</tr>
<tr>
<td>Emergency</td>
<td>1372</td>
<td>3.7</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>3538</td>
<td>9.6</td>
</tr>
<tr>
<td>Paediatric &amp; Child Health</td>
<td>1563</td>
<td>4.2</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>718</td>
<td>1.9</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>558</td>
<td>1.5</td>
</tr>
<tr>
<td>Geriatric / Gerontology</td>
<td>5842</td>
<td>15.8</td>
</tr>
<tr>
<td>Community &amp; Occupational Health</td>
<td>1525</td>
<td>4.1</td>
</tr>
<tr>
<td>Mental Health / Drug &amp; Alcohol</td>
<td>2082</td>
<td>5.6</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>724</td>
<td>2.0</td>
</tr>
<tr>
<td>Remote / Rural</td>
<td>170</td>
<td>0.5</td>
</tr>
<tr>
<td>Other</td>
<td>921</td>
<td>2.5</td>
</tr>
<tr>
<td>No One Area of Practice</td>
<td>512</td>
<td>1.4</td>
</tr>
<tr>
<td>Total</td>
<td>36837</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Notes:
- Medicine includes the follow sub-specialties: General, Cardiology, Dermatology, Endocrinology, Gastroenterology, HIV/AIDS, Sexual Health, Immunology, Neurology, Oncology – General/Radiology, Haematology, Renal medicine, Respiratory Medicine, Spinal Injuries, and Medical Imaging – Nuclear/Radiology/Other.
- Surgery includes the following sub-specialties: General, Burns, Cardiothoracic, Colorectal, ENT, Neurosurgery, Ophthalmology, Orthopaedics, Plastic & Reconstructive, Upper GIT, Urology, Vascular, and Transplantation.
- Intensive Care includes Burns, Coronary, Neonatal, Paediatric, General and other.
- Women’s Health includes Gynaecology, Midwifery/Obstetrics, Reproductive Endocrinology & Fertility, and Women’s Health.
- Paediatric & Child Health includes Mothercraft, Child and Family, Paediatric, and School Childrens Health.
- Mental Health / Drug & Alcohol includes Child & adolescent Mental Health, Drug & Alcohol, Psychogeriatric, General Mental Health, and Other Mental Health.
A statistical difference was found between the male nurse sample and the NSW male nurse workforce in the principal area of practice ($\chi^2_{(15, n=3550)} = 76.894, p<0.0001$). However, the difference between the two groups was the result of the difference in observed and expected frequencies in the other category for both the male nurse sample and NSW male nurse workforce, and the lower than expected frequency of the male nurse sample in the developmental disability category. Other than these two categories, no difference could be detected between the male nurse sample and the NSW male nurse workforce in the principal area of nursing practice ($\chi^2_{(13, n=3121)} =18.9632, p>0.1$). In each case the difference between the male sample with the NSW male nurse workforce and the female sample with the NSW female nurse workforce are explained by the differences in the frequencies across two categories. It is concluded that the samples are representative of their population for principal area of practice.

Comparisons for age and discipline type between the male engineer sample and the NSW male members of the Institute of Engineers Australia are shown in table 4 and table 5. The mean age of the male engineer sample was lower than the calculated mean age for the NSW members of the Institute of Engineers Australia, where the mean ages were 45.6 and 51.4 respectively. The calculated mean age for the NSW members of the Institute of Engineers Australia was compared to the male engineer sample with the use of a single sample t test, which indicated a significant difference between the two groups ($t_{(251)} = -6.79, p < 0.0001$). The most notable difference is in the over representation of the sample in the below 30 years of age group. Also worth noting is the under representation of the sample in the above 75 years of age group. There was a significant statistical difference in the distribution of the male engineer sample for engineer discipline, compared to the NSW members of the Institute of Engineers Australia ($\chi^2_{(5, n=6636)} = 138.4601, p<0.0001$). However, caution should be used in the interpretation of this result, because the expected frequency for structural and biomedical engineers for the sample group was less than 5. According to Gravetter and Wallnau (2007) the chi-square statistic can be distorted when the expected frequency of any cell is small (<5). In this case the difference found between the sample and Engineers Australia in discipline type was only found in the
comparison of structural engineers. Some of the difference between the groups may be contributed by the higher percent of missing data for the NSW members of the Institute of Engineers Australia.

Table 4: Comparison of Age Distribution between NSW Male Members of the Institution of Engineers of Australia with the Male Engineer Sample.

<table>
<thead>
<tr>
<th>Age Group (Years)</th>
<th>NSW IEA Engineers</th>
<th>Sample</th>
<th>No</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>53</td>
<td>31</td>
<td>0.8</td>
<td>12.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-34</td>
<td>283</td>
<td>25</td>
<td>4.2</td>
<td>9.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-39</td>
<td>618</td>
<td>28</td>
<td>9.1</td>
<td>11.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td>1012</td>
<td>34</td>
<td>14.9</td>
<td>13.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>1307</td>
<td>31</td>
<td>19.3</td>
<td>12.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-54</td>
<td>1214</td>
<td>37</td>
<td>17.9</td>
<td>14.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-59</td>
<td>811</td>
<td>28</td>
<td>11.9</td>
<td>11.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-64</td>
<td>488</td>
<td>18</td>
<td>7.2</td>
<td>7.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-69</td>
<td>321</td>
<td>18</td>
<td>4.7</td>
<td>7.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70-74</td>
<td>222</td>
<td>3</td>
<td>3.3</td>
<td>1.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75+</td>
<td>452</td>
<td></td>
<td>6.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6781</td>
<td>253</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. Data for the Institution of Engineers Australia was obtained from Engineers Australia Pty Ltd.

Table 5: Comparison of Discipline Type between NSW Male Members of the Institution of Engineers of Australia with the Male Engineer Sample.

<table>
<thead>
<tr>
<th>Engineers</th>
<th>NSW IEA Engineers</th>
<th>Sample</th>
<th>No</th>
<th>%</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical</td>
<td>68</td>
<td>0</td>
<td>1.0</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical</td>
<td>302</td>
<td>8</td>
<td>4.4</td>
<td>3.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil</td>
<td>3307</td>
<td>101</td>
<td>48.8</td>
<td>39.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical</td>
<td>1322</td>
<td>53</td>
<td>19.5</td>
<td>20.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanical</td>
<td>1367</td>
<td>70</td>
<td>20.2</td>
<td>27.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structural</td>
<td>23</td>
<td>15</td>
<td>0.3</td>
<td>5.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>392</td>
<td>6</td>
<td>5.8</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6781</td>
<td>253</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. Data for the Institution of Engineers Australia was obtained from Engineers Australia Pty Ltd.

Sample Characteristics

Descriptive statistics indicating mean age, number of dependents, relationships, qualification levels and sexuality for each of the occupational groups are shown in Table 6.
Table 6: Descriptive Statistics for Age, Dependents, Relationships and Qualifications.

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>Male Engineer</th>
<th>Female Nurse</th>
<th>Male Nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Mean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>45.69</td>
<td>33.80</td>
<td>42.31</td>
<td>40.01</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>12.40</td>
<td>8.02</td>
<td>8.35</td>
</tr>
<tr>
<td>Dependents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No child</td>
<td>N</td>
<td>91</td>
<td>176</td>
<td>367</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>36.1</td>
<td>51</td>
<td>40.5</td>
</tr>
<tr>
<td>Children</td>
<td>N</td>
<td>161</td>
<td>169</td>
<td>539</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>63.9</td>
<td>49</td>
<td>59.5</td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>N</td>
<td>33</td>
<td>69</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>13.0</td>
<td>19.9</td>
<td>14.6</td>
</tr>
<tr>
<td>Married</td>
<td>N</td>
<td>202</td>
<td>206</td>
<td>617</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>79.5</td>
<td>59.5</td>
<td>67.9</td>
</tr>
<tr>
<td>Defacto</td>
<td>N</td>
<td>9</td>
<td>43</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>3.5</td>
<td>12.4</td>
<td>11.0</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>N</td>
<td>10</td>
<td>28</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>3.9</td>
<td>8.1</td>
<td>6.5</td>
</tr>
<tr>
<td>Qualification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certificate</td>
<td>N</td>
<td>18</td>
<td>48</td>
<td>242</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>7.1</td>
<td>13.9</td>
<td>15.5</td>
</tr>
<tr>
<td>Diploma</td>
<td>N</td>
<td>20</td>
<td>66</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>7.9</td>
<td>19.1</td>
<td>13.8</td>
</tr>
<tr>
<td>Degree</td>
<td>N</td>
<td>126</td>
<td>153</td>
<td>366</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>49.6</td>
<td>44.2</td>
<td>40.3</td>
</tr>
<tr>
<td>Graduate Cert./Dip.</td>
<td>N</td>
<td>17</td>
<td>67</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>6.7</td>
<td>19.4</td>
<td>16.3</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>N</td>
<td>58</td>
<td>12</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>22.8</td>
<td>3.5</td>
<td>12.1</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>N</td>
<td>15</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5.9</td>
<td>0.6</td>
<td>0.2</td>
</tr>
<tr>
<td>Sexuality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusively hetero.</td>
<td>N</td>
<td>242</td>
<td>312</td>
<td>242</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>95.3</td>
<td>90.2</td>
<td>87.7</td>
</tr>
<tr>
<td>Predominantly hetero., incidentally homosexual</td>
<td>N</td>
<td>9</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>3.5</td>
<td>5.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Predominantly heterosexual, more than incidentally homosexual</td>
<td>N</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.6</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Equally hetero./homo. Sexual</td>
<td>N</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>1.2</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Predominantly homosexual, more than incidentally heterosexual</td>
<td>N</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.4</td>
<td>0.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Predominantly homo., incidentally heterosexual</td>
<td>N</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.3</td>
<td>0.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Exclusively homosexual</td>
<td>N</td>
<td>2</td>
<td>8</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.8</td>
<td>2.3</td>
<td>5.7</td>
</tr>
</tbody>
</table>
The mean age of the male engineer sample was higher than that of the two nursing samples, with male nurses having a higher mean age than female nurses. The numbers of female nurses who reported having and not having children was approximately equal, whereas the majority of male nurses and engineers reported having children. The proportion of female nurses who reported being single, or separated/divorced, was higher than for the two male samples, who in turn reported higher rates of current marriage than the females. The proportion of male nurses and female nurses who reported being in a defacto relationship was higher than male engineers.

Male engineers clearly held higher qualifications on the whole, but in particular had higher percentages in the Masters and Ph.D. categories. On the Kinsey sexuality scale, there was a clear ordering of percentages who reported being exclusively heterosexual, with male engineers having the highest percentage in this category, followed by female and male nurses, respectively. The difference between the two latter groups was associated primarily with a higher percentage of male nurses falling within the exclusively homosexual category.

The results of the survey are presented in chapter 4 and chapter 5. Chapter 4 reports the results to section C of the survey, that is, the perceptions of nursing as an occupation for men and the experiences of male nurses with work related discrimination, harassment and stereotypes. Chapter 5 reports on the comparisons of the samples for self-reported gender descriptions. This chapter reports on the findings obtained from the Bem Sex Role Inventory (Short version) and the Australian Sex Role Scale (Form A).
CHAPTER 4
Perceptions of Men in Nursing

Introduction
This chapter reports the results of section C of the survey, and attempts to capture the beliefs about and perceptions of male nurses from the perspectives of the three samples. This chapter reports the findings to the following questions:

Is nursing a suitable profession for men?
Is there a gender difference in the suitability of nursing as a career?
Do male nurses believe they are stereotyped?

Nursing as a Suitable Profession for Men
To ascertain if there were differences in the perception of the suitability of nursing as a profession for males, the participants were asked to give their opinion, using a 5 point Likert scale (where a score of 1 equates with strongly disagree and a score of 5 is strongly agree), to the following statements:-

Nursing is a suitable profession for males, and
Nursing is a more suitable profession for females.

As an ordinal Likert type scale was used to measure the responses to each statement, the Kruskal Wallis test was used to make statistical comparisons between the three independent samples.

The majority (80%) of male engineers agreed, 12.2% disagreed and 7.8% were unsure that nursing was a suitable profession for males (Table 7). In comparison, 88.7% of female nurses and 92.6% of male nurses agreed, 6.7% of female nurses and 3.8% of male nurses disagreed, and 4.7% of females and 3.5% of male nurses were unsure. A statistical significant difference was found between the male engineers and the nursing samples ($\chi^2 = 75.408, p < 0.0001$).
Table 7: Nursing as a suitable profession for men.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean Rank</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Engineers</td>
<td>12</td>
<td>19</td>
<td>20</td>
<td>149</td>
<td>54</td>
<td>354.38</td>
<td>254</td>
</tr>
<tr>
<td>Male Nurses</td>
<td>6</td>
<td>6</td>
<td>11</td>
<td>111</td>
<td>176</td>
<td>460.78</td>
<td>310</td>
</tr>
<tr>
<td>Female Nurses</td>
<td>10</td>
<td>13</td>
<td>16</td>
<td>160</td>
<td>145</td>
<td>529.57</td>
<td>344</td>
</tr>
</tbody>
</table>

$\chi^2 = 75.408, p < 0.0001$

The largest portion of male engineers stated that nursing was more suitable for females (49.2%), 40.1% disagreed and 10.7% were unsure. In comparison, only 19.3% of female nurses and 13.2% of male nurses agreed, 71.7% of female nurses and 78.4% of male nurses disagreed, and 9% of females and 8.4% of male nurses were unsure. These results were statistically significant ($\chi^2 = 124.038, p<0.0001$), with male engineers having the highest mean rank (Table 8).

Table 8: Nursing is a more suitable profession for females?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean Rank</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Engineers</td>
<td>24</td>
<td>78</td>
<td>27</td>
<td>91</td>
<td>34</td>
<td>596.94</td>
<td>254</td>
</tr>
<tr>
<td>Male Nurses</td>
<td>125</td>
<td>117</td>
<td>26</td>
<td>34</td>
<td>7</td>
<td>425.09</td>
<td>309</td>
</tr>
<tr>
<td>Female Nurses</td>
<td>103</td>
<td>143</td>
<td>31</td>
<td>41</td>
<td>25</td>
<td>367.13</td>
<td>343</td>
</tr>
</tbody>
</table>

$\chi^2 = 124.038, p<0.0001$

Of the 125 male engineers who agreed that nursing was a more suitable profession for females, 118 made 130 responses to the question of why? In contrast, of the 66 female nurses and 41 male nurses who agreed that nursing was a more suitable profession for females, 57 females made 57 responses and 35 males made 42 responses. Content analysis was conducted on the open-ended responses to why nursing was more suited to females. All of the responses with the exception of 6 were explained by one of 5 themes: Essentialist View of Gender; Female Sex Role; Preference for Female Carers; Women’s Work; Negative Consequences for Men (see Appendix E). Table 9 shows the frequency of responses for each sample for the 5 identified themes.
Table 9: Identified Themes: Why Nursing is More Suitable for Females?

<table>
<thead>
<tr>
<th>Themes</th>
<th>Male Engineers</th>
<th>Female Nurses</th>
<th>Male Nurses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essentialist Views of Gender</td>
<td>89</td>
<td>36</td>
<td>18</td>
<td>143</td>
</tr>
<tr>
<td>Female Sex Role</td>
<td>12</td>
<td>2</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Preference for Female Carers</td>
<td>12</td>
<td>5</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Women’s Work</td>
<td>14</td>
<td>13</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>Negative Consequences for Men</td>
<td>3</td>
<td>1</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>130</td>
<td>57</td>
<td>42</td>
<td>229</td>
</tr>
</tbody>
</table>

Essentialist Views of Gender

The essentialist views of gender accounted for 62.4% of all the comments made. The majority of comments within this theme were made by the male engineer sample (62.2%) when compared with the female nurse (25.5%) and male nurse (12.6%) samples. Despite this the essentialist theme accounts for the majority of responses within each sample (68% male engineers, 63% female nurses and 43% male nurses).

Comments under the essentialist theme centre on qualities perceived to be naturally or biologically determined for females and are not natural for males. Examples of these include:

- *Feminine instinct/protective of their perceived natural role in society.*

- *Motherhood, natural instincts.*

- *Women have a perceived tendancy for mothering/ caring and nursing has strong elements of this personal characteristics.*

- *Females can be more understanding and caring for others with their maternal instincts.*

- *Women have more affection and care built into their system by gift of God.*

- *Natural carers / nurturers.*

Essentialism assumes that social differences such as those between men and women, people of different races or social classes are due to intrinsic biological or psychic
differences between the members of the different groups (Clatterbaugh, 1995, 49). These differences are believed to be innate and immutable, and are seen as more significant than environmental factors in explaining differences among people (Ferber, 2000, 37).

**Female Sex Role**

The Female Sex Role theme categorises the qualities of the nurse as the female sex role, and therefore is not appropriate for males. Sex roles were defined as patterns of social expectation, norms for behaviour of men and women, which were transmitted to the youth in a process of socialization. Social behaviour was explained in terms of conformity and deviancy. Examples of the Sex Role Theme include:

- *Women should belong to more female based roles.*
- *It tends to be more female oriented role, probably based on old age preconceptions about men’s and women’s roles in society.*
- *Traditional role for females.*

The Female Sex Role theme accounts for 7.4% (n=17) of all the comments. The majority of comments within this theme were made by the male engineer sample (70.6%) when compared with the female nurse (11.8%) and male nurse (17.6%) samples. Despite this the Sex Role theme accounts for 9%, 3% and 7% of responses within the male engineer, female nurse and male nurse samples, respectively.

**Preference for Female Carers**

This theme reflects an acceptance by male and female patients of female carers but questions the suitability of males caring for female patients. Examples of the preference for women carers theme include:

- *There is not total acceptance by female patients that male nurses should be involved in personal attendance eg. Showering female patients.*
- *Patients are more comfortable with women nurses.*
- *Women’s bodies are more complex, greater need for nursing.*
- *Women are more likely to know more about women’s as well as men’s needs.*
This theme accounts for 8.3% (n=19) of all the comments. The majority of comments within this theme were made by the male engineer sample (63.2%) when compared with the female nurse (26.3%) and male nurse (10.5%) samples. Despite this, the Preference for Women Carers theme accounts equally for responses within the male engineer and female nurse samples at 9%, and 5% of responses for the male nurse sample.

Women’s Work

This theme reflects the respondent’s views of a gendered division of labour where nursing is perceived to be the same as housework, which is devalued by men. Comments within this theme center on the domination of females within nursing and the tasks and skills required for nurses are more suited and accepted by females. Comments center on the females’ acceptance to do “menial, minor, mundane, home related and housewife” type tasks which are related to nursing. Other comments relate to poor employment conditions and salary potential within nursing. Examples of the Women’s Work theme include:

- More women seem to be interested in the skills required for nursing.
- Women will do menial tasks happily.
- Males are not willing to do all the aspects of the jobs.
- They (female nurses) are more willing to put up with a lot of shit.
- Because females are in the majority

The Women’s Work theme accounts for 14.9% (n=34) of all the comments. The majority of comments within this theme were made by the male engineer sample (41.2%) when compared with the female nurse (38.2%) and male nurse (20.6%) samples. Despite this, the Women’s Work theme accounts for 11%, 23% and 16% of responses within the male engineer, female nurse and male nurse samples, respectively. Comments made by the male nurse sample reflect their minority status and lack of willingness to accept working conditions, for example one male nurse respondent wrote:

In my view female nurses are less questioning and more accepting of hospital policies and procedures, so often have a less conflictual relationship with management.
In contrast, the female nurse comments reflect a perception that male nurses are not willing to do mundane tasks. A female nurse respondent wrote:

*Males are not willing to do all the aspects of the job. Men seem mostly happy to sit and chat, which is nice, but for example, they would leave someone uncomfortable, incontinent and wouldn’t worry.*

Comments by the male engineer sample reflect a willingness of women to accept lower wages, poorer employment conditions and domestic skills of nurses.

**Negative Consequences**

In contrast to the other themes, the majority of the comments which constitute the negative consequence theme are predominantly from the male nurse sample, which accounts for 28% (n=12) of all the male nurse responses. This theme is defined by comments that relate to public attitudes, perceptions, and expectations which stereotype men in nursing. Examples of this theme include:

- *Feel that there are still expectations that men will not become nurses.*
- *Social conventions including salary, public perceptions / expectations.*
- *Society expectations make the professional role easier for women.*
- *Homosexual connotation.*

Other comments from respondents within this theme stem from a feeling of discrimination from their female peers, for example:

- *I believe that nursing is controlled by the ‘Feminist Mafia’ - men are at a disadvantage - men are victims and discriminated against.*
- *Far too many traditionalists or feminists making us feel unwelcome. There still remains the old girls club network for promotions and dispute resolution.*
Male Nurse Discrimination, Harassment and Stereotypes

Two hundred and forty nine male nurses were asked to report on whether they had experienced workplace sex-based discrimination or harassment. One hundred and two male nurse respondents (41%) believed that they had experienced sex discrimination from female nurses at work. Fifty five male nurse respondents (22%) reported experiencing sex-based harassment by female nurses. Table 10 presents the frequency of respondents that have experienced specific forms of sex based harassment in the workplace: written or printed material that put them down and is displayed publicly, circulated, or put in their work space; verbal abuse or comments that put them down or stereotype them; jokes that was found offensive; and being ignored, isolated or segregated.

Table 10: Frequency of Respondents Reporting experienced Workplace Harassment

<table>
<thead>
<tr>
<th>Form of Harassment</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written or printed material</td>
<td>Yes 37 (14.9)</td>
</tr>
<tr>
<td>Verbal comments</td>
<td>Yes 78 (31.3)</td>
</tr>
<tr>
<td>Jokes</td>
<td>Yes 50 (20.1)</td>
</tr>
<tr>
<td>Isolation or segregation</td>
<td>Yes 52 (20.9)</td>
</tr>
</tbody>
</table>

Male nurses were asked to indicate on a five point Likert scale if they believed men in nursing are stereotyped. Sixty nine percent of male nurses believed that men in nursing are stereotyped resulting from their chosen occupation. Seventeen percent of respondents disagreed, indicating that men in nursing are not stereotyped. Of the 310 male nurse participants, 177 respondents gave 228 examples of how men in nursing are stereotyped. Content analysis was conducted on the open-ended responses. Six themes were identified from the responses (see Appendix F). All of the responses were categorised into one of the 6 themes: Questioned Sexuality; Career Driven; Technical Vs Caring; Manual Handling; Non-achievers; and Lazy. Table 11 shows the frequency of responses for each identified theme.
Table 11: Identified Themes: Male Nurse Stereotypes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questioned Sexuality</td>
<td>130</td>
</tr>
<tr>
<td>Manual Work/ Dealing with</td>
<td>25</td>
</tr>
<tr>
<td>Aggression</td>
<td></td>
</tr>
<tr>
<td>Technical Vs Caring</td>
<td>23</td>
</tr>
<tr>
<td>Career Driven</td>
<td>17</td>
</tr>
<tr>
<td>Lazy</td>
<td>17</td>
</tr>
<tr>
<td>Non-achievers</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>228</strong></td>
</tr>
</tbody>
</table>

Work is a location where masculinity is reproduced and maintained. Men's gender identity, value and worth are bound up with work, resulting in the maintenance of gender power relations. For male nurses, the choice of nursing as an occupation has resulted in stereotypes related to the contradictions of a masculine identity and choice of a feminine occupation. The contradiction of gender identity and occupation creates workplace tension for male nurses. On the one hand male nurses are perceived to be losers and not real men. This is reflected in the questioned sexuality and nonachiever stereotypes. On the other hand male nurses are perceived to not have the feminine qualities needed in nursing and to focus on the masculine aspects of work, which is reflected in the manual work, technical vs caring, career driven and lazy stereotypes.

The Questioned Sexuality theme consists of comments that describe the male nurses as effeminate and/or homosexual. This theme reflects the notion that male nurses are perceived to be weak and female like. Examples are:

*In my experience nursing is usually regarded by the general public as being a less than manly occupation. My male sporting associates often joke, seem surprised or have difficulty associating me with the role (or perhaps their perception of it). When studying at uni my male relatives often referred to my course as 'your trade' at the time it seemed like a feeble attempt to masculinise the profession. It was as though they were embarrassed."

*I have been to parties basically getting the "green light" from girls I have spoken to and when they find out you're a nurse they just walk off. Some male and rarely female patients treat you as if you're automatically gay. Often their whole attitude towards you changes when they find out your married with kids."
In this theme there is a thread that links effeminacy with homosexuality and the fact that male nurses are perceived to be doing women’s work, therefore they must be like women and therefore are gay. This theme is consistent with the ‘homosexual’ role trap described by Heikes (1991) and the broader nursing literature.

The Manual Work/Dealing with Aggression theme defines work practises along body difference that are perceived to be more appropriate for men. Male nurses are expected to take on those work practises that require strength and manual handling, such as lifting patients and other heavy loads, and dealing with aggression and violence. This theme is consistent with the previously discussed ‘He-man’ role trap described by Heikes (1991) and Evans (2004) and the ‘Enforcer role’ described by Evans (2004). Examples of the comments within this theme are:

Again from my experience male nurses are regarded as being most appropriate in settings where behaviorally changing clients are encountered. Certainly in my current clinical setting female staff often state that they feel a male presence has the effect of reducing incidence and minimising levels and duration of physical violence directed at staff.

Given jobs which involve danger or that will benefit from added muscle. Male staff used to resolve disputes with hostile patients. Male staff used as bodyguards for other health care staff.

The Technical vs Caring stereotype identifies male nurses as being more technology orientated and less caring, person oriented. This stereotype results from culturally constructed characteristics of the nurse according to sex norms. The essentialist view of gender and prescribed sex role norms limits men’s legitimacy in caring roles and imposes a more masculine orientation. Male nurses are perceived to be less caring and are perceived to be focused on the masculine technical aspects of nursing. For example:

[Males] are generally perceived as rough, less sensitive and caring. Males are seen as being aware of the big picture, but not paying attention to smaller tasks required for complete patient care.

Considered more concerned with administration, technical side of nursing, computing etc. rather than people orientated.
The Career Driven theme consists of comments that describe male nurses as being focused, ambitious and career driven. There is a perception that male nurses actively orchestrate their careers, to progress up the hierarchical ladder as fast as possible. Such a view is reinforced by the disproportionate representation of males in nursing leadership roles. There is a belief that male nurses are occupationally ambitious, a trait that is threatening to a female-dominated occupation. The resentment of men by female nurses because of their perceived ambition and success has been documented by Gans (1987).

This theme is consistent with Heikes (1991) ‘ladderclimber’ role trap. Examples of the comments in this theme include:

*Very driven ambitions, people who aspire to the peak of the profession without regard for others.*

*Aggressive and after the top jobs within the shortest time frame.*

*Thought to be out to be managers and nothing else, just more eager to achieve.*

The Non-achiever stereotype stems from nursing as an occupation contradicting the cultural construction of men’s work. The open responses in this theme indicate that male nurses are failures as they are unable to get a masculine job or they are presumed to be doing medicine. There is a lack of acceptance that nursing can be a legitimate career choice for men. Due to the de-legitimization of nursing for men, male nurses lose status. Examples of comments in this theme are:

*[Male nurses] are often viewed as not being able to secure a real job for example bricklayer, engineer etc.*

*[Male nurses] are often thought to be less intelligent, competent and capable.*

*Male nurses are individuals that didn’t have the marks/brains to get into medicine.*

The Lazy theme stems from female nurses’ views of male nurses. According to the respondents, male nurses are seen by some as being lazy or not dedicated to the job.
Examples of comments in this theme are:

*All seen as lazy, not as dedicated.*

*Not seen as hard workers*

**Concluding Thoughts**

These results highlight the tensions for male nurses created by the cultural construction of gender identity and its congruence with gendered occupations and work type. Whilst most participants agreed that nursing was an acceptable occupation for men, the largest portion of male engineers stated that nursing was a more appropriate occupation for women. Both male engineers and female nurses rationalized this with essentialist views of gender and sex roles. In their eyes nursing is synonymous with a feminine identity, feminine characteristics inherent in women. In addition, many male nurse participants (69%) expressed being stereotyped because of their occupation. Content analysis of the examples of stereotypes given by these participants support the view that nursing is culturally constructed as a feminine occupation and that stereotyping of male nurses occurs as a result of the contradictions of being male and having a masculine identity, and being a nurse.

What is not explored here is the impact on gender relations of the conflict between gender identity and occupational identity. Conclusions regarding inequalities in gender relations – power relations; production relations, such as income, division of labour and nursing labour processes; relations of cathexis; and symbolic relations - cannot be drawn. How male nurses construct their masculinity, the position male nurses occupy in the nursing profession and the broader gender order, cannot be identified or explained by this form of research.

As the survey found, nursing is culturally constructed to be essentially feminine. The leading justification for nursing to be more acceptable for females as an occupation is due to beliefs in essentialist and categorical definitions of gender, where gender is defined by opposing sets of characteristics. How these perceived configurations of gender characteristics impact on the everyday lives of male nurses is yet to be seen.
The survey highlights some of the pressures male nurses face through stereotypes and differing forms of sex-based harassment and discrimination, but cannot reveal the impact of such pressures on the everyday lives of male nurses.

One of the major pitfalls in the study of men in nursing is the failure to examine the impact of the conflict of gender and occupational identities, and the construction of masculinities on male nurse labour processes. As the survey found, approximately 15% of respondents believe that nursing work is women’s work and 9% of respondents believe that there is a cultural preference for female nurses. How male nurses engage in nursing work, particularly body care and caring, is yet to be fully examined. How male nurses combat stereotypes and develop strategies to provide a ‘safe’ environment for them to work, have not been thoroughly explored in the nursing literature. For example, how do cultural constructions of nursing impact on male nurse-patient relations? More specifically, how do male nurses ‘perform’ to combat the homosexual stereotype in order to gain entry into the nurse-patient relationship so they can provide nursing care?

Evans (2002) examined men’s touch in nursing practice and concluded that the problem of male nurse touch becomes a driving force for men to gravitate to low touch ‘masculine’ specialties. The limitation of Evan’s study centres on her narrow analysis where she fails to examine reciprocal relations. Men’s touch in nursing practice is a response to broader gender relations, rather than simply men choosing specialties that advantage them. How male nurses engage in nursing work requires deeper investigation.

The results of the survey presented here provide a platform for further investigation. A life history study will assist in overcoming these limitations. The life history method will allow the examination of gender relations in the professional and personal lives of male nurses.
CHAPTER 5
Gender Self-Descriptions

Introduction
In this chapter comparisons of gender self-descriptions for male and female nurses and male engineers are presented. One-way analysis of variance (ANOVA) was employed to make direct comparisons between the groups on the masculinity and femininity sub-scales of the ASRS and the BSRI. Principal components analysis (PCA) was used to combine the items of the ASRS and BSRI into a smaller set of component scores. To determine whether component scores differed across the three occupational groups (male nurses, female nurses, male engineers), two one-way multivariate analyses of variance (MANOVAs) were performed, one for scores on the feminine components, and one for scores on the masculine components. Path analysis was then used to determine what portion of the relationship between occupational group and gender descriptions was directly ascribable to differences in occupation, versus the portion that could be ascribed to variables confounded with occupational choice.

Internal Consistency Reliability
The internal consistency for each sub-scale of the ASRS and the BSRI was estimated using Cronbach’s coefficient alpha. Item-to-total correlation coefficients were computed to test the unidimensionality of each sub-scale. The computed values of Cronbach’s coefficient alpha for the feminine positive, feminine negative, masculine positive, and masculine negative sub-scales of the ASRS were 0.78, 0.80, 0.66 and 0.79 respectively. The computed values of Cronbach’s coefficient alpha for the feminine and masculine sub-scales of the BSRI were 0.88 and 0.82 respectively. According to de Vaus (1991), a scale with a computed alpha greater than 0.70 is considered to have an acceptable level of internal consistency (although the consistency for other types of scales, such as achievement tests, is generally expected to be at or above 0.80). Item-to-total correlation coefficients and alphas if the item was deleted for each sub-scale of the ASRS and BSRI are presented in tables 12 and 13.
Table 12: Item-to-total correlation coefficients and alphas if item deleted for each sub-scale of the ASRS

<table>
<thead>
<tr>
<th>Sub-scale</th>
<th>Item</th>
<th>Item-total correlation coefficient</th>
<th>Alpha if item deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feminine Positive</strong></td>
<td>Loves Children</td>
<td>0.31</td>
<td>0.78</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>0.41</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Appreciative</td>
<td>0.59</td>
<td>0.74</td>
</tr>
<tr>
<td></td>
<td>Sensitive to the needs of others</td>
<td>0.63</td>
<td>0.74</td>
</tr>
<tr>
<td></td>
<td>Grateful</td>
<td>0.56</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>Responsible</td>
<td>0.39</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Emotional</td>
<td>0.51</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>Devotes self to others</td>
<td>0.37</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Loyal</td>
<td>0.56</td>
<td>0.74</td>
</tr>
<tr>
<td></td>
<td>Gentle</td>
<td>0.28</td>
<td>0.79</td>
</tr>
<tr>
<td><strong>Feminine Negative</strong></td>
<td>Dependent</td>
<td>0.19</td>
<td>0.82</td>
</tr>
<tr>
<td></td>
<td>Needs Approval</td>
<td>0.37</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Nervous</td>
<td>0.61</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Timid</td>
<td>0.54</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Self-critical</td>
<td>0.30</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Weak</td>
<td>0.56</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Bashful</td>
<td>0.54</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Shy</td>
<td>0.57</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Anxious</td>
<td>0.59</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Worrying</td>
<td>0.53</td>
<td>0.77</td>
</tr>
<tr>
<td><strong>Masculine Positive</strong></td>
<td>Firm</td>
<td>0.36</td>
<td>0.64</td>
</tr>
<tr>
<td></td>
<td>Confident</td>
<td>0.48</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td>Competitive</td>
<td>0.39</td>
<td>0.63</td>
</tr>
<tr>
<td></td>
<td>Casual</td>
<td>0.13</td>
<td>0.68</td>
</tr>
<tr>
<td></td>
<td>Forceful</td>
<td>0.42</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td>Skilled in business</td>
<td>0.31</td>
<td>0.64</td>
</tr>
<tr>
<td></td>
<td>Strong</td>
<td>0.47</td>
<td>0.61</td>
</tr>
<tr>
<td></td>
<td>Carefree</td>
<td>0.24</td>
<td>0.66</td>
</tr>
<tr>
<td></td>
<td>Outspoken</td>
<td>0.39</td>
<td>0.62</td>
</tr>
<tr>
<td></td>
<td>Pleasure-seeking</td>
<td>0.18</td>
<td>0.67</td>
</tr>
<tr>
<td><strong>Masculine Negative</strong></td>
<td>Bossy</td>
<td>0.48</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Noisy</td>
<td>0.49</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Show-off</td>
<td>0.56</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Aggressive</td>
<td>0.53</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Sarcastic</td>
<td>0.44</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Mischievous</td>
<td>0.32</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Feels superior</td>
<td>0.49</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Boastful</td>
<td>0.56</td>
<td>0.76</td>
</tr>
<tr>
<td></td>
<td>Rude</td>
<td>0.46</td>
<td>0.77</td>
</tr>
<tr>
<td></td>
<td>Sees self running</td>
<td>0.37</td>
<td>0.78</td>
</tr>
</tbody>
</table>
Table 13: Item-to-total correlation coefficients and alphas if item deleted for the feminine and masculine sub-scales of the BSRI

<table>
<thead>
<tr>
<th>Sub-scale</th>
<th>Item</th>
<th>Item-total correlation coefficient</th>
<th>Alpha if item deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feminine</td>
<td>Affectionate</td>
<td>0.61</td>
<td>0.87</td>
</tr>
<tr>
<td></td>
<td>Sympathetic</td>
<td>0.69</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>Sensitive to the needs of others</td>
<td>0.64</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>Understanding</td>
<td>0.66</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>Compassionate</td>
<td>0.71</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>Eager to soothe hurt feelings</td>
<td>0.53</td>
<td>0.87</td>
</tr>
<tr>
<td></td>
<td>Warm</td>
<td>0.69</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>Tender</td>
<td>0.69</td>
<td>0.86</td>
</tr>
<tr>
<td></td>
<td>Love children</td>
<td>0.59</td>
<td>0.87</td>
</tr>
<tr>
<td></td>
<td>Gentle</td>
<td>0.32</td>
<td>0.88</td>
</tr>
<tr>
<td>Masculine</td>
<td>Defend my own beliefs</td>
<td>0.40</td>
<td>0.82</td>
</tr>
<tr>
<td></td>
<td>Independent</td>
<td>0.43</td>
<td>0.82</td>
</tr>
<tr>
<td></td>
<td>Assertive</td>
<td>0.65</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Strong personality</td>
<td>0.63</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Forceful</td>
<td>0.53</td>
<td>0.81</td>
</tr>
<tr>
<td></td>
<td>Have leadership abilities</td>
<td>0.50</td>
<td>0.81</td>
</tr>
<tr>
<td></td>
<td>Willing to take risks</td>
<td>0.38</td>
<td>0.82</td>
</tr>
<tr>
<td></td>
<td>Dominant</td>
<td>0.62</td>
<td>0.79</td>
</tr>
<tr>
<td></td>
<td>Willing to take a stand</td>
<td>0.61</td>
<td>0.80</td>
</tr>
<tr>
<td></td>
<td>Aggressive</td>
<td>0.37</td>
<td>0.82</td>
</tr>
</tbody>
</table>
Group Comparison in ASRS and BSRI Sex Types

Table 14 presents the mean scores and standard deviations of the male engineer, male nurse and female nurse samples for masculinity and femininity on the BSRI and the ASRS respectively. Reported femininity and masculinity scores were subjected to one-way analysis of variance (ANOVA). A statistically significant difference in the measures of femininity was found between all the samples on both the ASRS and the BSRI \( (F(2,908)=20.24, p<0.00001; F(2,908)=60.13, p<0.00001, \text{respectively}) \). Post-hoc analyses based on Tukey's HSD indicated male nurses scored lower in femininity than females but significantly higher than male engineers on both scales. A statistical difference in masculinity scores was found between female nurses and the two male samples on the ASRS and BSRI \( (F(2, 908)=12.48, p<0.000001; F(2,908)=6.94, p=0.001, \text{respectively}) \). There was no difference in masculinity between male engineers and male nurses.

Table 14: Mean Scores and Standard Deviations on the ASRS and BSRI Femininity and Masculinity Sub-scales

<table>
<thead>
<tr>
<th></th>
<th>Bem Femininity Mean (SD)</th>
<th>ASRS Femininity Mean (SD)</th>
<th>Bem Masculinity Mean (SD)</th>
<th>ASRS Masculinity Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Engineers</td>
<td>5.1 (0.8)</td>
<td>84.3 (10.5)</td>
<td>4.7 (0.7)</td>
<td>75.2 (11.8)</td>
</tr>
<tr>
<td>Male Nurses</td>
<td>5.5 (0.7)</td>
<td>87.1 (11.4)</td>
<td>4.7 (0.8)</td>
<td>73.3 (12.8)</td>
</tr>
<tr>
<td>Female Nurses</td>
<td>5.7 (0.6)</td>
<td>90.0 (10.8)</td>
<td>4.5 (0.8)</td>
<td>70.2 (12.6)</td>
</tr>
<tr>
<td>Total Sample</td>
<td>5.5 (0.8)</td>
<td>87.4 (11.2)</td>
<td>4.6 (0.7)</td>
<td>72.6 (12.6)</td>
</tr>
</tbody>
</table>

For both scales, subjects were classified into one of four distinct sex types (feminine, masculine, androgynous and undifferentiated), on the basis of a median split for the masculine and feminine scales. Individuals who score above the sample median on one of the scales and below the sample median on the other, have a definite tendency for a specific sex type (masculine or feminine). Individuals who score above the sample median on both scales was classified as androgynous, and individuals who score both scales below the sample median were classified as undifferentiated.
Tables 15 and 16 show the frequency in sex type for the 3 groups as measured by the ASRS and BSRI respectively. Using a series of chi-squared analyses a statistically significant difference was found in sex types between the samples on both scales ($\chi^2(6) = 61.074, p < 0.000001; \chi^2(6) = 87.919, p < 0.000001$, respectively). More male nurses were sex typed feminine and androgynous and fewer sex-typed as masculine than male engineers. When compared to female nurses, fewer male nurses were sex typed feminine and more were sex typed masculine.

### Table 15: Group Comparisons by ASRS sex type.

<table>
<thead>
<tr>
<th></th>
<th>Masculine</th>
<th>Feminine</th>
<th>Androgynous</th>
<th>Undifferentiated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male Engineer</strong></td>
<td>108</td>
<td>43</td>
<td>51</td>
<td>52</td>
<td>254</td>
</tr>
<tr>
<td></td>
<td>42.5%</td>
<td>16.9%</td>
<td>20.1%</td>
<td>20.5%</td>
<td></td>
</tr>
<tr>
<td><strong>Male Nurse</strong></td>
<td>86</td>
<td>84</td>
<td>75</td>
<td>66</td>
<td>311</td>
</tr>
<tr>
<td></td>
<td>27.7%</td>
<td>27%</td>
<td>24.1%</td>
<td>21.2%</td>
<td></td>
</tr>
<tr>
<td><strong>Female Nurse</strong></td>
<td>57</td>
<td>126</td>
<td>99</td>
<td>65</td>
<td>347</td>
</tr>
<tr>
<td></td>
<td>16.4%</td>
<td>36.3%</td>
<td>28.5%</td>
<td>18.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>252</td>
<td>253</td>
<td>225</td>
<td>183</td>
<td>912</td>
</tr>
<tr>
<td></td>
<td>27.5%</td>
<td>27.7%</td>
<td>24.7%</td>
<td>20.1%</td>
<td></td>
</tr>
</tbody>
</table>

### Table 16: Group Comparisons by BEM sex type.

<table>
<thead>
<tr>
<th></th>
<th>Masculine</th>
<th>Feminine</th>
<th>Androgynous</th>
<th>Undifferentiated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male Engineer</strong></td>
<td>95</td>
<td>32</td>
<td>54</td>
<td>73</td>
<td>254</td>
</tr>
<tr>
<td></td>
<td>37.4%</td>
<td>12.6%</td>
<td>21.3%</td>
<td>28.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Male Nurse</strong></td>
<td>65</td>
<td>62</td>
<td>115</td>
<td>69</td>
<td>311</td>
</tr>
<tr>
<td></td>
<td>20.9%</td>
<td>19.9%</td>
<td>37%</td>
<td>22.2%</td>
<td></td>
</tr>
<tr>
<td><strong>Female Nurse</strong></td>
<td>54</td>
<td>120</td>
<td>118</td>
<td>54</td>
<td>346</td>
</tr>
<tr>
<td></td>
<td>15.6%</td>
<td>34.7%</td>
<td>34.1%</td>
<td>15.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>214</td>
<td>214</td>
<td>257</td>
<td>196</td>
<td>911</td>
</tr>
<tr>
<td></td>
<td>23.5%</td>
<td>23.5%</td>
<td>31.5%</td>
<td>21.5%</td>
<td></td>
</tr>
</tbody>
</table>

**Principal Components Analysis of Combined ASRS and BSRI Scores**

Although the analyses reported above indicate differences in sex role *categories* across the three occupational groups, these analyses do not indicate the specific sex role *characteristics* that differentiated between these groups. For example, the ASRS differentiates between “positive” and “negative” feminine and masculine characteristics, which are not reflected in the overall sex types assigned by the scale. Thus, although the analysis above did indicate that male nurses were classified as
“feminine” more frequently than male engineers, these analyses do not indicate the specific feminine characteristics on which the two groups differed (e.g., whether the discriminating characteristics generally fell within the “positive” or “negative” feminine sub-scales).

For this reason, all subsequent analyses were performed on the item scores from the two scales rather than on the sex types produced by these scales. As there is considerable overlap in the constructs measured by the two scales, a principal components analysis was initially performed on items from both scales to determine whether the combined item pool could be summarised by a smaller set of component scores. In addition, as indicated in chapters 2 and 3, previous factor analytic studies on the two scales have produced conflicting results. There is some reason to suggest that these differences reflect differences in factor structures for different groups, or for the same groups measured at different time points. Thus, this analysis provided a sample-specific summarization of the items across the two scales.

In this procedure, scores for the 913 respondents were intercorrelated and subjected to a principal components analysis (PCA). Mahalanobis distances (computed separately for each of the three groups) indicated no multivariate outliers at the \( \alpha = 0.001 \) level. The Kaiser Meyer Olkin (KMO) measure of sampling adequacy for the pooled sample was considered excellent at 0.917. Means and standard deviations for the pooled items are presented in Table 17.

Intercorrelations between the BSRI and ASRS items are presented in Table 18. Cattell’s scree test (e.g., Cattell, 1966) from the initial PCA suggested that four components be retained for interpretation, which together accounted for 40.97% of the variance in the combined item pool. As some of the components were expected to be correlated (i.e., within the masculinity and femininity domains), these were initially rotated to approximate simple structure using both oblique (direct oblimin) and orthogonal (varimax) procedures. Given that the results of this preliminary analysis indicated some degree of overlap between the resulting components, the outcomes of the oblique rotation are presented here.
Table 17: Means (Ms) and Standard Deviations (SDs) For Scores on the Pooled Items

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loves children</td>
<td>5.99</td>
<td>1.20</td>
</tr>
<tr>
<td>Firm</td>
<td>4.97</td>
<td>1.08</td>
</tr>
<tr>
<td>Dependant</td>
<td>3.33</td>
<td>1.70</td>
</tr>
<tr>
<td>Patient</td>
<td>5.23</td>
<td>1.19</td>
</tr>
<tr>
<td>Bossy</td>
<td>3.19</td>
<td>1.37</td>
</tr>
<tr>
<td>Noisy</td>
<td>2.79</td>
<td>1.42</td>
</tr>
<tr>
<td>Needs approval</td>
<td>3.55</td>
<td>1.46</td>
</tr>
<tr>
<td>Show-off</td>
<td>2.32</td>
<td>1.23</td>
</tr>
<tr>
<td>Appreciative</td>
<td>5.63</td>
<td>1.01</td>
</tr>
<tr>
<td>Nervous</td>
<td>3.24</td>
<td>1.32</td>
</tr>
<tr>
<td>Sensitive to the needs of others</td>
<td>5.65</td>
<td>1.08</td>
</tr>
<tr>
<td>Aggressive</td>
<td>2.68</td>
<td>1.26</td>
</tr>
<tr>
<td>Confident</td>
<td>5.17</td>
<td>1.06</td>
</tr>
<tr>
<td>Competitive</td>
<td>4.30</td>
<td>1.57</td>
</tr>
<tr>
<td>Casual</td>
<td>4.53</td>
<td>1.41</td>
</tr>
<tr>
<td>Timid</td>
<td>2.62</td>
<td>1.30</td>
</tr>
<tr>
<td>Self-critical</td>
<td>4.87</td>
<td>1.33</td>
</tr>
<tr>
<td>Grateful</td>
<td>5.59</td>
<td>1.00</td>
</tr>
<tr>
<td>Sarcastic</td>
<td>3.41</td>
<td>1.46</td>
</tr>
<tr>
<td>Forceful</td>
<td>3.59</td>
<td>1.41</td>
</tr>
<tr>
<td>Weak</td>
<td>2.37</td>
<td>1.07</td>
</tr>
<tr>
<td>Bashful</td>
<td>2.63</td>
<td>1.34</td>
</tr>
<tr>
<td>Mischievous</td>
<td>3.44</td>
<td>1.55</td>
</tr>
<tr>
<td>Responsible</td>
<td>6.20</td>
<td>0.75</td>
</tr>
<tr>
<td>Emotional</td>
<td>4.48</td>
<td>1.50</td>
</tr>
<tr>
<td>Skilled in Business</td>
<td>4.65</td>
<td>1.49</td>
</tr>
<tr>
<td>Shy</td>
<td>3.17</td>
<td>1.43</td>
</tr>
<tr>
<td>Anxious</td>
<td>3.13</td>
<td>1.31</td>
</tr>
<tr>
<td>Devotes self to others</td>
<td>4.71</td>
<td>1.38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feels superior</td>
<td>2.90</td>
<td>1.37</td>
</tr>
<tr>
<td>Boastful</td>
<td>2.27</td>
<td>1.09</td>
</tr>
<tr>
<td>Loyal</td>
<td>6.15</td>
<td>0.86</td>
</tr>
<tr>
<td>Strong</td>
<td>5.36</td>
<td>1.06</td>
</tr>
<tr>
<td>Carefree</td>
<td>3.90</td>
<td>1.39</td>
</tr>
<tr>
<td>Rude</td>
<td>2.02</td>
<td>1.06</td>
</tr>
<tr>
<td>Sees self running the show</td>
<td>3.30</td>
<td>1.63</td>
</tr>
<tr>
<td>Outspoken</td>
<td>3.73</td>
<td>1.48</td>
</tr>
<tr>
<td>Worrying</td>
<td>3.58</td>
<td>1.42</td>
</tr>
<tr>
<td>Gentle</td>
<td>5.32</td>
<td>1.13</td>
</tr>
<tr>
<td>Pleasure-seeking</td>
<td>4.16</td>
<td>1.52</td>
</tr>
<tr>
<td>Defends my own beliefs</td>
<td>5.62</td>
<td>1.14</td>
</tr>
<tr>
<td>Affectionate</td>
<td>5.39</td>
<td>1.22</td>
</tr>
<tr>
<td>Independent</td>
<td>5.82</td>
<td>0.95</td>
</tr>
<tr>
<td>Sympathetic</td>
<td>5.49</td>
<td>1.06</td>
</tr>
<tr>
<td>Assertive</td>
<td>4.74</td>
<td>1.19</td>
</tr>
<tr>
<td>Strong personality</td>
<td>5.13</td>
<td>1.25</td>
</tr>
<tr>
<td>Understanding</td>
<td>5.67</td>
<td>0.91</td>
</tr>
<tr>
<td>Compassionate</td>
<td>5.54</td>
<td>1.06</td>
</tr>
<tr>
<td>Have leadership abilities</td>
<td>5.41</td>
<td>1.21</td>
</tr>
<tr>
<td>Eager to soothe hurt feelings</td>
<td>5.30</td>
<td>1.17</td>
</tr>
<tr>
<td>Willing to take risks</td>
<td>4.34</td>
<td>1.37</td>
</tr>
<tr>
<td>Warm</td>
<td>5.36</td>
<td>1.04</td>
</tr>
<tr>
<td>Dominant</td>
<td>3.91</td>
<td>1.39</td>
</tr>
<tr>
<td>Tender</td>
<td>4.91</td>
<td>1.22</td>
</tr>
<tr>
<td>Willing to take a stand</td>
<td>5.13</td>
<td>1.21</td>
</tr>
<tr>
<td>LOVE</td>
<td>FIRM</td>
<td>DEPE</td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>0.100</td>
<td>1.000</td>
<td>0.000</td>
</tr>
<tr>
<td>0.191</td>
<td>1.000</td>
<td>0.000</td>
</tr>
<tr>
<td>0.008</td>
<td>0.000</td>
<td>1.000</td>
</tr>
<tr>
<td>0.348</td>
<td>0.159</td>
<td>0.000</td>
</tr>
<tr>
<td>0.254</td>
<td>0.030</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Table 18: Inter Item Correlation Matrix
| ANXIO | DEVO | SUPE | BOAS | LOYA | STRO | CARE | RUDE | RUNS | OUTSW | GENT | PLEA | DEFD | AFPE | INDE | SYMP | ASSE | STGP | UNDE | COMP | LEAD | SOOT | TAKE | WAR | DOMI | TEND | TAKS |
|-------|------|------|------|------|------|------|------|------|-------|-------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| 1.000 | 0.104| 1.000 | 0.048| -0.681| 1.000 | 0.124| -0.057| 0.558| 1.000 | -0.052| 0.242| -0.097| -0.163| 0.000 | 0.0228| 0.093| 0.111| 0.036| 0.350| 1.000 | 0.026| 0.411| -0.138| -0.122| 0.258| 0.102| 0.038| -0.275| -0.169| -0.154| 0.051| 1.000 | 0.002| 0.044| 0.131| 0.162| 0.052| 0.067| 0.236| 0.121| -0.061| 0.074| 1.000 | 0.006| 0.007| 1.000 | 0.019| 0.169| 0.128| 0.167| 0.471| 0.105| 0.092| 0.264| 0.427| -0.135| -0.029| 0.128| 0.368| 0.129| 0.385| 0.074| 1.000 | -0.025| 0.364| -0.185| -0.131| 0.341| 0.257| 0.668| -0.267| -0.104| -0.015| -0.028| 0.463| 0.060| 0.209| 0.392| 0.207| 0.590| 0.166| 0.206| 1.000 | -0.179| 0.014| 0.173| 0.125| 0.148| 0.445| 0.026| -0.042| 0.358| 0.293| -0.115| 0.034| 0.027| 0.233| 0.112| 0.357| 0.103| 0.436| 0.425| 0.200| 0.112| 1.000 | 0.101| 0.396| -0.050| -0.008| 0.216| 0.128| 0.031| -0.125| -0.087| -0.061| 0.141| 0.352| 0.106| 0.094| 0.374| 0.077| 0.465| 0.055| 0.070| 0.408| 0.437| 0.123| 1.000 | -0.096| 0.001| 0.100| 0.124| 0.023| 0.235| 0.209| 0.060| 0.171| 0.230| -0.146| 0.054| 0.153| 0.194| 0.085| 0.220| 0.012| 0.280| 0.268| 0.085| 0.034| 0.229| 0.039| 1.000 | -0.093| 0.331| -0.148| -0.130| 0.268| 0.215| 0.144| -0.230| -0.096| -0.022| -0.075| 0.448| 0.132| 0.178| 0.553| 0.163| 0.481| 0.187| 0.179| 0.534| 0.544| 0.148| 0.376| 0.154| 1.000 | -0.018| 0.377| -0.097| -0.082| 0.253| 0.142| 0.135| -0.181| -0.129| -0.106| -0.027| 0.523| 0.136| 0.092| 0.555| 0.086| 0.480| 0.063| 0.054| 0.485| 0.556| 0.095| 0.405| 0.064| 0.619| -0.057| 1.000 | -0.160| 0.045| 0.124| 0.076| 0.128| 0.399| 0.067| 0.038| 0.234| 0.394| -0.159| 0.031| 0.054| 0.473| 0.136| 0.330| 0.105| 0.488| 0.456| 0.195| 0.149| 0.398| 0.022| 0.377| 0.217| 0.361| 0.132| 1.000 |
The oblique solution suggested a modest degree of overlapping variance between Components I and II \((r = -0.20)\), Components II and IV \((r = -0.15)\) and Components III and IV \((r = -0.12)\). Remaining correlations were negligible \((rs = 0.00)\). The structure and pattern matrices from the direct oblimin rotation are presented in Tables 19 and 20. The traditional criterion of 0.30 (see Stevens, 1998) was used to determine loadings that should be retained for interpretation. Based on this criterion, most of the ASRS and BSRI items loaded uniquely on one of the four components. In cases where items cross-loaded, the item was located with the higher component loading. The items "casual" and "dependent" did not load on any of the components using a cutoff loading of 0.30.

As shown in the pattern matrix, Component I was defined by 17 of the pooled items. These items seemed to reflect caring characteristics, such as compassion, understanding, and sympathy. This component was labeled Expressive Orientation. Component II was defined by 19 items. These items seemed to relate to leadership characteristics such as assertive, willing to take a stand, and competitive and was therefore labeled Instrumental. Component III was defined by 9 items, which appeared to relate to feelings of insecurity, for example, anxiety, nervousness, and worrying. This component was labeled Vulnerability. Component IV comprised 8 items, which appeared to relate to ego-centric characteristics such as show-off, boastful, pleasure-seeking. This component was labeled Self Display.

In general, the pattern of results was consistent with the ASRS classifications. However, there were several notable discrepancies. Of the 17 items that loaded onto Component I (Expressive Orientation), 10 items were from the Form A Feminine Positive sub-scale of the ASRS. The remaining 7 items (compassionate, sympathetic, understanding, warm, tender, affectionate and eager to soothe hurt feelings) were from the BSRI Feminine sub-scale.

Of the 19 items that loaded onto Component II (Instrumental), 7 items were from the Form A Masculine Positive sub-scale of the ASRS and 8 items were from the BSRI Masculine sub-scale. The remaining 4 items (Aggressive, Sees self-running the show,
Bossy, Feels superior) were from the Form A Masculine Negative sub-scale of the ASRS. The loading of the items from the Masculine Negative sub-scale of the ASRS onto this component reflect a change in the desirability of these characteristics since the development of the ASRS in 1981.

All 9 items that loaded onto Component III (Vulnerability) were from the Form A Feminine Negative sub-scale of the ASRS.

Of the 8 items that loaded onto Component IV (Self Display), 6 items were from the Form A Masculine Negative sub-scale of the ASRS. The two remaining items (Carefree, and Pleasure seeking) were from the Form A Masculine Positive sub-scale of the ASRS. Again the loading of these two items onto this component reflect a change in the desirability of these characteristics.
# Table 19: Structure Matrix

<table>
<thead>
<tr>
<th>Item</th>
<th>Communality ($h^2$)</th>
<th>Factor I (Expressive Orientation)</th>
<th>Factor II (Instrumental)</th>
<th>Factor III (Vulnerability)</th>
<th>Factor IV (Self display)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassionate</td>
<td>0.571</td>
<td>0.751</td>
<td>-0.017</td>
<td>-0.013</td>
<td>-0.0007</td>
</tr>
<tr>
<td>Understanding</td>
<td>0.545</td>
<td>0.733</td>
<td>0.084</td>
<td>-0.097</td>
<td>0.087</td>
</tr>
<tr>
<td>Sympathetic</td>
<td>0.541</td>
<td>0.733</td>
<td>-0.033</td>
<td>-0.013</td>
<td>0.051</td>
</tr>
<tr>
<td>Warm</td>
<td>0.550</td>
<td>0.716</td>
<td>0.061</td>
<td>-0.177</td>
<td>-0.088</td>
</tr>
<tr>
<td>Sensitive</td>
<td>0.512</td>
<td>0.708</td>
<td>-0.005</td>
<td>0.013</td>
<td>0.111</td>
</tr>
<tr>
<td>Tender</td>
<td>0.527</td>
<td>0.700</td>
<td>-0.051</td>
<td>-0.042</td>
<td>-0.115</td>
</tr>
<tr>
<td>Gentle</td>
<td>0.476</td>
<td>0.659</td>
<td>-0.176</td>
<td>0.041</td>
<td>0.135</td>
</tr>
<tr>
<td>Appreciative</td>
<td>0.415</td>
<td>0.636</td>
<td>0.093</td>
<td>-0.034</td>
<td>0.065</td>
</tr>
<tr>
<td>Affectionate</td>
<td>0.428</td>
<td>0.622</td>
<td>0.020</td>
<td>-0.086</td>
<td>-0.144</td>
</tr>
<tr>
<td>Grateful</td>
<td>0.364</td>
<td>0.588</td>
<td>0.078</td>
<td>0.020</td>
<td>0.081</td>
</tr>
<tr>
<td>Eager to soothe hurt feelings</td>
<td>0.371</td>
<td>0.565</td>
<td>0.093</td>
<td>0.151</td>
<td>0.063</td>
</tr>
<tr>
<td>Devotes self to others</td>
<td>0.330</td>
<td>-0.058</td>
<td>0.142</td>
<td>0.004</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>0.285</td>
<td>0.194</td>
<td>0.598</td>
<td>-0.253</td>
<td>0.039</td>
</tr>
<tr>
<td>Loyal</td>
<td>0.217</td>
<td>0.301</td>
<td>0.588</td>
<td>-0.373</td>
<td>0.027</td>
</tr>
<tr>
<td>Responsible</td>
<td>0.329</td>
<td>0.434</td>
<td>0.238</td>
<td>-0.159</td>
<td>0.287</td>
</tr>
<tr>
<td>Emotional</td>
<td>0.327</td>
<td>0.363</td>
<td>-0.048</td>
<td>0.354</td>
<td>-0.214</td>
</tr>
<tr>
<td>Loves children</td>
<td>0.129</td>
<td>0.353</td>
<td>0.054</td>
<td>-0.078</td>
<td>0.002</td>
</tr>
<tr>
<td>Dominant</td>
<td>0.544</td>
<td>-0.148</td>
<td>0.702</td>
<td>-0.049</td>
<td>-0.275</td>
</tr>
<tr>
<td>Assertive</td>
<td>0.524</td>
<td>0.151</td>
<td>0.696</td>
<td>-0.280</td>
<td>-0.108</td>
</tr>
<tr>
<td>Strong personality</td>
<td>0.528</td>
<td>0.153</td>
<td>0.695</td>
<td>-0.280</td>
<td>-0.150</td>
</tr>
<tr>
<td>Forceful</td>
<td>0.446</td>
<td>-0.198</td>
<td>0.625</td>
<td>-0.041</td>
<td>-0.217</td>
</tr>
<tr>
<td>Outspoken</td>
<td>0.391</td>
<td>-0.096</td>
<td>0.600</td>
<td>-0.117</td>
<td>-0.240</td>
</tr>
<tr>
<td>Have leadership abilities</td>
<td>0.417</td>
<td>0.194</td>
<td>0.598</td>
<td>-0.253</td>
<td>0.039</td>
</tr>
<tr>
<td>Strong</td>
<td>0.493</td>
<td>0.301</td>
<td>0.588</td>
<td>-0.373</td>
<td>0.027</td>
</tr>
<tr>
<td>Willing to take a stand</td>
<td>0.397</td>
<td>0.200</td>
<td>0.585</td>
<td>-0.261</td>
<td>-0.052</td>
</tr>
<tr>
<td>Competitive</td>
<td>0.295</td>
<td>-0.071</td>
<td>0.536</td>
<td>-0.071</td>
<td>-0.065</td>
</tr>
<tr>
<td>Confident</td>
<td>0.435</td>
<td>0.161</td>
<td>0.536</td>
<td>-0.461</td>
<td>0.034</td>
</tr>
<tr>
<td>Sees self running show</td>
<td>0.286</td>
<td>-0.177</td>
<td>0.497</td>
<td>-0.065</td>
<td>-0.171</td>
</tr>
<tr>
<td>Aggressive</td>
<td>0.438</td>
<td>-0.295</td>
<td>0.488</td>
<td>0.174</td>
<td>-0.352</td>
</tr>
<tr>
<td>Firm</td>
<td>0.252</td>
<td>0.102</td>
<td>0.477</td>
<td>-0.174</td>
<td>0.041</td>
</tr>
<tr>
<td>Independent</td>
<td>0.317</td>
<td>0.234</td>
<td>0.458</td>
<td>-0.288</td>
<td>0.078</td>
</tr>
<tr>
<td>Bossy</td>
<td>0.365</td>
<td>-0.229</td>
<td>0.471</td>
<td>-0.174</td>
<td>-0.283</td>
</tr>
<tr>
<td>Skilled in business</td>
<td>0.237</td>
<td>0.134</td>
<td>0.428</td>
<td>-0.242</td>
<td>0.089</td>
</tr>
<tr>
<td>Feels superior</td>
<td>0.287</td>
<td>-0.244</td>
<td>0.398</td>
<td>0.098</td>
<td>-0.305</td>
</tr>
<tr>
<td>Defends my own beliefs</td>
<td>0.211</td>
<td>0.232</td>
<td>0.386</td>
<td>-0.191</td>
<td>-0.014</td>
</tr>
<tr>
<td>Willing to take risks</td>
<td>0.173</td>
<td>0.081</td>
<td>0.354</td>
<td>-0.176</td>
<td>-0.203</td>
</tr>
<tr>
<td>Anxious</td>
<td>0.530</td>
<td>-0.033</td>
<td>-0.113</td>
<td>0.725</td>
<td>-0.047</td>
</tr>
<tr>
<td>Nervous</td>
<td>0.501</td>
<td>0.026</td>
<td>-0.212</td>
<td>0.698</td>
<td>-0.052</td>
</tr>
<tr>
<td>Worrying</td>
<td>0.460</td>
<td>-0.009</td>
<td>-0.075</td>
<td>0.670</td>
<td>-0.033</td>
</tr>
<tr>
<td>Weak</td>
<td>0.458</td>
<td>-0.057</td>
<td>-0.431</td>
<td>0.582</td>
<td>-0.140</td>
</tr>
<tr>
<td>Shy</td>
<td>0.383</td>
<td>-0.002</td>
<td>-0.320</td>
<td>0.568</td>
<td>0.089</td>
</tr>
<tr>
<td>Bashful</td>
<td>0.332</td>
<td>-0.025</td>
<td>-0.255</td>
<td>0.556</td>
<td>-0.021</td>
</tr>
<tr>
<td>Timid</td>
<td>0.362</td>
<td>0.037</td>
<td>-0.394</td>
<td>0.517</td>
<td>0.031</td>
</tr>
<tr>
<td>Needs approval</td>
<td>0.275</td>
<td>0.077</td>
<td>-0.192</td>
<td>0.414</td>
<td>-0.029</td>
</tr>
<tr>
<td>Self-critical</td>
<td>0.174</td>
<td>0.200</td>
<td>-0.034</td>
<td>0.341</td>
<td>0.012</td>
</tr>
<tr>
<td>Dependent</td>
<td>0.045</td>
<td>-0.036</td>
<td>-0.125</td>
<td>0.192</td>
<td>-0.013</td>
</tr>
<tr>
<td>Show-off</td>
<td>0.461</td>
<td>-0.180</td>
<td>0.234</td>
<td>0.125</td>
<td>-0.648</td>
</tr>
<tr>
<td>Noisy</td>
<td>0.408</td>
<td>-0.112</td>
<td>0.264</td>
<td>0.099</td>
<td>-0.608</td>
</tr>
<tr>
<td>Boastful</td>
<td>0.356</td>
<td>-0.224</td>
<td>0.286</td>
<td>0.184</td>
<td>-0.500</td>
</tr>
<tr>
<td>misconductive</td>
<td>0.252</td>
<td>0.018</td>
<td>0.152</td>
<td>-0.016</td>
<td>-0.490</td>
</tr>
<tr>
<td>Pleasure-seeking</td>
<td>0.201</td>
<td>0.114</td>
<td>0.103</td>
<td>0.035</td>
<td>-0.420</td>
</tr>
<tr>
<td>Rude</td>
<td>0.317</td>
<td>-0.342</td>
<td>0.204</td>
<td>0.223</td>
<td>-0.405</td>
</tr>
<tr>
<td>Sarcastic</td>
<td>0.267</td>
<td>-0.310</td>
<td>0.193</td>
<td>0.197</td>
<td>-0.376</td>
</tr>
<tr>
<td>Carefree</td>
<td>0.213</td>
<td>0.142</td>
<td>0.052</td>
<td>-0.254</td>
<td>-0.319</td>
</tr>
<tr>
<td>Casual</td>
<td>0.092</td>
<td>0.063</td>
<td>-0.044</td>
<td>-0.041</td>
<td>-0.264</td>
</tr>
</tbody>
</table>
Table 20: Pattern Matrix

<table>
<thead>
<tr>
<th>Factor I (Expressive Orientation)</th>
<th>Factor II (Instrumental)</th>
<th>Factor III (Vulnerability)</th>
<th>Factor IV (Self display)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassionate</td>
<td>0.761</td>
<td>0.019</td>
<td>0.049</td>
</tr>
<tr>
<td>Sympathetic</td>
<td>0.738</td>
<td>-0.027</td>
<td>0.052</td>
</tr>
<tr>
<td>Understanding</td>
<td>0.729</td>
<td>0.086</td>
<td>-0.004</td>
</tr>
<tr>
<td>Warm</td>
<td>0.717</td>
<td>0.003</td>
<td>-0.124</td>
</tr>
<tr>
<td>Tender</td>
<td>0.715</td>
<td>-0.085</td>
<td>-0.012</td>
</tr>
<tr>
<td>Sensitive</td>
<td>0.712</td>
<td>0.021</td>
<td>0.094</td>
</tr>
<tr>
<td>Gentle</td>
<td>0.662</td>
<td>-0.152</td>
<td>0.082</td>
</tr>
<tr>
<td>Appreciative</td>
<td>0.638</td>
<td>0.106</td>
<td>0.054</td>
</tr>
<tr>
<td>Affectionate</td>
<td>0.634</td>
<td>-0.024</td>
<td>-0.054</td>
</tr>
<tr>
<td>Grateful</td>
<td>0.593</td>
<td>0.106</td>
<td>0.107</td>
</tr>
<tr>
<td>Eager to soothe hurt feelings</td>
<td>0.592</td>
<td>0.036</td>
<td>0.206</td>
</tr>
<tr>
<td>Devotes self to others</td>
<td>0.560</td>
<td>-0.026</td>
<td>0.188</td>
</tr>
<tr>
<td>Patient</td>
<td>0.465</td>
<td>-0.146</td>
<td>-0.166</td>
</tr>
<tr>
<td>Loyal</td>
<td>0.425</td>
<td>0.159</td>
<td>-0.011</td>
</tr>
<tr>
<td>Emotional</td>
<td>0.417</td>
<td>-0.006</td>
<td>0.369</td>
</tr>
<tr>
<td>Responsible</td>
<td>0.405</td>
<td>0.274</td>
<td>-0.020</td>
</tr>
<tr>
<td>Loves children</td>
<td>0.351</td>
<td>0.042</td>
<td>-0.039</td>
</tr>
<tr>
<td>Dominant</td>
<td>-0.132</td>
<td>0.692</td>
<td>0.060</td>
</tr>
<tr>
<td>Assertive</td>
<td>0.139</td>
<td>0.662</td>
<td>-0.138</td>
</tr>
<tr>
<td>Strong personality</td>
<td>0.143</td>
<td>0.654</td>
<td>-0.143</td>
</tr>
<tr>
<td>Forceful</td>
<td>-0.187</td>
<td>0.622</td>
<td>0.054</td>
</tr>
<tr>
<td>Have leadership abilities</td>
<td>0.173</td>
<td>0.591</td>
<td>-0.104</td>
</tr>
<tr>
<td>Outspoken</td>
<td>-0.088</td>
<td>0.572</td>
<td>-0.028</td>
</tr>
<tr>
<td>Willing to take a stand</td>
<td>0.185</td>
<td>0.557</td>
<td>-0.131</td>
</tr>
<tr>
<td>Strong</td>
<td>0.272</td>
<td>0.550</td>
<td>-0.229</td>
</tr>
<tr>
<td>Competitive</td>
<td>-0.073</td>
<td>0.548</td>
<td>0.035</td>
</tr>
<tr>
<td>Aggressive</td>
<td>-0.256</td>
<td>0.500</td>
<td>0.223</td>
</tr>
<tr>
<td>Sees self running show</td>
<td>-0.171</td>
<td>0.487</td>
<td>0.007</td>
</tr>
<tr>
<td>Bossy</td>
<td>-0.192</td>
<td>0.487</td>
<td>0.260</td>
</tr>
<tr>
<td>Firm</td>
<td>0.086</td>
<td>0.480</td>
<td>-0.057</td>
</tr>
<tr>
<td>Confident</td>
<td>0.121</td>
<td>0.473</td>
<td>-0.347</td>
</tr>
<tr>
<td>Independent</td>
<td>0.207</td>
<td>0.453</td>
<td>-0.163</td>
</tr>
<tr>
<td>Skilled in business</td>
<td>0.109</td>
<td>0.420</td>
<td>-0.131</td>
</tr>
<tr>
<td>Feels superior</td>
<td>-0.215</td>
<td>0.394</td>
<td>0.132</td>
</tr>
<tr>
<td>Defends my own beliefs</td>
<td>0.220</td>
<td>0.368</td>
<td>-0.094</td>
</tr>
<tr>
<td>Willing to take risks</td>
<td>0.082</td>
<td>0.300</td>
<td>-0.129</td>
</tr>
<tr>
<td>Anxious</td>
<td>0.036</td>
<td>0.044</td>
<td>0.743</td>
</tr>
<tr>
<td>Worrying</td>
<td>0.054</td>
<td>0.074</td>
<td>0.697</td>
</tr>
<tr>
<td>Nervous</td>
<td>0.093</td>
<td>-0.071</td>
<td>0.694</td>
</tr>
<tr>
<td>Shy</td>
<td>0.004</td>
<td>-0.191</td>
<td>0.548</td>
</tr>
<tr>
<td>Bashful</td>
<td>0.026</td>
<td>-0.145</td>
<td>0.532</td>
</tr>
<tr>
<td>Weak</td>
<td>0.036</td>
<td>-0.351</td>
<td>0.496</td>
</tr>
<tr>
<td>Timid</td>
<td>0.081</td>
<td>-0.294</td>
<td>0.470</td>
</tr>
<tr>
<td>Self-critical</td>
<td>0.233</td>
<td>0.048</td>
<td>0.378</td>
</tr>
<tr>
<td>Needs approval</td>
<td>0.137</td>
<td>-0.163</td>
<td>0.360</td>
</tr>
<tr>
<td>Dependent</td>
<td>-0.019</td>
<td>-0.091</td>
<td>0.171</td>
</tr>
<tr>
<td>Show-off</td>
<td>-0.122</td>
<td>0.158</td>
<td>0.072</td>
</tr>
<tr>
<td>Noisy</td>
<td>-0.058</td>
<td>0.192</td>
<td>0.065</td>
</tr>
<tr>
<td>Mischievous</td>
<td>0.054</td>
<td>0.067</td>
<td>-0.056</td>
</tr>
<tr>
<td>Pleasure-seeking</td>
<td>0.148</td>
<td>0.032</td>
<td>-0.027</td>
</tr>
<tr>
<td>Boastful</td>
<td>-0.172</td>
<td>0.256</td>
<td>0.168</td>
</tr>
<tr>
<td>Carefree</td>
<td>0.145</td>
<td>-0.065</td>
<td>-0.298</td>
</tr>
<tr>
<td>Rude</td>
<td>-0.286</td>
<td>0.195</td>
<td>0.195</td>
</tr>
<tr>
<td>Sarcastic</td>
<td>-0.268</td>
<td>0.182</td>
<td>0.171</td>
</tr>
<tr>
<td>Casual</td>
<td>0.080</td>
<td>-0.107</td>
<td>-0.090</td>
</tr>
</tbody>
</table>
Impact of Occupational Group on Sex Roles

To determine whether sex role scores differed across the three occupational groups (male nurses, female nurses, male engineers), two one-way multivariate analyses of variance (MANOVAs) were performed, one for scores on the feminine components, and one for scores on the masculine components. In each case, factor scores generated by the factor analysis were entered as dependent variables.

The Pillai-Bartlett trace (V) was used as the multivariate criterion, given that this criterion has been found to be more robust to minor violations of MANOVA assumptions than others such as the Wilks’ Lambda (see Tabachnick and Fidell, 1989). Given that there were significant correlations between the four factor scores (Bartlett’s $\chi^2(1) = 12.40, p < 0.001$), stepdown analyses were used in addition to univariate ANOVAs in the interpretation of significant MANOVA effects, to assess the extent to which effects obtained on individual dependent measures were independent (i.e., partialling out effects associated with overlapping variance in the subscale scores; see Stevens, 1996). In each analysis, the positive subscale was entered prior to the negative subscale in the stepdown analysis. All univariate and stepdown $F$s were tested for significance at adjusted $\alpha$ levels to maintain familywise $\alpha$ at or below 0.05 for the pair of dependent measures within each subset. Significant univariate effects are also accompanied with an effect size estimate based on the partial eta squared ($\eta^2$) statistic, to indicate the proportion of variance associated with each effect.

Further screening procedures for conformity to univariate and multivariate analysis of variance assumptions produced satisfactory results. Mahalanobis distances (calculated separately for each of the three cells of the design) suggested no significant multivariate outliers at the 0.001 level, and determinants for all within-cell correlation matrices suggested no threat of multicollinearity between the three dependent measures. Assumptions for univariate and multivariate normality were

1 As indicated by Tabachnick and Fidell (1989), however, the partial $\eta^2$ statistic considers each effect only in terms of the variance attributable to that effect plus error. As such, the partial $\eta^2$ statistics for all significant effects in a design do not strictly sum to the proportion of systematic variance in the dependent variable, and often sum to a number greater than 1.00.
judged to be tenable, although some degree of negative skew was evident for all three subscales. This, in turn, produced marginal violations of the homogeneity of variance assumption. However, as noted by Stevens (1996), the $F$ statistic is robust to violations of normality and homogeneity that result from skewness as long as cell sizes are approximately equal (i.e., provided that the ratio between the smallest and largest cell numbers is less than one to one-and-a-half). As this criterion was met in the present case, the modest levels of skewness present across the three subscales would have a negligible effect on the analysis outcomes.

**Feminine Subscales**

Means and standard deviations for scores on the Expressive Orientation and Vulnerability sub-scales are shown in Table 21. Based on the Pillai-Bartlett criterion, the multivariate test for the effect of occgroup was significant ($V = 0.12, F_{(4,1802)} \approx 29.88, p < 0.0001$). Given that there were significant correlations between the four factor scores (Bartlett's $\chi^2_{(1)} = 12.40, p < 0.001$), stepdown analyses were used in addition to univariate ANOVAs in the interpretation of significant MANOVA effects, to assess the extent to which effects obtained on individual dependent measures were independent (i.e., partialling out effects associated with overlapping variance in the subscale scores; see Stevens, 1996). In each analysis, the positive (Expressive Orientation) subscale was entered prior to the negative (Vulnerability) subscale in the stepdown analysis.

Table 21: Means ($M$s) and Standard Deviations ($SD$s) for Scores on the Expressive Orientation and Vulnerability sub-scales

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>Male Engineer</th>
<th>Female Nurse</th>
<th>Male Nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressive Orientation</td>
<td>$M$</td>
<td>-0.493</td>
<td>0.321</td>
<td>0.055</td>
</tr>
<tr>
<td></td>
<td>$N$</td>
<td>254</td>
<td>340</td>
<td>310</td>
</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>0.999</td>
<td>0.828</td>
<td>0.913</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>$M$</td>
<td>0.012</td>
<td>0.0710</td>
<td>-0.090</td>
</tr>
<tr>
<td></td>
<td>$N$</td>
<td>254</td>
<td>340</td>
<td>310</td>
</tr>
<tr>
<td></td>
<td>$SD$</td>
<td>0.852</td>
<td>0.950</td>
<td>0.969</td>
</tr>
</tbody>
</table>
Univariate ANOVAs indicated a significant effect on the Expressive Orientation subscale at an adjusted $\alpha$ level of 0.025 ($F_{(2,901)} = 59.36, p < 0.0001$, partial $\eta^2 = 0.11$), but only a marginal effect on the Vulnerability subscale ($F_{(2,901)} = 2.46, p = 0.086$, partial $\eta^2 = 0.005$). The effect on the Vulnerability subscale did, however, become significant at stepdown, $F_{(2,900)} = 3.79, p = 0.023$), indicating that with the scores on the Expressive Orientation subscale accounted for, there was a significant difference on this subscale. However, given that this effect only emerged at stepdown, the effect should not be interpreted as independent of the effect on the Expressive Orientation subscale. From the means presented in Table 21, the effect on the Expressive Orientation subscale indicated that female nurses scored higher than male nurses, who in turn scored higher than male engineers. Post-hoc tests using Tukey’s HSD indicated that the differences amongst the means for all groups were significant ($p < 0.025$).

**Masculine subscales**

Means and standard deviations for scores on the Instrumental and Self-display subscales are shown in Table 22. Based on the Pillai-Bartlett criterion, the multivariate test for the effect of occupational group was significant ($V = 0.04, F_{(4,1802)} = 9.55, p < 0.0001$). Given that there were significant correlations between the two factor scores (Bartlett’s $\chi^2(1) = 44.80, p < 0.0001$), stepdown analyses were used in addition to univariate ANOVAs in the interpretation of significant MANOVA effects, to assess the extent to which effects obtained on individual dependent measures were independent (i.e., partialling out effects associated with overlapping variance in the subscale scores; see Stevens, 1996). In this analysis, the positive (Instrumental) subscale was entered prior to the negative (Self-display) subscale in the stepdown analysis.
Table 22: Means (Ms) and Standard Deviations (SDs) for Scores on the Instrumental and Self-display sub-scales

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>Instrumental</th>
<th>Self Display</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Engineer</td>
<td>0.171</td>
<td>0.173</td>
</tr>
<tr>
<td>Female Nurse</td>
<td>-0.149</td>
<td>-0.085</td>
</tr>
<tr>
<td>Male Nurse</td>
<td>0.024</td>
<td>-0.049</td>
</tr>
<tr>
<td>Total</td>
<td>0.001</td>
<td>-0.001</td>
</tr>
<tr>
<td>N</td>
<td>254</td>
<td>340</td>
</tr>
<tr>
<td>SD</td>
<td>0.931</td>
<td>0.925</td>
</tr>
<tr>
<td></td>
<td>310</td>
<td>340</td>
</tr>
<tr>
<td></td>
<td>904</td>
<td>904</td>
</tr>
<tr>
<td>N</td>
<td>254</td>
<td>340</td>
</tr>
<tr>
<td>SD</td>
<td>0.848</td>
<td>0.887</td>
</tr>
<tr>
<td></td>
<td>310</td>
<td>340</td>
</tr>
<tr>
<td></td>
<td>904</td>
<td>904</td>
</tr>
</tbody>
</table>

Univariate ANOVAs indicated a significant effect on both the Instrumental and Self-display subscales at an adjusted $\alpha$ level of 0.025 ($F(2,901) = 8.46, p < 0.0001$, partial $\eta^2 = 0.02$; $F(2,901) = 7.01, p = 0.001$, partial $\eta^2 = 0.02$). The effect on the Self-display subscale also remained significant at stepdown, ($F(2,900) = 10.81, p < 0.0001$), indicating that the effects on the two subscales were independent of one another.

From the means presented in Table 22, the effect on both the Instrumental and Self-display subscales indicated that female nurses scored lowest, followed by male nurses, and then male engineers. Post-hoc tests using Tukey's HSD on the Instrumental subscale indicated a significant difference only between the male engineers and female nurses. On the Self-display scale, both male nurses and male engineers differed significantly from female nurses, but did not differ significantly from one another ($\alpha = 0.025$).

**Decomposition of the Relationship Between Occupational Group and Sex Roles**

Based on the outcomes presented in the previous section, scores on both the positive and negative masculine and feminine sex role scales differed significantly across occupational groups. As indicated in the descriptive statistics presented in Chapter 3, however, a number of demographic characteristics (age, number of dependents, qualification level, sexuality, and relationships) also differed significantly across occupational groups. Previous studies on the nature of sex roles have suggested that these variables may also correlate with feminine and masculine characteristics. For
example, several cross-sectional (Hyde and Phillis 1979; Hyde, Krajnik and Skuldt-Niederberger 1991; Turner and Turner 1991) and longitudinal studies (Hyde, Krajnik and Skuldt-Niederberger 1991; Paker and Aldwin 1997) have investigated the effects of age on sex role. The results of these studies suggest that a crossover effect occurs with age, where men decrease in masculinity as they become older (Paker and Aldwin 1997; Turner and Turner 1991) and become more androgynous (Hyde and Phillis 1979; Hyde, Krajnik and Skuldt-Niederberger 1991) and women increase in masculinity until they reach middle age. Similarly, several studies have identified differences in perceived sex role characteristics between homosexual and heterosexual men and women (Carlson and Baxter 1984; Kurdek 1987; Hellwege, Perry and Dobson 1988).

As such, it was necessary to determine what portion of the relationship between occupational group and sex roles was directly ascribable to differences in occupation, versus the portion that could be ascribed to variables confounded with occupational choice. To decompose the relationship between occupational group and scores on the four sex role subscales, a path analysis was used. A conceptual diagram of the model tested is presented in Figure 1.

Figure 1. Conceptual Path Diagram for Relationships Tested Between Occupational Group and Sex Roles
Preliminary screening analyses for conformity to multiple regression and path analysis assumptions were performed separately for each subsample used. In each case, adequate conformity was established for the assumptions of sample size, multicollinearity, normality, linearity, additivity, and homoscedasticity.

The correlation matrix for all variables included in the analysis is presented in Table 23. Given that the variables included in the analysis represented different levels of measurement (categorical, ordinal, and interval), each of the correlations within this matrix was determined separately. As recommended by Joreskog & Sorebom (1996), canonical correlation analysis was used to compute the correlations between all of the categorical and ordered categorical (ordinal) variables used in the matrix. Canonical correlations were also used for mixtures of these and the interval-level variables. Pearson correlations were performed for all interval-interval pairs within the matrix.

<table>
<thead>
<tr>
<th></th>
<th>occgroup</th>
<th>age</th>
<th>qualific</th>
<th>depend</th>
<th>sexpref</th>
<th>relation</th>
<th>Expressive Orientation</th>
<th>Vulnerability</th>
<th>Instrumental</th>
<th>Self-display</th>
</tr>
</thead>
<tbody>
<tr>
<td>occgroup</td>
<td>1.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>age</td>
<td>0.4682</td>
<td>1.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>qualific</td>
<td>0.2321</td>
<td>0.0150</td>
<td>1.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>depend</td>
<td>0.1902</td>
<td>0.4041</td>
<td>0.0065</td>
<td>1.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sexpref</td>
<td>0.2525</td>
<td>0.0106</td>
<td>0.0293</td>
<td>0.2291</td>
<td>1.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>relation</td>
<td>0.1139</td>
<td>0.3144</td>
<td>0.0732</td>
<td>0.4856</td>
<td>0.4340</td>
<td>1.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressive Orientation</td>
<td>0.3537</td>
<td>0.1282</td>
<td>0.1171</td>
<td>0.0130</td>
<td>0.0622</td>
<td>0.1042</td>
<td>1.0000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vulnerability</td>
<td>0.0739</td>
<td>0.0059</td>
<td>0.0297</td>
<td>0.0710</td>
<td>0.0372</td>
<td>0.1181</td>
<td>-0.0005</td>
<td>1.0000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instrumental</td>
<td>0.1437</td>
<td>0.1717</td>
<td>0.0764</td>
<td>0.1420</td>
<td>0.0267</td>
<td>0.0510</td>
<td>0.0064</td>
<td>-0.0566</td>
<td>1.0000</td>
<td></td>
</tr>
<tr>
<td>Self display</td>
<td>0.1404</td>
<td>0.1595</td>
<td>0.0206</td>
<td>0.0874</td>
<td>0.0652</td>
<td>0.1081</td>
<td>-0.0208</td>
<td>0.0541</td>
<td>0.0674</td>
<td>1.0000</td>
</tr>
</tbody>
</table>
Outcomes of the path analysis on this matrix, showing standardised coefficients for the model parameters and corresponding standard errors (in parentheses) are shown in Figure 2. Based on a critical $t$-value of 1.96 ($\alpha = 0.05$ for $df > 120$), occupational group correlated significantly with all five of the demographic variables included in the analysis: age ($t = 15.96$), qualification level ($t = 7.19$), the number of dependents ($t = 5.83$), sexuality ($t = 7.86$), and relationships ($t = 3.45$).

Figure 2: Path Diagram showing standardised coefficients for the model parameters and corresponding standard errors (in parentheses)

Significant relationships were also found between these demographic variables and sex roles. Expressive Orientation and Vulnerability were found to be significantly related to age ($t = -0.10, -2.76$), qualification level ($t = -14.84, -4.00$), dependents ($t = -13.74, -11.02$), sexuality ($t = 19.73, -9.05$) and relationships ($t = 23.89, 13.55$).
Self display was also significantly related to all of these variables \((t_s = -11.47, -4.50, -11.15, -11.14, 16.72, \text{ respectively})\). Instrumental was, however, related to only three of these variables (age: \(t = 3.28\), qualification: \(t = 2.15\), and dependents: \(t = 3.54\)). Sexuality and relationships did not correlate significantly with Instrumental \((t_s = 0.42\) and \(-1.87, \text{ respectively})\).

This analysis also indicated significant indirect effects of occupational group on Expressive Orientation \((t = -12.37)\), Vulnerability \((t = -5.62)\), Instrumental \((t = 4.04)\), and Self-display \((t = -9.38)\). Based on the pattern of relationships shown in Figure 2, these indirect effects were mediated primarily through the age, qualifications, dependents, and sexuality variables.

After taking these indirect effects into account, however, the analysis still indicated strong significant direct relationships between occupational group and Expressive Orientation \((t = 27.67)\) and Self display \((t = 12.42)\). The direct relationship between occupational group and Vulnerability was also significant, although weaker \((t = 6.37)\), while the relationship between Instrumental and occupational group was not significant \((t = 1.32)\).

These outcomes indicate that after differences in age, qualifications, dependents, sexual preferences, and relationships across occupational groups are taken into account, there was a significant relationship between occupational group and Expressive Orientation, Self display, and Vulnerability characteristics. From the results presented in the previous section, female nurses were significantly higher than male nurses who were in turn significantly higher than male engineers on the Expressive Orientation subscale. No difference was found between male engineers and male nurses on the Self display subscales, however, there was a statistically significant difference found between female nurses and both male groups. Female nurses were higher on the Vulnerability subscale than male engineers, followed by male nurses. However, the differences between the occupation groups on the Vulnerability subscale were only significant after step-down.
Despite the fact the MANOVAs indicated significant differences across the three groups on Instrumental, the outcomes of the path analysis suggested that these effects were primarily due to the impact of demographic variables that were confounded with the occupational group categories. In particular, for Instrumental, there were three such variables (age, dependants, and qualification level). All of these variables, in turn, correlated significantly with the occupational group variable. Therefore, the relationship between occupational group and Instrumental can be ascribed to the joint relationship between these two sets of variables, rather than to a direct effect of occupation on positive masculine characteristics per se.

**Concluding Thoughts**

These results are not surprising as they partly support the findings from previous studies in other countries and in Australia. Whilst there was a significant difference between the three groups for Expressive Orientation and between female nurses and the male samples for Self Display, no differences were found for Instrumentality. A weak difference was found for Vulnerability but this only occurred when the effect of the Expressive Orientation component was partitioned out. These results do not support the notion of sex specific characteristics. Whilst male nurses are significantly lower than female nurses for Expressive Orientation, they were also significantly higher than male engineers. It appears that there is an occupational difference for Expressive Orientation for men. In addition, the no difference finding for the Instrumental component supports that the items within the Instrumentality component are socially desirable and do not reflect masculine traits.

The fact that four reliable components were uncovered within this population that are consistent with previous research (Antill et al 1981) indicates that the components are in fact measuring differing personality characteristics, but these characteristics may no longer have anything to do with masculinity and femininity as identified through traditional sex role stereotypes (Ballard-Reisch and Elton 1992). These results simply reflect the differences in characteristics of the occupations. However, these results do support the notion that male nurses have characteristics that are perceived to be essential for nurses, at least when compared with other males.
The results of this study do confirm the multiplicity in self-perceived identity, as measured by personality characteristics. Whilst differences in expressive characteristics were found between male and female nurses, a similar difference was found between male nurses and male engineers, supporting the notion that male nurses perceive themselves as having feminine characteristics essentially required for nursing. Alternatively, male engineers subscribe to a more traditional view of masculine identity, by identifying most strongly with masculine characteristics and distancing themselves from the feminine characteristics. The male engineer sample scored the highest on the instrumental component and the lowest on both feminine components (Expressive Orientation and Vulnerability).

This study examined self descriptions, the way the participant perceives themselves to be, rather than the reality of how they are. As previously discussed in chapter 1, a limitation of categorical theories of gender is their inability to explain gender inequalities, within each gender and between genders. Male nurses clearly identify themselves as having the characteristics that others, female nurses and male engineers, attributed to women. Male nurses also self-identify occupational stereotypes, which can be understood as a consequence of conflicting with gender norms. The methodology used in this study examines perceptions, highly influenced by social expectations, rather than the reality of individuals’ lives. How society constructs cultural norms and how these impact on those whose identities do not comply with the norm cannot be conclusively examined using this methodology. The theoretical underpinnings of this survey do not allow for individual agency, the way individuals engage in gender politics through social practice. How male nurses combat stereotypes and position themselves in nursing and in the broader society remains to be understood. For these reasons a Life History project with a sample of male nurses was undertaken.

The results of the Life History study are presented in Chapters 7, 8, and 9. Chapter 7, Life History Case Studies documents 4 individual case studies, giving a comprehensive narrative of the participants’ lives. Chapter 8, Gender Structures and Types of Masculinity, presents a collective analysis of the lives of 21 participants,
showing how three patterns of masculinity emerge from these life stories. Chapter 9, *Cautious Carer: Professional Injury and Male Nurse Care*, presents two themes that emerge from the collective analysis of the men’s lives: *Professional Injury* and *Being a Chameleon* — sexual identity, performance masculinity and men’s caring.
CHAPTER 6
Methodology and Method: The Life History Project

Introduction

This chapter presents the methods used in the second stage of this thesis. The methodological framework that informed this stage was based on gender relations and masculinity theory. The broader purpose of this study was to document and examine the life experiences of men who are nurses. This project adopts the view that masculinity is not a fixed unaltered identity, but is defined as configurations of social practice, forever being contested and reconstructed, producing multiple masculinities that are complex, contradictory and ordered (Connell 1995). The aim of this project is to investigate social practises in which relationships between male nurses and others are constructed, in order to locate their position in the gender order. The study will inextricably address the following research questions.

- How do male nurses describe their gender relationships within the institutions of the family, work and other social networks?
- What are the social practises that construct gender relations between male nurses with others?
- What are the issues for male nurses that place their construction of masculinity under pressure?
- What strategies do male nurses employ to overcome these pressures placed on their construction of masculinity?

Life History as Method

The Life History method aims to document a person’s life or a significant part of their life as narrative, through the telling and recording of one’s life (Plummer 2001). The life story (biography) is not the life experience but a representation of it and is a way of organizing the experience and fashioning or verifying identity (Atkinson 1998). The life story is a constructed account, a representation of the life as lived, which is interpreted and reconstructed in a historical moment by the informant (Denzin 1989). Despite the life story being a reconstruction, the personal narrative (life story) is a most helpful way to gain a perspective on and understanding of the gendered experiences of men who are nurses.
Life history is used to explain an individual’s understanding of social events, movements and political causes or how individual members of groups or institutions, see certain events and how they see, experience and interpret those events. In this study the life history can help the researcher define a person’s place in the social order of things, the processes used and social structures that influence gender relations.

Plummer (2001) in his book *Documents of Life 2*, outlines the distinctions between different kinds of life stories: the long and the short; the comprehensive, the topical and the edited; and the naturalistic, researched and reflexive. In this study focused, topical, short life stories of several men were examined rather than a single in depth life story. Unlike the comprehensive life story, the topical life story, according to Plummer (2001), does not aim to grasp the totality of the informant’s life but rather examines a highly focused area of the life. These life stories are edited and woven together to create a map of sociological meaning. The life stories produced for this study are not naturalistic, they did not naturally occur, but were researched in order to bring into being sociological life histories that otherwise would not have been evident in every day life.

**Participant Inclusion**

The sampling procedure for this stage of the project aimed to capture the life stories from men who work in a cross-section of nursing specialties. It was important to capture the stories of men who work in areas of nursing practice where traditionally males are under-represented, including midwifery and paediatric nursing. Twenty-one men who were currently practising as a registered nurse in the State of New South Wales were selected to participate in this study using a combination of passive snowballing and quota sampling techniques. In the first instance, academics in the Faculty of Nursing, University of Sydney, were asked to discuss the research with contacts that they thought would be interested in volunteering as subjects. Those potential subjects were then asked to contact myself. These subjects were then asked for their assistance in getting in touch with others who had similar characteristics. This process of sampling continued until the sample was selected.
In order to get representation from a cross-section of nursing specialties, a quota sampling system was used in conjunction with snowballing. Subjects were selected based on their area of nursing practice. The five specialty nursing groups consisted of medical/surgical nursing, mental health nursing, critical care nursing, maternal and child health nursing, and gerontological, rehabilitation and palliative care nursing. Four participants were selected for each of the 5 specialty groups. An additional participant was included in the study as he provided insight into the experiences of a military nurse. The inclusion of this participant allowed the examination of gender relations with male nurses within an alternative, traditionally masculine institution.

Seventeen of the participants approached the researcher directly to volunteer for inclusion in the study, after they had been made aware of the study by colleagues of the researcher. Four participants approached the researcher indirectly through colleagues of the researcher. All participants gave written consent to participate in the study. No participants withdrew from the study. There were two potential participants willing to take part who were not included in the study because they lived and worked in remote rural areas, making the scheduling of the interview too difficult.

The Interview
The design of this project is qualitative, specifically focused interviews (semi-structured). In this study, the life story interview seeks to obtain an in-depth, rich, life narrative (biography). The use of semi-structured interviews allowed the researcher to focus on broad areas of interest, however allowing the respondent to tell their story, in an attempt to understand the complex behavior of members of society without imposing any apriori categorization that may limit the field of inquiry (Denzin & Lincoln 1998). The interviews were conversation style with no fixed questions, yet each interview covered a series of predetermined topics (See Appendix J: Interview schedule). This approach has been used in similar research on men and masculinities (Messner 1992; Connell 1995).
The following key topics were explored during each interview:

- The personal social background: ethnicity, class, family relationships, friendships, sexuality and sexual relations.
- The professional history: job history and its meaning; experience of gender relations in nursing and; the position of male nurses.
- Labour processes of nursing: daily work and interactions with patients, other health professionals, administration and the public.
- Workplace practises: relations with management; industrial practises, and; occupational health and safety issues, including body issues in nursing work and the division of labour, violence and safety, and wear and tear.
- Images of men in nursing
- Difficulties and disadvantages for men in nursing
- Advantages for men in nursing
- The future gender dynamics of nursing: personal accounts of how the profession is changing.

Each interview was conducted in three stages. Each interview was commenced by asking the informant to give a biographical account of their nursing career, commencing from the time they left school. This allowed the examination of the informant’s professional history, labour processes, and workplace practises.

Secondly, the informants were asked to provide a description and a historical account of their childhood, where their childhood background (family make-up, careers of parents, relationships with siblings and parents, and friendships) and experiences were examined. Thirdly, the informant’s current situation (sexual relationships, partnerships, offspring, friendships, extended family) was examined. The key interview topics were discussed at each of the stages of the interview where appropriate.

The interviews averaged 128 minutes, the shortest being 82 minutes, the longest 180 minutes. The taped interviews were transcribed verbatim, with the permission of the informant, by an experienced confidential typist familiar with this kind of research. This yielded over 670 single-spaced pages of transcribed text.

All interviews were conducted in private, at a place and time which was convenient to the participant. Most of the interviews were conducted at the informant’s place of employment (n=11) or at their residence (n=6), in a quietly located room or office. Two interviews were conducted at the researcher’s place of employment, in an office.
in the Faculty of Nursing, The University of Sydney. One interview was conducted at
the interviewer's residence and another was conducted in a hotel room, as the
informant was visiting Sydney. In the most part the interviews were free from
interruption. One interview, that of Adam Pearce, was conducted at his home and had
several interruptions with phone calls and tradesmen who were working on his
property. This interview was cut short due to constant interruptions and is the shortest
of all the interviews.

The tone of the interviews was collegial, supportive of the project, where several of
the informants used the interview as an avenue for engaging in gender politics. All
participants were eager and freely offered information, including information of a
somewhat personal nature and potentially embarrassing. All informants were willing
to display emotions during the interview. Three of the interviewees - Darren Josephs,
Ken Smythe, and Sam Wood - over the course of the interview became passionate,
loud and at times were angry in their responses. This was not directed at the
researcher but rather in response to their experiences with gender relations. No
participant refused to answer any of the questions asked.

Nineteen of the interviews were conducted without any hiccups. However, the last
two interviews resulted in poor quality audio recording due to tape malfunction
associated with low battery energy. As a result, the last interview was re-conducted in
its entirety. Most of the twentieth interview was recorded but the later part of the
interview was of an insufficient quality, preventing transcription. To capture the
missing narrative the interview was supplemented with a telephone conversation. The
phone interview was not recorded but the researcher made notes of the points
discussed.
Data analysis and the written account

Data analysis consisted of the identification of patterns of social response. Analysis was conducted of the issues and themes that were identified in the interviews. A progressive-regressive method of analysis was employed where individual conversations (life story narrative) provide the personal and are linked to wider issues of history and culture (Plummer 2001). Each life story is presented as a life history case study following structural analysis of the narrative where the gender relations approach and the gender sub-structures (Connell 1995; 2000; 2002) were applied to the data to inform key patterns of gender. This approach of analysis is commonly used in gender research. Although common themes and unique experiences are explored, it is not the intent to reach a sense of ‘data saturation’ looking for all possibilities, as with other qualitative approaches, rather to make sense and meaning from the lives of the informants as individuals and to locate their position in the gender order. Life history studies have commonly used this form of inquiry to adequately examine the topic of interest (Messner 1992; Dowsett 1996; Connell and Wood 2002; Connell 2006).

In the first phase of analysis, tapes and transcripts were indexed and each interview was examined from three points of view, and then written up as a life history case study. Firstly, a biographical narrative was constructed summarizing the informant’s: significant life events; nursing career; childhood social background (ethnicity, class, religion and family relations); and their current social position.

Secondly, a four-dimension structural model of gender relations described by Connell (2000; 2002) was used to enlighten the case study (the informant’s experiences of and position in gender) in the form of structural analysis through the compiling of an inventory of the structural features. Connell (2002) claims that a four dimensional model is needed to highlight the complexities of the gender system. To define gender as a single structure would be over simplistic, creating discrete gender categories and ignoring the complexities (contestations, contradictions and remaking) of the gender order (Connell 1987). To this end, the four gender sub-structures outlined by Connell (2000; 2002) were used in the analysis. They are: a) gender production relations, the gender division of labour, is the allocation, nature and organization of paid and
unpaid work; b) gender power relations, include both the form of organized institutional power, the oppression of one group over another, and diffuse discursive power and the way power is contested and the way groups mobilize to counteract power inequalities; c) cathexis or gender emotional relations, are organized around a person’s emotional attachment with another (or an object), positive or negative, which include desire, sexuality and sexual relations; and d) symbolism, the communication of gender ideologies.

Each dimension examines different aspects of gender relations, yet they are not discrete, but are interwoven and interrelated, together accounting for most of the structural dynamics of gender currently understood.

Thirdly, each transcript was analyzed to map the informant’s gender project, the construction and reconstruction of masculinity. Gender starting points and the trajectories of the gender projects are highlighted. This includes mapping the informant’s life and establishing the impact that doing nursing has on gender relations in their life history.

The life history case studies averaged 7.5 single spaced pages of text, the shortest being 4 pages, the longest was 9 pages long. The bulk of each case study consisted of the structural analysis of each transcript presented under the headings of the gender sub-structures.

In the second phase of the analysis, the case studies were re-analyzed in groups to explore similarities and differences in the trajectories of male nurses in social locations and to understand their collective locations. In this final phase of analysis, the four structures of gender - production, power, emotion and symbolism - were used to inform the analysis, providing a portrait of individual and collective social change. These methods are consistent with that used in masculinities research by Messner (1992), Connell (1995) and Messerschmidt (2000). Wedgwood (2000) used this method of analysis successfully in her doctoral thesis, which examined gender in Australian Rules football.
The Lives of Male Nurses – Introductions

The narratives of these men’s lives will be presented in two forms, as life history case studies, and collectively as analyzed narrative. The life histories of four men will be presented in some detail in chapter 7. These case studies will provide representations of masculinity, highlighting the starting points of the participant’s construction of gender and the trajectories taken. Reference to the other fifteen men will be made when their contribution illustrates or adds to the analysis of issues presented in chapters 8 and 9. All informants have been de-identified, where their names, the names of third persons and places have been replaced with pseudonyms. Where required, employment positions and other identifying histories have been sufficiently altered to ensure the confidentiality and privacy of the informants. Care was taken when making these changes to ensure the meanings of their stories did not become out of context and artificial.

In order to help the reader to become acquainted with the twenty-one men, I would like to present the following micro biographies.

Andre Dzop is a clinical nurse educator in Hematology and Oncology in a tertiary hospital in Sydney. Andre is in his mid-thirties and is married with two children under the age of 5 years. His wife is also a full-time nurse. He was born in Australia, the oldest child (brother and sister considerably younger) of non-English speaking migrant working-class parents. As a teenager he had many racially based conflicts, both at home and at school, as he strove for acceptance as an Australian. Andre left school prior to completing his HSC. He had a succession of manual or semi skilled jobs. He completed both his HSC and following that a degree in nursing as a mature age student. He completed his BN in 1993 and did his new graduate program in a large metropolitan teaching hospital where he continues to be employed.

Darren Josephs, mid thirties, is a research officer, managing and coordinating medical research. He is married with two children; a son aged 6 years and a daughter 8 years. Darren’s wife is also a registered nurse who works part-time. Like Andre, Darren is the son of immigrant parents. He entered the Diploma of Nursing straight after completing his HSC in 1984. After graduating he moved quickly into intensive
care nursing where he has held several positions, including clinical nurse consultant at two tertiary hospitals. In 1998 he held the position of CNC Acute Surgical Services in a major tertiary hospital, a position he occupied until recently.

Ken Smythe, also in his mid thirties, is currently working as a clinical nurse specialist (CNS) in theatres of a private hospital in the eastern suburbs. His partner is a registered nurse who he works with. He has a daughter from a previous marriage, 13 years old, who he does not maintain contact with. Ken left school in year 10, completed an apprenticeship as a boilermaker, which he did not like. He commenced his trainee enrolled nursing certificate in 1986. During this time his then girlfriend fell pregnant. They soon married before the baby was born. He commenced his Diploma of Nursing in 1990. He soon divorced his wife after his marriage broke down. Ken has continued to work as a theatre scrub-nurse since he completed his Diploma.

Simon Bruce, late forties, is semi-retired and is currently working part-time in anesthetics and recovery, in a small private hospital. Simon is in a long-term homosexual relationship (over 20 years); his partner works full time in the hospitality and travel industry. After completing his higher school education he worked with the Catholic clergy as a teachers aid with developmentally disabled children. He entered nursing soon after in 1972 in a hospital in Auckland, New Zealand, where only one hospital out of three took men. Simon has predominantly worked in intensive care, where for 16 years he worked in a major tertiary hospital before moving to his current position.

Richard Johnson, mid thirties, is not married but has a long-term partner with a daughter 8 years of age. He currently works on a casual basis as a midwife for various hospitals, running childbirth and postnatal classes, and he works for a university facilitating undergraduate nursing students' clinical practicum. These flexible working conditions suit Richard as they allowed him to actively participate in the care of his daughter.
Ralf Cooks is the oldest informant at 61 years. Despite previously having sexual relationships with women, he describes himself as being gay. He has not been successful in maintaining any long-term relationships. Ralf doesn’t have traditional masculine tastes, enjoying classical music, antique furniture and fine art. He appears to live comfortably, above the means of a nursing wage. Ralf began his nursing career late when he was in his mid fifties, after a successful career in law. He currently works part time as a registered nurse in an aged care residential institution (nursing home). This provides him with sufficient financial security to live comfortably.

Ricky Davidson is 25 years old, married and has a 10 month old baby. Ricky is Deputy Director of Nursing of a metropolitan aged care facility. Ricky’s parents were divorced when he was five, but he has kept a close relationship with both parents. It was Ricky’s father who suggested he do nursing; Ricky wanted to be in the ambulance service like his father. Ricky is ambitious, strategically working on a career path in order to make money. He graduated from his Bachelor of Nursing in 1998, worked in palliative care for 2 years before working in an ambulatory care unit in a small hospital in Sydney’s South West for a further 12 months. After conflict with his nursing unit manager, he left and eventually moved into aged care nursing.

Warren Anthony is a 26-year old nurse educator in mental health nursing. He is married with a 2-year old daughter. Like Ricky’s parents, Warren’s parents divorced when he was relatively young (8 years). Like Ricky, Warren wanted to join the ambulance service, however, his father suggested nursing. Warren’s father was a teacher, a career advisor at a local high school. Ricky has predominantly worked in mental health nursing since he graduated from a Bachelor of Nursing in 1998.

Warwick Fredericks, mid forties, lives alone and is the Nursing Unit Manager of a critical care unit in a large metropolitan Sydney hospital. He was married at eighteen and divorced at twenty-six years of age. He has 3 grown up children. Warwick grew up in the western suburbs of Sydney in a violent household. His parents divorced when he was young. He was kicked out of home at the age of 17 years, worked doing manual work before commencing nursing in 1978.
*Brad Ronald* is a 36-year old health services manager, is married to a nurse and has 2 children under the age of 3 years. Brad’s current job is as a project officer, working with the College of Surgeons, looking at quality improvement in surgical services. He enjoys music, literature, films (including foreign) and landscape gardening. Brad is the only child from the marriage of older parents, both parents having older children from previous marriages. He has had a lengthy career (over 10 years) in critical care nursing.

*Aless Ianelli*, nearly fifty, is a Clinical Nurse Consultant in paediatric nursing. He is married to a nurse and has five children. His childhood was ‘chaotic’ and at times he was abused; his mother died when he was seven, his four sisters were farmed out to relatives, and his father drank and lived a transient life-style. Alex left school at sixteen, did manual labour before entering into psychiatric nursing in a country town. He failed to complete this and moved to Sydney to do general nursing in 1971. He has since completed post graduate certificates in midwifery and paediatric nursing and has had extensive experience in emergency nursing.

*Derrick Andrews*, mid thirties, is a health service manager for Sexual Health Services in a metropolitan Area Health Service. Derrick is currently in a long-term homosexual relationship. Derrick doesn’t have a strong sense of family as a result of parental domestic violence and divorce. His parents never accepted Derrick’s sexuality, both parents dying when he was in his late teens. Whilst Derrick is not an “AIDS lover” as he puts it, his career has benefited from his concentration of expertise and long experience in the HIV/AIDS area.

*Andrew Williamson*, early forties, is a Clinical Nurse Consultant in the emergency department of a country base hospital. He is married with two children. Andrew had a comfortable childhood; his father was a country doctor and his mother was a nurse, but did not work after having children. After completing school Andrew commenced a science degree at university but left this after 12 months. He did his general nurses training in a large metropolitan hospital in Melbourne. He has since had a long career in critical care and emergency nursing.
Paul Stuart, mid-forties, is married with two teenage children. He is currently a Clinical Nurse Consultant in palliative care nursing on the mid-north coast of NSW. He completed his high school certificate in 1975 and undertook a Bachelor of Education/Psychology, but did not complete his final year. After being rejected by Royal North Shore, Paul commenced his nursing training in a smaller district hospital in the western suburbs of Sydney. After graduating, he worked in hematology and oncology nursing and at the same time completed a Bachelor of Arts degree with an education major. The majority of Paul’s career has been in nurse education, working in both a hospital school of nursing and at a regional university, until 1997 when he commenced his current position.

Greg Gerard, early forties, is married with four children. He completed high school and commenced psychiatric nursing. He was raised in a loving family environment in a major country town. It was not uncommon in the town for young men to work in the psychiatric hospital. After completing his training he commenced engineering at the University of NSW, but did not complete this. In 1985 he completed his general nursing conversion certificate, worked in ICU and emergency nursing until 1987 when he commenced an aged care certificate. He has worked in aged care and psycho-geriatrics since that time. Greg is currently a Clinical Nurse Consultant in aged care.

Anthony Hammond is a Clinical Nurse Specialist in a community mental health service. Anthony was raised in a relatively traditional Catholic family; his father doing manual labour, his mother a domestic housewife. Anthony and his two siblings went to Catholic schools. He has previously been married on two occasions. The first was when he was 20 years of age and lasted 6 years. He had no children from this marriage. He married again when he was in his thirties and had two children. He now lives alone and has a girl friend, working in a rural coastal town on the far north coast of NSW. Anthony is 50 years old.

Scot McMurray is 45, married with three teenage children. Scot is a clinical nurse specialist in community mental health. He lives and works on the south coast of NSW. Scot was raised in the western suburbs of Sydney in a nontraditional family
where both parents were registered nurses. Scot’s father was a mental health nurse who worked full time night duty, his mother worked part time shift work. His grandparents, who lived next door, provided support and childcare. Scot was close to his grandmother. Scot left school in the middle of year 11, commencing an apprenticeship that he did not complete due to economic downturn and the bankruptcy of his employers. He commenced his psychiatric nursing certificate in 1975.

Adam Pearce is 51 years old, married without children. He is currently a clinical nurse specialist in paediatric nursing in a metropolitan tertiary hospital. Adam was the eldest of three children who were raised in a middle class country family. His father was the town general practitioner and his mother was a registered nurse, yet she left paid work after getting married. At the age of 7 Adam was sent to boarding school in another town. Adam feels unloved by his parents and blames his mother for his psychological problems. Adam completed his schooling and commenced a Bachelor of Arts degree. He failed his last year, left and commenced his nursing certificate in 1973. Whilst working night duty, he completed his BA majoring in archaeology, fine arts and medieval history. During this time he began having panic attacks, which led to a ‘nervous breakdown’. He was unemployed for twelve months. Adam’s nursing career has been turbulent, working in several nurse education and clinical positions. He has been in his current position for over 15 years.

Samuel Wood is in his late forties, married for the second time, to a registered nurse. Sam works on a casual basis in the emergency department of a metropolitan district hospital. Samuel was raised in a dysfunctional family: his father, a truck driver, was an alcoholic and abusive. There was a lot of domestic violence in this family. Sam’s first marriage was a shotgun wedding; he has a daughter whom he has no contact with. He was deeply hurt by his ex-wife, who had a sexual affair with another man. After completing his higher school certificate he commenced civil engineering at the institute of technology, but he did not complete this due to workplace bullying from a more senior apprentice. He commenced nursing in the mid 70’s. After completion he did his midwifery training and then moved to aged care where he worked as a Deputy Director of Nursing of a nursing home. In 1985 he moved to Intensive Care Nursing
where he worked for 15 years. He left this job following a depressive illness.

Geoffrey Craig is in his mid forties, is single and lives alone. Geoffrey is homosexual, has not had a long intimate relationship, more one-night stands and short-term sexual encounters. He is not into the gay scene and avoids beats. He meets his men over the Internet or through the use of telephone chat/matchmaker services. Geoff is in the closet to his family, friends and at work. Geoff was raised in a working class family. His father was a fireman, drank a lot and was physically abusive. His mother died when he was three. His father remarried soon after. Geoff has never been close to his stepmother. As a teenager Geoff lived on the fringe of gang culture, unlike his brother and friends, many of who ended up on the wrong side of the law. Geoff has had a long and varied nursing career, taking very different and contradictory trajectories, including critical care nursing, caring for women following termination of pregnancy, rural and remote nursing, and more recently as a naval nurse and his current position of Captain in the Australian Army as a nursing officer. Geoff is religious, at one stage contemplating becoming a priest and completing a Bachelor of Theology.

Michael Little is married with three school age children. His wife is an occupational therapist who runs her own practice from home. Michael is a Nursing Unit Manager of paediatric services for a fringe district hospital. Michael’s father was a butcher, often absent from Michael’s life. His mother died when he was nine; Michael’s father remarried soon after. Whilst his parents never mistreated him he felt deprived of emotional contact. Michael commenced nursing in 1984 in the last hospital trained group. In 1990 he completed midwifery training where he worked for a further 5 years. In 1996 he attained his current position. Michael is religious, actively participating in church activities; church services, church groups and prayer meetings. Michael is in his late thirties.
Ethical Considerations

Plummer (2001) points out that life histories are not just stories but are forms of the political, used in many ways for political action. This project is at the forefront of gender politics within the discipline of nursing. In many ways this project offers alternative views to the previous research conducted on men as nurses. I am mindful that my informants are very much a minority and in many cases are the only men in a particular health service. This raises many ethical questions including questions of confidentiality; consent; ownership; honesty; deception; exploitation; and, hurt and harm (Plummer 2001).

The University of Sydney Human Ethics Committee granted approval for the conduct of this study (See Appendix G: Human Ethics Approval for Life History Study). To avoid deception all informants received a written information sheet (Appendix H), which outlined the aims, research questions and intentions of the study, the commitments required of each informant and a contact for complaints in the event that any of the informants were not happy with the conduct of the study. Prior to the conduct of each interview written consent was obtained from the informant (Appendix I). When giving their consent the informants were made aware that they could withdraw from the study at any time without any negative repercussions. No informants failed to give consent, and none withdrew from the project after giving their consent. All informants agreed to be audiotaped and for these recordings to be transcribed with identifying features removed.

In writing this project I have struggled with the interplay of confidentiality, ownership, honesty, deception and exploitation. To ensure that the informants' well being, reputations and employment were not affected by their participation in the project and to prevent any potential informant embarrassment, exploitation and hurt, informant anonymity was guaranteed. In order to maintain confidentiality of the informants, names of individuals, the time and location of events required alteration. However, to avoid misrepresentation such changes had to be made with conscious thought about the meanings attributed to the location of the participant and the timing of events. In order to prevent deception of the reader and maintain honesty, informant pseudonyms were carefully selected to ensure the life story remained close to the
informant's construction without blowing their cover.

During the course of the interviews I was privileged to share personal feelings and information. In many cases these were very sensitive and had not been previously shared with anyone. The feelings and stories told in this project are accounts that were bestowed upon me by the informants in an act of good faith. The informants own these stories and accompanying feelings, and I have an obligation to ensure their use causes them no harm. Care was taken to ensure the stories of the individuals in this project were honestly reconstructed. In order to do this I became more aware of my own feelings, to put a check on them to ensure that the stories of the informants were not manipulated or exploited, to maintain their honesty through respect and recognition of differences.
CHAPTER 7
Life History Case Studies

Introduction
This chapter focuses on the life stories of four men from working-class backgrounds involved in nursing: Derrick, Anthony, Michael and Geoffrey. These life histories were chosen from the larger pool of 21 informants for the following reasons. Firstly, these life histories demonstrate differences in the structures of gender, the organization of social practice that constructs their masculinity. Secondly, the experiences of being a male nurse and the impact of this on their masculinity are varied. These four case studies allow the close examination of the men’s lives, to identify the social practises that maintain gender relations.

Derrick – ‘a very straight gay’
Derrick is currently in a long-term homosexual relationship. He is a health service manager of Sexual Health Services in a metropolitan Area. Despite displaying a conventionally masculine appearance his interests are not traditionally masculine. Derrick enjoys fine music, art and architecture and despises the traditional male engagement with sport, either as a participant or as a spectator.

Childhood and the construction of masculinity
The term ‘a very straight gay’ used to describe Derrick was borrowed from Connell (1995; 143) as there are many parallels between Derrick and Connell’s eight life history case studies of gay men (Connell 1995). Like the men in Connell’s study, Derrick grew up in a family with a conventional division of labour and a conventional power structure. Derrick is from a working class family. His father was a butcher with his own shop. His mother worked casually in the butcher shop; otherwise she was a housewife providing the main source of parenting. Derrick’s father was the major source of identification of masculinity for Derrick, an identity Derrick rejected early in his teens. His father was dominant, often in the form of violence, over his wife and children. His father left the marriage on several occasions. Eventually his parent’s marriage broke down when Derrick was 16 years old, when his father walked out for good. During Derrick’s childhood his father was
emotionally absent, getting up early in the morning to go to the abattoir and usually coming home late drunk after ‘drinking with the boys’ after work. Derrick was never close to his father who was always too busy for him. Unlike some of the participants in Connell’s (1995) study, Derrick didn’t identify himself with his mother as an alternative in emotional relations to his father. He was not particularly close to his mother, nor to his siblings. He states that he withdrew from his family because he didn’t want to get involved in the fighting. Both parents died when he was relatively young. His mother died of a stroke and heart attack when he was 18 and his father died a year later of a brain tumour. Derrick has two older siblings, a brother who is now a pharmacist and a sister who is a social worker. His sister is also in a long term gay relationship. Derrick shows no emotional commitment to the sense of family.

During his childhood there was very much gender conformity, in the way he and his siblings were dressed and through encouragement to play gender appropriate sport. Both parents ensured Derrick met conventional representations of masculinity. It was not until high school that Derrick resisted the masculinized public culture. Derrick went to the local public school in the outer part of Nullangardie (a large country town referred to by Dowsett (1996). He describes the student population as being bipolar, on one side the ‘yobbos’, those who conformed to the stereotypical hegemonic projects and on the other the ‘arty’ sort, consisting of a smaller but significant group of students. Being a member of the arty crowd offered Derrick a place of refuge, a space where he could be different in his representations of masculinity and where difference was the norm. Mainstream portrayals of masculinity were not the project for this group, allowing for alternate representations of masculinity and sexuality. As long as Derrick wasn’t openly gay there weren’t any repercussions as the arty crowd was large enough to conceal him. Only a third of the year 11 and year 12 student population was male and a large portion of those were from the ‘arty crowd’.

Derrick ‘came out’ by accident. His mother and father caught him with a male friend when he was 15, this being his first sexual relationship. Like Mark Richards in Connell’s life history study (1995: 149), Derrick’s early-adolescent unhappiness and rejection of authority was resolved by his falling in love with a classmate. Both his
parents were hurt by his sexuality, neither parent accepting Derrick’s homosexuality. They saw it both as a failure in him and in their parenting. At the time, he was told by his mother to apologize for what he had done, as if he could correct his sexuality. He refused. Derrick never discussed his sexuality with his parents, nor lived openly as a gay man whilst they were alive, but continued to be discreetly sexually active. Derrick has never had a sexual relationship with a woman and has never been pressured to do so. He was somewhat protected by the crowd he belonged to at school. Derrick’s sexuality is neither a transient obsession around sex, even though early on it was a degree of fetish attraction and a string of fast-lane sexual relationships, but is like that of Mark Richards, a structure through which emotional relations are attached. Since his early twenties, Derrick’s sexuality defines his emotional relationships through his desire for and maintenance of long-term gay emotional relationships rather than the dominance of bodily pleasure through the act of male homosexual sex.

The death of his parents opened up the possibility for Derrick to engage in alternate directions to the socially masculinized direction of his childhood. Derrick finished school (HSC) and commenced a Bachelor of Arts Degree in the early 1980’s, which he discontinued in his second year. He then worked doing odd jobs, such as cleaning and working in a bookstore. This paid for a trip overseas that lasted six months. He then moved to the south coast and enrolled in a Bachelor of Environmental Science at university. After the first week he decided that he would rather do nursing so he transferred to the Diploma of Nursing. Derrick’s move to the south coast and choice of nursing provided security and acceptance, as there was a diverse gay community. Detachment from his family and the move south, gave Derrick the ability to experience his sexuality as freedom, the opportunity to experience his sexuality the way he wanted to.

Work and production – a safe place to be
After completing his nursing course, Derrick worked as a registered nurse (RN) at the local Base Hospital, rotating through orthopaedics, paediatrics, theatre and mental health during his graduate year. Then he moved to the medical/palliative care ward
for 5 years. Whilst working on this ward he became interested in HIV nursing. During this time he had nursed a relatively large number of patients with AIDS-related illnesses and he was aware that there were no specialty services in the semi-rural community. This prompted him to complete a certificate in HIV/AIDS nursing with the view to return to his semi-rural community. However after 9 years living in the country, he decided he needed a change, so he stayed in Sydney and got a job as an RN in a HIV unit in a large metropolitan tertiary hospital. In part, the move back to Sydney was the allure of the Sydney gay lifestyle, in addition to the explosion of science and development of HIV services at the time. He moved through the ranks relatively quickly and ended up as the Nursing Unit Manager (NUM) within 2 years. From here he got a Nursing Unit Manager position at an outpatient sexual health clinic for a few years. He has recently held a health service manager position as an Area Director of Sexual Health.

Derrick's choice of nursing specialty (HIV/AIDS) was related to his own sexuality and the security the specialty offered gay men. During his time down the south coast, Derrick became politically active in the local rural AIDS Council, which he described as 'a de facto gay scene'. He initially thought that AIDS work was something to be part of, both from a moral perspective and for developing a specialty knowledge. He claims that it was initially a sense of social duty that got him involved in HIV and AIDS. But it is no longer the sense of duty that keeps him in this line of work, rather the development of new technologies and knowledge.

*I'm very cynical about concepts of community especially gay community anyhow but I did at that time thought it was something to be involved in. As time went on and especially working in a specialised unit that very soon faded and it came to a point where I did it because it was what I knew, I'd become specialised and is still interesting. It's an ever-changing field and you know it's one of those areas of medicine where there's something new every week. There's something new, a new drug, or something new to learn so you do get quite a lot of stimulation from that side of it. I would certainly say now that you know the sexuality thing is not a factor in why I do this now.*
A contradiction in Derrick's construction of masculinity is his relations with his patients, the branding of people with AIDS as 'victims' – a term he uses in a condescending way. Initially Derrick chose to work in HIV and AIDS out of a sense of gay duty and solidarity. However, this sense of duty has now dissipated and he describes a practice which on the face of it appears homophobic:

One of the funniest things that happened in working in the HIV Unit was the absolute political incorrectness of the staff. We would make the most hideous jokes about the patients and say all the things that the media or yobbo homophobes would say, we'd call them AIDS Victims, we'd laugh and joke. It was just incredible the things we used to say as a coping mechanism, to deal with the daily trauma of what you were going through. We all joke about people with AIDS and precious queens and that's probably from the experience of going through a lot of destruction.

Here Derrick and his colleagues take part in the ridiculing of gay men with HIV and AIDS; a hegemonic practice normally reserved for heterosexual men. There is a sense from Derrick that he blames these men for contracting HIV, either through the lack of sexual precautions taken or multi-partner sexual behaviour. Derrick claims that the otherwise homophobic practice of blaming and ridiculing gay men with AIDS was a means of distancing themselves from the disease and coping with the impending death and destruction. However, as a consequence of this practice he is reinforcing traditional notions of masculinity and compulsory heterosexuality.

Being gay and working in the HIV/AIDS specialty advantaged Derrick. He is not an 'AIDS lover' as he coins it, referring to people whose whole life revolves around AIDS and where they have no boundaries between their social and work life. However, Derrick has successfully used social capital gained through his gay and AIDS networks, to structure his career and become upwardly mobile.

Derrick's choice of employment and specialty area of practice were deliberate strategies that offered him safety from homophobic attention. He worked in a country town renowned for acceptance of diverse alternate lifestyles, and he worked in sexual
health, HIV/AIDS, where there was a high proportion of gay and lesbian workers. He cannot remember any work related incidents where his sexuality was an issue.

I've never had that [non-acceptance] at all and whether that was because I've only really worked in hospitals in [name of town] or inner Sydney. [Name of town] is not a normal country town you know, there's a big gay community, there's a big arts community, there's a university, there's all the rainbow, feral hippy thing going on. It's far more open-minded than Sydney. Despite the redneck national party voters, it's not a normal country place. I think I was a bit sheltered in that regard.

Derrick acknowledges that all male nurses are stereotyped as gay. Derrick himself presents as a very straight gay, taking care not to appear outwardly gay - 'the stereotypical image, the hair and stuff'. People didn’t presume he was gay. Derrick is discreet about his sexuality for practical reasons. Derrick consciously performs gender in different ways to gain acceptance from his patients. He uses a masculine performance to cover his sexuality. He claims to alter his communication and touch depending on the patient, for example for an older male he 'talked about things old blokes talk about', 'talk a bit rougher', and 'say mate an awful lot'. He explains:

I wouldn't say anything that would indicate I was gay because at some levels you don’t want to create a bad dynamic because you’ve got to keep looking after these people. I think it's just very much a matter of adaptation. If you had a four-bed bay of older men, you just adapt to their way of being. You certainly try and work out their method of communication, they’re way of being and whilst not denying yourself and your own individuality, fit in as much as possible to make them feel comfortable with their disease process and what they were going through. I guess it was a tight rope of walking along and working out that balance.

This gender performance is not unique to Derrick nor to homosexual men. Most of the participants describe having to conform to the gender ideology of their patients in order to overcome homophobia and provide care, a unique form of symbolic labour. This form of labour requires the symbolic performance of social practices, practises
that construct the patient's view of a masculine identity. The symbolic performances are not fixed and are directed to meet the individual patient's gender ideology. This form of symbolic labour requires a gender performance to sustain an outward appearance that produces the proper state of mind in others, the sense of being cared for in a sexually safe manner.

Power and Authority – Being the boss
Derrick's current appointment is atypical for a nurse, a position normally reserved for medical officers. He was employed as a CNC but since starting has been given the directorship of the entire service. With this comes significant power. He is the medical executive for the service. He has the power to hire and fire, to make strategic changes, and he has a significant budget. In this job he is responsible for four clinics. He has two consulting medical officers under his management and several nurses and allied health professionals. Derrick has not previously had this level of power, despite occupying nursing management positions.

Derrick's relations with senior medical staff have been mixed. In his current position, one of the medical specialists is fairly supportive of him as he relieves her of the management burden. The other is 'sussing' him out; he gets the impression that this specialist doesn't like nurses to have autonomy and authority. Derrick claims that the service is old fashioned, where conventional roles have been maintained, excluding nurses from providing autonomous practice by preventing them from conducting their own clinics. Derrick puts this down to the 'handmaiden thing' - nurses serving doctors. He plans to change this. Derrick is quite calm and confident about dealing with doctors; however this has not always been the case. In a previous position as manager of a community health service, Derrick had continuous conflict with the medical director. 'He [medical director] ran it like his own empire'. The nurses were his 'handmaidens'. Derrick felt he was continuously undermined by the medical director. For example nursing staff were being employed by the medical director without Derrick's involvement, despite them being under Derrick's authority. Derrick felt he was pushed out, unable to function in this role and as a result was forced to leave this job. Derrick blames the medical director and the power inequalities between medicine and nursing for his exit.
"Disrespected, disempowered and put down on a daily basis" -

Power and Cathexis Collide

Derrick claims that as a clinical nurse he was 'disrespected, disempowered and put down on a daily basis'. Here he is referring to the power dynamics between all health professions, a hierarchy in power and production that exist between the health professions. Derrick claims that in specialty areas like HIV or sexual health, nurses become highly specialised and may have a higher level of knowledge than doctors. Despite this specialised knowledge in patient care, being a nurse limits him in the ability to practice independently. Derrick provides several examples where conflict between him and junior medical officers had occurred over patient care issues. Despite not having authority over patient care, Derrick has developed strategies to combat this. For example, if Derrick were concerned about the medical care of a patient by a junior medical officer he would contact directly the senior registrar or the consulting medical officer. If he felt that the junior medical officer wasn’t taking his advice or wasn’t appropriately concerned about a patient, Derrick would document a detailed account of the episode of care in the patient’s notes, forcing the medical officer to act. Such actions have led to poor relations with certain medical officers. Derrick believes that it is the lack of authority, which forces nurses to act in this way, often creating conflict.

The major emotions associated with being a nurse expressed by Derrick were those of worthlessness and being under valued. Prior to his current appointment, he had been contemplating getting out of nursing. In the most part these emotions stem from gender relations, especially in power and production. The title of nurse and the legislative limits to nursing practice, subordinate him and his professionalism. In addition, Derrick is aware of the differences in pay between nursing and other health disciplines. He is currently negotiating his wage for taking on the management of the service. He realises he will not be paid the same as the previous medical director. He claims that the medical specialists are on $150000 to 170000 per annum and they get paid a nominal extra for the management role. The wages of the two doctors in the service account for more than 50% of the service's budget. He realizes that as a nurse he will only make a fraction of this.
Derrick highlights feelings of difference. Derrick believes the title ‘male nurse’ implies a different ‘specialty’ of nurse, ‘specially’ trained. This is emphasized by the public categorical definitions of gender and the cross-gendered situation of male nurses. He states:

*Maybe people do stereotype it [nursing] as not being a very masculine thing to do. People, especially older people, used to say oh you’re a male nurse, like it was a different specialty, you’d been trained in being a male nurse, like it was something different, you were a different category altogether, which is the ‘male nurse’.*

Derrick has good emotional relations with women. Derrick’s friends are predominantly female nurses and he prefers female friends. He maintains one close friendship with a girl from school, the only friendship he has maintained from that time. He claims that nursing provides a strong social environment and is used by nurses for informal debriefing. He claims that nurses deal with ‘the same shit’ and ‘they have all chosen the same path, being involved and caring for patients and that is a hard path and that is why nurses go for drinks’. Derrick claims that this was absent from his job as a health service manager, a more typical masculine job. In this health service manager job Derrick found that the social network that he was used to as a nurse was absent. Despite having close friendships with women, he is also hurt by them. Derrick claims that women are more homophobic than men. This perception could be a result of his working in HIV/AIDS where there are more straight women than straight men, and therefore the probability of encountering homophobic expressions by women is greater.

Derrick has successfully structured his masculinity to place him in a complicit position. Derrick has been able to perform in ways that mirror traditional masculinity, a masculinity he was familiar with during his childhood, to successfully hide his sexuality in public spaces. At the same time he has been able to use social capital from gay and HIV/AIDS networks to become successful in his nursing career. Success for Derrick meant to gain recognition, power and authority, something he was not able to get as a clinical nurse. Derrick’s position as the Director of a Health Service gives him this recognition.
Geoff – ‘Closed with nowhere to turn’
Geoff is 46 years old, is single and lives alone. He has had few long-term relationships in the past, nothing that would resemble marriage. He now describes himself as being homosexual. He has not had a long intimate relationship, rather, one night stands and short term sexual encounters. He is not into the gay scene and avoids beats. He meets men over the internet or through the use of telephone chat and matchmaker services. He is religious, at one stage contemplating becoming a priest. Geoff is currently a Captain in the Australian Army.

Childhood and the construction of masculinity
Geoff is from a working class broken family, with a conventional division of labour and power structure. His father was a fireman; they lived above the fire station in a very poor part of Melbourne. His mother died when he was three years old and his father remarried soon after her death; ‘the children needed a mother figure’. His stepmother worked part time in a textile factory and later in a pub, cleaning up tables. She was the major source of parenting. Geoff is the younger of two sons; his brother is six years older. As with Derrick, Geoff’s father was substantially absent during his childhood, working long shifts and being too tired for the kids on his days off.

Geoff’s father, and to a lesser extent (during his teen years) his brother, were the major models of masculinity for Geoff. Traditional masculine conformity was enforced in this household. As with the five men in Connell’s (1995: 98) life history case studies ‘Live Fast and Die Young’, Geoff’s experience of power relations was as a recipient of violence. Power was held and maintained by his father, predominantly in the form of violence, often in conjunction with excess use of alcohol; his father often hit his wife and sons. Geoff’s stepmother was jealous of Geoff and his brother who were often physically abused by her and locked up in their rooms for long periods of the day. As an adolescent Geoff was on the fringe of the Melbourne gang culture, taking part in minor criminal activity. However, he never fully joined a gang like his brother and friends. Several of his friends have now ended up in jail. Geoff remains close to his brother but has not confided in him about his sexuality.
A turning point in Geoff’s life was in his late adolescence when he had his first relationship, a gay affair with a mate’s older brother. This relationship was on the surface a sexual one, on a part-time basis, without cohabitation, and was unknown by others. Yet this relationship provided Geoff with emotional attachment, this being his longest lasting relationship. Like Derrick, his early childhood unhappiness and rejection of authority was resolved by him falling in love. Geoff was deeply hurt when this relationship broke down; his partner left him to get married. He has not had another long-term emotional relationship and he blames his family upbringing for this. Geoff describes himself as being homosexual, yet in the past he has had transient sexual relationships with women. Geoff has remained single and states he is not looking for a long-term emotional relationship. Most of his relationships have been one-night-stands or short-term sexual relationships. He is satisfied with his sex arrangements; he is happy if he ‘gets it [sex] a couple of times a month’. Geoff doesn’t attend the ‘Oxford Street’ scene; he is uncomfortable in gay bars. Despite going on one occasion with a gay friend to a beat to pick up casual sex, he doesn’t enjoy it, thinking it is too risky, yet he was intrigued by it. He has not done this since. His preferred method of meeting men is over the internet, in gay chat rooms. An alternate method of picking up men is by using telephone chat lines or matchmaker services. He is aware of the difficulties that would occur if he were identified as being homosexual within the armed forces, despite antidiscrimination laws. He keeps his sexual relations to himself. He has not confided in his family, work or friends about his sexuality. He remains closeted.

Production, power and sexuality collide – Full of contradictions
Geoff’s experience of nursing training was similar to most men entering nursing at the time (early to mid 70’s). Geoff trained at a large Catholic hospital and was one of four males. He found these men to be a source of support. He was forced to live-in but was segregated from the women, with strict visitation rules. During this time he had no difficulties being accepted by other nurses or patients. He felt the males were not treated differently. He felt that all student nurses were treated like ‘handmaidens’, subordinate to other health disciplines: sewing buttons on the medical officers’ coats and serving silver tea service to the neurosurgeons, registrars and residents. There
was no gender division of labour, and the male students were expected to do the same as the female students, including female catheterisations and washes. However, the patient was given the option of having a female nurse and this was often taken up.

Geoff's career, sexuality and religious beliefs exemplify the complexities and contradictions of the construction of gender. Geoff has worked as a nurse in very iconic masculine social institutions, in heavy industry and the armed forces (the Australian Navy and the Australian Army). Geoff is gay, but holds very strong religious beliefs; belonging to a formal Christian religious community, completing a Bachelor of Theology and at one stage contemplating becoming a priest. Out of a sense of pastoral care, Geoff worked as a nurse in remote indigenous Australian communities.

In contrast to this pattern, he has also worked in areas of nursing requiring a feminine sensibility and at odds with his religious beliefs, such as working in an abortion clinic. It was out of a sense of male guilt that Geoff worked in the abortion clinic. He felt that he could help women who were predominantly damaged by other men. To this day Geoff is confused about his position on abortion and struggles with the contradictions of his religious beliefs and the personal accounts of the women he looked after. He states:

*I don't know what the right answer is. I still don't know what the right answer is, personal choice versus pro-life. The arguments are just, it's just too big for me to handle. I don't know and in those days I had to say I didn't know.*

The tensions of being a gay man working and living in compulsory heterosexual institutions have kept Geoff in the closet. Working in the armed forces and the convictions of a mainstream Christian religion, have constrained Geoff's ability to acknowledge his sexuality and deny him the ability to live as an openly gay man. Yet Geoff enjoys the rewards for doing this. Geoff enjoys the masculine nature of the armed forces, the tours of duty, the sense of danger and the power that this brings. Geoff toes the Army's political line by not disclosing his sexuality. Geoff describes the reason that females and homosexual men are not given or accepted in combat.
roles is one of desire. He states that:

*When in a combat situation you rely (have faith and trust) on your colleagues to watch your back, to protect you. Emotions of desire or love could detract individuals from what was required in that situation. Faith and trust may be compromised.*

Geoff joined the army in the late 1990s and is now a Captain. Not long after joining the Army he did a 5 month overseas peace-keeping stint. Following this tour of duty he completed an emergency-nursing course and was chosen as part of a specialised medical response troop developed for the Sydney Olympics. Since then, Geoff spent 2 years as a nursing officer for an armoured regiment, a combat role and more recently has been the nursing officer for a battalion regiment.

The laws preventing women taking on combat roles in the Australian armed forces have advantaged Geoff. Since Geoff joined the Royal Australian Navy as a male officer (Sub-Lieutenant) rather than joining the Navy Nursing Corps, he received more privileges than the female nurses. He had a couple of good overseas postings and was allowed to go to sea (but not in a nursing position). At that time female naval personnel weren’t allowed to go to sea. Similarly, female army nurses were only permitted to work in the field hospitals, base support or logistical support services and were not permitted to work in combat roles. In contrast, Geoff has worked in the field in combat positions, as a nursing officer in an armoured regiment and at sea in the navy.

When he was with the armoured regiment, he had a staff of 5 to 6 medics under his command. He was responsible for the provision of health services in the field, mainly primary resuscitation and first aid services. Geoff was the boss and responsible for the medical services for the regiment because the medical officer was a civilian, yet Geoff could not cross the medical/nursing barriers. The medical officer was required to do the medicals. However, when in the field Geoff as the nursing officer had greater power and autonomy in providing the health needs for the regiment without medical interference.
It was like I had extended practice rights to do that. I used to see people and prescribe antibiotics and prescribe drugs, initiate treatment, get them moved on if they were beyond my expertise. I would sort of move them on and make appointments for them. I would make sure the med plan was there so if we had anything happen I could call in a helicopter or get the guys out and stuff like that. It was very much my regiment; it was my practice pretty well and very much so. It was awesome.

As the nursing officer for the armoured regiment Geoff had direct access to the commanding officer of the regiment. Access to the commanding officer was restricted to the second in charge, the padre and the officer responsible for health services. As the nursing officer responsible for the regiment’s health, Geoff was given a voice. He was included in the decision-making processes and seen as an expert in his field. However, this privilege is not always afforded to a nurse. In his current position as a nursing officer in a battalion regiment, there are two regimental medical officers (Geoff and a medical doctor) of the same rank. Where there are two officers of the same rank, the medical officer is designated the director of the service. Geoff no longer has the same level of authority. As a result, Geoff’s role in the regiment was relegated to the provision of training, welfare, and the promotion of medics. Geoff describes the subordination of nursing to medicine as a formal position in the armed forces.

Geoff is becoming more frustrated with the subordinate position of nursing to medicine within the armed forces. Geoff enjoyed the power and autonomy when he was in the armoured regiment, but now as a nursing officer in a battalion regiment under the command of a medical officer of the same rank he finds it ‘hard to take’, he is ‘struggling with it’, and is at a ‘loose end’.

I am out of that and I hate it. I have gone from being the boss to just being the nurse, it’s just very hard.

Prior to joining the army, Geoff had worked as a nurse in a remote indigenous community. His decision to work in a disadvantaged community came immediately
following his degree in theology and was made out of compassion and a need to help. Yet his enthusiasm was short lived as he found the Indigenous Australian culture difficult to work within;

I never knew how it worked and why it worked, you just got to accept it. It's a whole different culture. You've just got to throw your white culture out and just try and learn how they do things.

Geoff has personally experienced the differences between white and indigenous cultures. Despite attempting to accept these differences you get a feeling that he views indigenous culture as inferior. The language used by Geoff highlights racial difference and racial tensions, where he directs the blame for this towards indigenous Australians. Geoff describes his relations with indigenous people as being 'superficial' and at times violent. He feels used by them and was frustrated by his inability to get to know their culture.

You can only really know as much as they're prepared to let you and if you did sort of start prying well then they'd clam up and they won't talk to you. Being white within the aboriginal community, you were someone who was there to help them and you know they used and abused you because you were a white fella and white fellas were there to give to them and that's how they saw it, you were their servant.

There was a clear gender division of labour in the aboriginal community near Alice Springs. As a male nurse Geoff was only permitted to be involved with men's business, i.e. men's health. Cultural Indigenous Australian beliefs prevent males from dealing with female's bodies and vice versa. It was possible for Geoff to treat women but this was limited. He was not permitted to treat any gynaecological or obstetric needs.

Working in a remote indigenous setting took its toll on Geoff. He explains:

I was just knackered you know. I'd just had enough and I was just, I was losing it. I knew I was losing it. I was losing patience and stuff like that and there was just some heroic people out there but I couldn't, I just couldn't do it. I'd had
enough and you do get burnt out quite easily. The turnover is quite large over there.

In many ways Geoff symbolizes a traditional masculinity, working in predominantly iconic masculine social institutions, as in the armed forces and in formal religion. Geoff is complicit, using the gendered division of labour in the armed forces for his own gain. Yet he is aware that his power is limited, with nursing being subordinate to medicine. However, his display of traditional masculinity is contradicted by his sexuality - Geoff is a closeted gay. He takes part in homosexual sex but in a way where he will not be found out. A long term gay relationship would place his masculinity under pressure. As a result Geoff is contented with transient gay sex. The construction of masculinity in Geoff's case is complex and contradictory.
Michael – ‘a soft masculinity’
Michael is 38 years old, married with three school age children. Michael is a Nursing Unit Manager of paediatric services situated in an urban fringe district hospital. His wife is an occupational therapist who runs her own practice from home. Religion plays a big part in Michael’s life. He holds strong Christian values, is a member of an evangelical church, and actively participates in church activities; church services, church groups and prayer meetings.

Childhood and the construction of masculinity
Michael was very close to his mother; however she died when he was 9 years old. She provided him with his care and emotional needs, whilst his father was distant, physically and emotionally. His father remarried 20 months after the death of Michael’s mother. Michael grew up in a working class family with a conventional division of labour and a conventional power structure. His father was a self-employed butcher, owned his own shops, always away from the family, not involved in caring. He worked long hours, early in the morning to late at night. On weekends he was too busy around the house to spend time with his family. His stepmother was once a legal secretary. However, she gave up work when she married Michael’s father to be the primary source of parenting and managing the household. There was little display of emotion within and amongst the family, yet Michael knew he was loved. Michael was aware of the love from his stepmother as she provided for his needs, but he knew this love was different from what he felt from his natural mother.

When his natural mother died it highlighted to Michael the lack of a relationship he had with his father. Michael and his sisters were often left to fend for themselves. His father often did not come home at night. His relationship with his father has always been very strained, where his father is ‘unapproachable’ and ‘predictable’ in the negative sense. This is exemplified when in his teenage years Michael had a relationship with a Korean woman, which he did not pursue the relationship because of his father’s racist views. Michael was unwilling to challenge his father’s authority at this stage of his life.
Michael has two sisters; both have X link chromosome mental retardation. The older sister is married with a child and the younger sister lives at home with his parents. He had a brother who was also affected with the same genetic disorder; however he died of cardiac abnormalities at 17 weeks. Michael has great admiration for his stepsister, ‘what she took on’, and the commitment that was required from her. His father and stepsister had no children of their own.

Michael’s father was his major source of identification of masculinity. Gender conformity was enforced in this family, where a conventional form of hegemonic masculinity was the project expected for Michael. By his late adolescence Michael seemed to be well on the way to hegemonic masculinity or at least to symbolizing it. However, like those men in Connell’s (1995) case studies on men in the environmental movement, Michael reforms the self, rejects hegemony and unravels the effects of oedipal masculinization. Michael’s pre-oedipal relationship with his mother and later his relationship with his stepsister supported this transformation. In addition and probably more importantly, the lack of relationship and emotional ties with his father, despite all attempts, were the most powerful stimuli for his masculinity reform.

He started a Bachelor of Economics in 1984 despite his dislike of Economics at school. He did it because he thought it was what his parents wanted him to do. At the time he was unsure of what he wanted to do. He completed one semester, passing all his units of study. He withdrew and started nursing at an inner city hospital. Michael’s father had difficulties accepting his choice to be a nurse. His father had stereotypical views of gender, and nursing was not his idea of a ‘man’s’ job. Despite the initial shock, over time he became accepting of Michael’s choice of career. Michael’s current relationship with his father remains distant with little emotional attachment. It is only out of a sense of duty that Michael maintains any form of relationship with his father.
The home – Towards equal power and an equal gender division of labour

Power and the gender division of labour between Michael and his partner are structured in an equal relationship. They have structured their work in ways to allow both to have equal career opportunities. Early in their marriage they moved to a small remote town so that his wife could get a new graduate position following the completion of her degree. He currently is very active in the home, where a gendered division of labour does not exist. This is not to say that Michael does half of everything all the time. At different periods of their relationship Michael has been the primary care giver and did the majority of unpaid house work and at other times it was his wife. Michael took twelve months long service leave so he could be the primary carer after the birth of his second child. At the time of the interview Michael’s wife was interstate on a weekend holiday with her friends, whilst he was the primary care provider. According to Michael decision making in this house is also collaborative and shared.

Work and Production – Not a place for men

Throughout his nursing career Michael chose two specialty areas of nursing practice, midwifery and paediatric nursing, which are atypical areas of nursing for men. It was his emotional experience of his wife’s first pregnancy and childbirth that prompted him to do his midwifery. He did his midwifery certificate in the last hospital based course at large metropolitan hospital. On completion of his midwifery certificate he worked permanent night duty in labour ward for approximately 12 months. In 1992 he moved to a smaller district hospital in the outer suburbs of Sydney, still working in delivery suite [the same unit that Richard did his midwifery certificate]. After three years he moved to the paediatric ward, completed a graduate diploma in Paediatric Nursing. In 1996 he was successful in getting the NUM position, which he currently holds. He has just completed a Masters of Health Management degree.

Michael was one of six male midwives in the tertiary hospital where he did his midwifery certificate. There were no gender issues expressed by Michael in his narrative about this employment period. He felt he was part of the team and supported, with no difference in expectations of him as a male midwife. However he
was the first male midwife to work at the fringe district hospital. During this time he had experienced difficulties and discrimination from the female manager and other female midwives. He provides us with the following account:

I was the first male midwife they'd ever employed. The first day I started there the Nursing Unit Manager in the delivery suite said, "I don't know what we're going to do with you, sit over there and I'll have to find out". I could only assume she meant gender-wise what she was going to do with me working in a female area. I was quite offended at her approach to me, so I took a bit of initiative and I spoke to the union about it. It very quickly got back to the Director of Nursing and it was all sorted out very quickly. I guess, in hindsight that was probably a wrong move because I got on her bad side straight away. Anyway I was young. I know better now.

Here he was consistent with other interviewees in being proactive in confronting work-related gender discrimination (for example Anthony, Darren and Brad). He involved the union as a form of gender politics. What is interesting here is his expression of remorse for his actions. In the short-term he had a win but suffered as a result. Michael remained on the outer with his manager, constantly being picked on for his clinical practice. Michael believes that the midwives in this unit had a view that males are unable to experience birthing and are therefore not in a position to provide empathy and care. He believes that they viewed labour ward as exclusively women’s business. Similar experiences of this manager and the other midwives in this unit were expressed by Richard (another informant), who had completed his midwifery certificate in this unit.

Michael sees his midwifery practice as being very low interventional [similar to Richard and Alex], but at the same time best practice. He would only perform vaginal examinations (VE) when clinically relevant. In many ways Michael’s midwifery practises are gendered, only performing intimate body task like vaginal examinations when necessary. This contradicts the traditional routine practises of other midwives. This protects him from accusations of sexual deviancy. As a result he was perceived as being dangerous, placing the patient in unnecessary potential harm. He goes on:
They [other midwives] found it a dangerous sort of practice in terms of leaving women too long in second stage, not doing lots and lots of VE. Clinically I believe that you don’t need to VE a woman a lot. Just by listening to them and what their body’s doing, you can pretty much work out where they are through their labour process. I was fairly confident in my approach in that way. They found that very threatening.

In many ways Michael has deliberately structured his clinical practice in an autonomous fashion, as a form of gender defiance. Michael describes the practice of the other midwives as being interfering and ‘handmaiden’ like - referring to the other midwives acting to serve the obstetricians. There were birthing plans for the mothers during delivery and he believed that most of the female midwives would intervene and not support the mother’s decision. He describes the unit he worked in as being highly interventional: caesarean sections, epidurals, episiotomies and other medical interventions. He claims that the other midwives wouldn’t make any decisions about patient care independent of the obstetrician.

They weren’t prepared to be solely responsible for the management of a normal labour. I didn’t find they would use their knowledge and experience around labour. They wouldn’t listen to a woman. There was a high epidural rate, a high caesar rate and it was very much a very high intervention rate. They relied very much on obstetricians to make decisions rather than being midwifery centred practice.

Michael was often in trouble because his ‘statistics’ were higher than the other midwives; his numbers of deliveries were higher than the unit average. It was unit practice that medical staff was called for the birthing deliveries. Michael respected this for private patients but would deliberately leave it too late for some of the multiparous public patients. Michael believed that the obstetricians were less likely to consider the mother’s wishes in the birthing process and in many cases were unnecessarily intervening in an otherwise natural event. Michael’s view was to support the mother in achieving her goals for the birthing process, to be the patient advocate and that this was his duty of care. His strong convictions of patient...
advocacy, where in many cases required defiance of routine practises and the failure to subordinate the self to medicine, caused conflict with other midwives and several of the obstetricians.

There was one male obstetrician out of nine who was low intervention and Michael was often given his patients. There was a mutual respect between this obstetrician and Michael. However, there was not the same respect from the other obstetricians. The other obstetricians compared his practice to his peers and he wasn’t intervening quickly enough. Michael sees his practice as in the best interest for his patients; respecting the patient’s wishes and optimising their experiences.

Michael is conscious of the sexualization of the work he does as a midwife, where ‘you’re touching areas around female genitalia’. He practises in a conscious manner to prevent being accused of being inappropriate; doing something that was breaking a professional boundary. Like Richard, Michael would not examine a female without a third person being present. If Michael felt uncomfortable with the patient-nurse relationship he would insist on the presence of another staff member during examinations. He would not be put in a situation where he was with an adolescent girl on his own.

*It would depend on the rapport that I felt I had and how comfortable I felt with those two people, be it partners or friends or whatever. And that would be intuitive; it would just be something that I would feel. If I didn’t feel comfortable and I’d be assessing their reactions, their responses and you can pretty well tell how people are responding to you, if they trust you or don’t trust you or are uncomfortable with you, you can read that in their body language and the way they speak to you, the tone, the intonation they give you in answers, yeah then I’d go and get someone else.*

Michael emphasises the importance of communication in his nursing and midwifery practice. He states that he needed to get permission to access parts of their body, ensure there were no surprises, show respect, and overcome boundaries. Michael feels that there is a belief that men are unable to understand what it is like for women
during labour. He overcomes this by gaining trust and respect by the communication and demonstration of knowledge. He states:

  I needed their permission to move into areas where there were lots of boundaries and where they weren't used to having people pry, to access parts of their body that they normally wouldn't give to other people. I was always very aware, more so than my female peers, of respecting their rights as customers because of that gender barrier and in some ways I felt that I needed almost to demonstrate that I had an understanding of what their bodies were going through and what they needed. As a male it's almost taken for granted that you're not going to understand and it becomes a bit of a joke. Like you know, oh don't bother explaining it to him, he's not going to understand. I just find that you almost had to gain their respect and trust and I did that by demonstrating knowledge and a verbal explanation of what would be happening.

Like midwifery practice, paediatric nursing has similar social expectations and restrictions for male nurses. Both specialties are atypical for men, with an extreme minority distribution of men compared with all other areas of nursing practice. As it is perceived to be an unusual place for males to work and nursing children is culturally women's work, males who work in paediatrics have to overcome the social barriers placed upon them and guard themselves from negative consequences. Michael is aware that the majority of paedophiles are male and that he had to be aware of the potential label. He was also aware of the gender norms of care and the public image of men as carers. He states

  I find culturally that a lot of women don't trust men with children; men just aren't seen as being nurturing. As carers they're seen as being rough, inconsiderate, very unaware of the needs of others. I think those sorts of generalisations and those sorts of judgements often came into the ward with those people, so you'd need to try and work around those.

In order to prove his ability he would openly talk about his own kids to reassure them that he was capable.
It appears that being male has advantaged Michael in his career progression. When Michael was appointed as the Nursing Unit Manager of the Paediatric ward he had the least experience in paediatric nursing when compared with the other ward staff. This created a degree of ‘animosity’ between Michael and a small number of his female staff. He accuses these nurses of attempting to ‘undermine/sabotage’ him. Michael had difficulties in maintaining authority, where he was often the target of accusations from this small band of females. There appears to be a lack of trust from both sides. Over time these relations have improved, but not without effort and cost. Michael has been very conscious of the image he portrays and the symbolic representations of his body. He is aware of his physicality, in particular his voice projection. Michael states that as a manager, if he begins to raise his voice it is perceived as being intimidating.

I think that gender thing that men aren't seen as being as caring and as sensitive ... In situations where I'm relating to my peers I've got to be very conscious of how my voice sounds because if they see me as getting angry and me being male, then that's more threatening for them. It's okay for me to have them yell at me and for them to raise their voices to me because I'm a male and it's different for me. For me to be angry with them I've got to tackle it a whole different way.

Michael is a NUM of a large inpatient and outpatient Paediatric health service. He is responsible for nursing budgets and nursing human resources for a 30-bed inpatient paediatric ward, a short stay mothercraft/Tresillian facility and 6 community child and family health centres. He has a relatively large number of staff and they are mostly female. His supervisor and the two other divisional Nursing Unit Managers are female. Michael is in middle management with limited corporate power, yet he is seen by his staff as ‘the manager’. Michael is very much caught in the middle, between senior management and his nursing staff, and struggles to mediate the divide between the two groups. He implements the corporate decisions and cops the consequence from his staff for the decisions that are made. I get the impression that he is reluctant to make changes, which are often handed down from senior
management. However, he toes the corporate line and is complicit in the organization's agenda. He likes to implement change gradually and on his terms, but he lacks the authority to ensure this occurs. Michael was uneasy with his role as manager. Soon after the interview Michael resigned from his position as Nursing Unit Manager and left the organization.

Cathexis – social isolation and limited social capital

The strongest emotion expressed by Michael was one of isolation. Michael provides a strong account of how being a nurse threatens the social construction of masculinity and therefore socially isolates him from other men. In addition, culturally constructed gender roles and norms inhibit his participation in female social networks. These limit his social capital.

Despite most of his friends being women, Michael found it difficult to socialise with women from work, especially with nurses from his ward unless it was an open invitation to all staff. He notices that other nurses [females] meet for lunch or coffee on days off, but he was never invited. He identifies a difficulty for male nurses where they are the only male on the ward. He claims that there is an assumption made by women that men are not interested in female activities.

_I don't get asked out if I've got a day off. One of my colleagues wouldn't ring me up and say hey let's go and see a movie or are you free for coffee or lunch or something. That never happens and maybe that's because I'm the boss. They all have their own little networks and little groups and they often do things as a group together and I'm never included in those groups. It's always assumed that I'd never go to those sorts of things [product parties eg Tupperware] so I never get asked._

Michael was excluded from socializing with the 'inner circle', a term he used to describe the network of his boss and the other two divisional Nursing Unit Managers. They regularly meet for coffee, an activity in which he was excluded. It wasn't until he saw them in the cafeteria and invited himself that they realised they were excluding him. Michael now makes a point of joining them when asked. He states:
I always try and make a point of going because I see it as being a really important team-building thing. Just having a rapport and building a relationship with them, one that isn’t just work based and I think having a bit more of a social relationship changes the work relationship a little bit more. It makes it easier and things flow a little bit better than just being professionally based.

Michael claims that the most isolating period was when he was on paternity leave. ‘There was no-one around’; ‘all my friends were all at work’. When they weren’t at work, they couldn’t understand why meet for a coffee; ‘what did we have to talk about’. During this time Michael took his son to play group. He felt accepted but he felt that there was a change in the group’s dynamics with him there.

I’d go to a playgroup and it wasn’t like I wasn’t accepted but it was obvious that things weren’t flowing as normally and as naturally. It was like they weren’t comfortable about talking about breastfeeding and any problems they were having when I was around.

Michael describes the Paediatric ward that he manages as being very social, often going on ward nights out. He is the only male working in the unit but feels included in these events. However, the ward staff go on weekend trips away and Michael feels uncomfortable participating in these. Firstly he feels that the staff should go with freedom to express themselves and he feels that his inclusion would alter that in two ways, as a manager and as a male. Secondly he doesn’t feel comfortable being a married man going away with so many females. He does acknowledge that the social discourse is female dominated and often concerns their poor relations with men.

Michael claims that his assumptions/opinions about male generalisations/images/symbols are based on what he hears in the tearoom.

I’m not comfortable with their behaviour a lot of the time. They’re a very rowdy bunch, they drink a lot of alcohol, they’re very loud, and a lot of them are very extroverted in terms of their behaviour. It’s nothing for them to be dancing on a table. I just don’t feel comfortable around in that sort of situation. Some of them need that performance. They usually all hop in their
pyjamas and there are bottles of wine and they’re just chatting and talking and stuff. It’s a whole lot of stuff that I don’t feel comfortable with, being in situations, being in with them.

Michael has difficulty conversing with other men. He didn’t have things in common and he felt ‘locked out a lot of the time’. They weren’t interested in his work. This is consistent with many of the other informants’ experiences.

I was the only one who was in health and I don’t know whether I lacked confidence back then or whether they felt uncomfortable with what I did. I still don’t know which was it, but the conversation always was around banking, finance, courses, conferences and I found it very difficult to participate in that conversation. That wasn’t my area of expertise. When I tried talking about work there was very little response. It was always oh that’s interesting and the conversation would change. The language was that they weren’t interested. They didn’t want to know. They didn’t feel comfortable talking about it. So I very quickly didn’t bother talking about work because it just didn’t get me anywhere.

He believes that he is viewed by other men as being different because he is a nurse. That he hasn’t succeeded. He doesn’t have the ability to produce. Being a manager does provide some distance from the ‘just a nurse’ tag.

My wife is an occupational therapist and she’s got her own practice. It’s been obvious that she’s had more respect than I have and there have been comments made that based on my income we wouldn’t be anywhere. We really need her income and that’s true, we do, but the facts that we can’t survive on my income a lot of the blokes have a real problem with that, that I depend on her for an income as well for our lifestyle that we enjoy. They have a real problem with that, whereas I don’t. I see myself as doing what I want and we are a partnership. Because we’re a partnership we both bring something to the relationship so for her that’s finance, part of what she brings is her financial gain as well.
Despite this he claims to have many male friends. However he only has two or three close friends. Michael has a clear understanding on what it means to be close.

*I've got a lot of male friends. What I would consider close probably isn't what most men would consider close. For me someone to be close would be someone that I would feel comfortable telling them anything and to have them listen to me and participate back in that conversation. That to me is a close friend and for him to be able to confide in me in lots of ways. So I probably have two or three mates that I would consider I have a relationship at that level. For the majority of my friends it's more of a superficial relationship, one that we would all sort of get together and watch the football and talk about things, but then to take the conversation deeper than that, it doesn't happen.*

Symbolism

Despite finding it difficult Michael engages in male social discourse and socializes with men with common interests, predominantly from a church community. He engages in male social activities like watching football and drinking with mates. He can see the difference in the way women network and communicate at a personal level, where males are more superficial or closed, 'much to our detriment'.

*Male conversation's not flowing, it's always based around football and sport. It's never personal sort of stuff and women network really, really well together and talk really, really well. Men don't do that kind of stuff. Men relating their feelings about things and even just how they feel about their children and caring for their children, there's no language for men. Men don't have a real way of communicating all that kind of stuff, because we don't, we don't open up very much. I think that extends into lots of areas.*

Michael has a clear view of men, one that he is not comfortable with and rejects for himself. He has a clear insight into the closed nature of men's emotions and their unwillingness to disclose them. For this reason he prefers to engage in female social networks.

Michael has a clear view of people creating their own gender arrangements, i.e. women and men could both choose to stay home and raise children. Michael hates
the stereotypical images in advertising portraying men as inadequate in home
domestic work. He likes to challenge them, for example he likes to cook morning tea
for his staff. He has a strong sense and desire for gender equity and men’s rights.
This was exemplified by his annoyance during his kid’s upbringing due to the lack of
public facilities for fathers; mothers’ rooms were always available, yet he was forced
to change his son’s nappies out in the plaza. Gender neutrality is his goal, changing
mothers’ groups to parenting groups.

*I like to demonstrate that I don’t fit into their expectations or their little
boundaries for what men are able to do. I like to break those boundaries and do
different things.*

Michael is frustrated by society’s construction of gender and its enforcement of
norms. He symbolizes an alternative for men, a form that challenges traditional male
power and male dominated gender divisions of labour. Michael prefers female social
networks. Michael is unconventionally masculinized. He challenges the notions of
hegemonic masculinity. He works in typically female dominant areas of nursing;
midwifery and paediatrics. He sees himself as the manager, making the tough
decisions, yet is reluctant to upset his staff. Male discourse is frustratingly superficial,
yet he engages in it to a limited degree. He has many male friends but only three of
them are close. He enjoys watching football and having a beer with his mates, but
finds them very superficial. He enjoys the social networks of women, but finds it
difficult to engage and is reluctant to participate. He feels socially isolated.
Anthony – 'a true bloke'

Anthony is a Clinical Nurse Specialist in a community mental health service. He has previously been married on two occasions. The first was when he was 20 years of age and lasted 6 years. He had no children from this marriage. He married again when he was in his thirties and had two children. He now lives alone and has a girlfriend. He works and lives in a rural town on the north coast of NSW.

Childhood and the construction of masculinity

Anthony is the youngest of three children; he has a brother 2 years older and a sister 4 years older. Anthony grew up in a post war, working class family with a conventional division of labour and a conventional power structure. His father did abstract labour, laying carpet and then worked in retail. His father was absent from the home, working a lot, doing a lot of overtime in order to provide for the family. His mother was a housewife, providing the main source of parenting. It wasn’t until Anthony had left home that she started employment. His mother was the strong member of the household, controlling the financial affairs, paying the bills and ensuring there was food on the table. ‘Mum set all the rules and dad was very supportive’. Anthony describes his parents as unusual, believing in gender equality, encouraging their daughter to go to university, and encouraging and teaching their sons to do traditional female work such as ironing, knitting and sewing. Despite a move towards gender equality in the division of household labour, the family project to a great extent ensured gender conformity. Anthony’s sporting pursuits (rugby and cricket), dress and special interests met conventional representations of masculinity.

Anthony’s mother, unlike his father, was a devout Catholic. All of Anthony’s schooling was at Catholic schools. In many ways the religious brothers and male teachers were a major source of masculine identity for Anthony, where male power and authority were institutionalized. Anthony’s resistance against authority figures stems from his experiences with the dominant authority of the Catholic brothers; ‘The brothers ruled with an iron fist’. Anthony was generally well behaved at school but he was unable to avoid the injustices of hegemony and the unquestionable authority of the teachers.
Anthony describes his relationship with his family as ‘not close’. As a child he was close to his brother, confiding in each other, but not with his parents. He always felt loved and supported, his parents were always there if there was a problem. As an adult he has very little emotional attachment to his family.

Work history

Prior to entering nursing Anthony worked in male dominant, traditionally masculine areas. Anthony left school in 1967 at the age of 15 years. He started work as an apprentice auto-electrician, completed 3 years of his trade, and then decided he no longer wanted to be an auto-electrician. After leaving his apprenticeship he engaged in abstract labour in a heavy industry for a multi-national company in Nullangardie. He moved to Nullangardie with four friends from school.

Anthony and one of his four flat mates decided to do nursing at the same time. They perceived the labouring work to be ‘leading nowhere’. This was not a difficult choice of profession for Anthony as he was raised in a country town where there was a mental health institution, which was a major employer of the town. A couple of his mate’s fathers were mental health nurses working at the local asylum. As a school child he had played sport on fields that were situated within the grounds of the asylum. Nursing provided the opportunity to attain a qualification and an opportunity to earn a wage whilst learning. At the time of training Anthony was living away from home and had to support himself financially.

His parents were pleased and encouraged him when he started his Developmentally Disabled (DD) Nursing Certificate in 1971 at the local schedule five hospital, as they perceived it to be an education and a qualification. Whilst encouraging him, they had difficulties in understanding and accepting that a male can be a nurse. It took 5 years for them to come to terms with it.

Prior to commencing developmentally disabled nursing (DD) Anthony applied to the major public hospital to do his general nursing training but his application was rejected; they didn’t take men. He completed the DD Certificate in 1974 and went
straight away to do psychiatric nursing. He completed this after 12 months (1975) and worked there for a short time prior to going back to the schedule five DD institution for a further 12 months. He then left for an overseas working holiday for 7 months. On return he went back to the psychiatric hospital for a couple of years. In 1979 Anthony began his general nursing conversion certificate at the local teaching hospital. After 18 months training and six months from graduation he was coerced by the nursing administration to leave.

In 1982 he temporarily left nursing, moved to the country and worked as a fencing contractor and a forestry worker. He was burnt out from psychiatric nursing and an opportunity arose where a property was made available to him. He found working for himself hard going. He could only take his days off during rainy days, the money was sporadic and he was working long periods. In 1986 he worked for the local University as a clinical facilitator/instructor in mental health nursing. In 1994 he obtained a job as a community mental health nurse in a large country town. In 1998 the health service was restructured and his position was moved to a different town. In 2001 he moved to the far north coast where he is currently a community mental health nurse.

**Undermining female power and authority – Conflict as gender politics**

Anthony’s masculinity was threatened by the organizational structures of nursing and power relations with female managers. This has not been the case with male authority. He has had difficulty throughout his career with female authority, with frequent turbulent relations with female managers. He has never held a nursing position of power and authority. His ability to engage in gender politics within the nursing arena and combat against perceived injustices were limited to the use of confrontation. Anthony attempted to be assertive in combating power struggles. He used ‘his rights’ to challenge the status quo. He describes himself as being a ‘little more assertive than the general run of the mill of people’. He states that ‘he is prepared to accept less elk’, causing him conflict with management.

Anthony describes nursing and the hospital environment as being ‘militaristic, a much regimented rigid system with a lot of demarcation between staffing levels’.
There were clear rules and regulations that everybody had to follow. Anthony found it difficult to fit in with the ‘rigid/overbearing, over regulated system demanded of general nursing’. ‘You weren’t allowed to use your own initiative and think for yourself’. Anthony had already attained 2 nursing certificates and he felt ‘undervalued and a little put upon’. He ‘ran into a lot of hostility from the [female] hierarchical system’. He states:

*I think they wanted everybody to fit into a little box and it was inconvenient to have anybody outside the box. I questioned their rules and regulations, I didn’t really think that their rules and regulations were in the best interests of patients nor staff and often they just made life more difficult. An instance was when I was a second year nurse I was in charge of a shift on a particular ward, but they wouldn’t give me the drug keys, despite me being double registered. If I had anybody that required pain relief or any sort of medication I had to go to the next ward, get the registered nurse there, she’d have to come to my ward, get the drugs out and then administer them.*

Anthony had mixed relations with different [female] nurse managers. He believes the relations between him and the manager was dependent on the life experiences of the individual manager, as well as the situation and time. He states:

*As a male I felt that at times I was unfairly treated in comparison to females just by virtue of the fact that I was male. I think that stemmed more from the individuals’ own life experiences, whether they were fighting with their husband at the time. As a male you tended to bear the brunt of their discontent at times, to the other side of the coin where being a male allowed you to enjoy a few more freedoms that some females didn’t get just by virtue of the fact that your immediate boss quite liked males and went out of their way to make sure that they were treated well.*

Anthony was confronted by a network of female managers who according to him collectively worked to subordinate him. The classic example of this was during his general nursing training at a small district hospital where he was rotated through several wards. It happened that two of the managers were related and had strong
friendships with the other managers. According to Anthony, as a result of a situation where he stood up to a manager early on in the course, he was labelled as a ‘troublemaker’ and was unfairly treated by subsequent managers. He believed his demise was orchestrated by these women. Anthony, following consultation with the Matron, decided to leave. The matron had organised it so Anthony could leave without financial penalty as he was on a bond. He was bought off so to speak. He did not complete his general nursing training.

Anthony had been an active member of the union and used collective union action as a form of gender politics. During the period of his general training he was an active union delegate. On several occasions he used his position in the local union branch to fight for improved employment conditions. In part this was his demise at that institution. He used the services of the union to assist in the negotiations of his departure from the district hospital. Anthony believes nurses in general are not good at political action in collective groups and this frustrates him. He blames women for the lack of political action. He states:

I think one of the disadvantages of being in a mostly female profession is it’s very difficult to get much in the way of solidarity when you’re looking at negotiating work practises or wages or anything like that. I’ve always found it very frustrating to be tied up with a group of people who are never prepared to take a hard line. They’re always prepared to compromise and bend rather than allowing somebody else to compromise and bend and I think it’s acted to the detriment of nurses generally.

Like the other participants Anthony describes the power relations between medicine and nursing to be a hierarchical one where nursing is definitely subordinate. However he believes this had changed over time. Nursing remained subordinate but was valued as a health profession by medicine.

I think there’s still a hierarchical system. I think the whole system is a lot more open, there’s more exchange of views, there’s more respect for nurses as professionals than there used to be by medical officers. I think your opinion is more valued or at least listened to, I’m not suggesting that’s everybody there
are individuals who will always hold to the view that they know it all and nobody else there knows anything unless they've got at least an equal qualification.

Despite the hierarchy between nursing and medicine, Anthony describes his relationship with the [male] psychiatrists as very good. The professional relationship described by Anthony was one of mutuality, where the specialist medical officers were prepared to listen to what you had to say and were prepared to give credit where credit was due. Anthony was able to use his specialized knowledge and masculinity to maintain this position in the relationship with psychiatrists. But he described the relationship as being different with general practitioners. They do not take nurses' professionalism at face value, but require a proof of ability. There is a sense that they do not trust nurses' judgement until the nurses have proven their worth.

Unlike his relations with female authorities, Anthony avoids conflict with males who assert authority, like general practitioners. If he had a concern for a patient and the general practitioner didn't take his advice Anthony got around it by organising the patient to see the psychiatrist. He was able to use his relations with psychiatrists to manipulate and override the decisions of general practitioners, avoiding direct confrontation. Whilst other participants were angry and frustrated at the subordination of nurses by medical practitioners, Anthony excuses the general practitioners' behaviour, and is willing to accept it. Yet like the other participants Anthony engages in gender politics with the general practitioners, using subservient means to get what he wants from them.

Anthony's relations of power with women are clearly patriarchal. He has difficulty with female authority, especially when it is used to subordinate him as a man. He engages in conflict as a means of gender politics. Despite his subordination in power and authority with other men, he does not use the same strategies with them. Anthony does not seek power or authority. He has no real career aspirations. He sees management as the only career path open to him but he is not willing to go down that path. He doesn't want to be like his previous managers.
Labour and production

In the domestic arena Anthony holds a typically dominant position. The gender arrangements in housework and child care have been unequal, where his partners have undertaken the largest portion of these responsibilities. However, this was not always the case. After the birth of his daughter Anthony worked part-time for several years to be the primary carer of his child. Anthony hated this and negotiated to take back the breadwinner role.

As previously stated Anthony has a history of working in traditionally masculine jobs, such as automotive services, labouring in heavy industry, contract fencing and a forestry worker. His nursing career has also taken a more masculine track working predominantly in mental health nursing. In part this was forced upon him, for example when he started his nursing career the local hospital did not take men into general nursing. Despite finally being general trained he continues to work in mental health nursing.

His duties in the schedule five hospital included providing and assisting in the activities of daily living for up to ten residents. This included showering, dressing and giving meals. He makes the distinction between developmental disability (DD) nursing and mental health; ‘DD is long term basic care, where mental health is more acute counselling, dealing with adverse behaviour’. The ratio of men to women was different between DD and mental health institutions, where DD was predominantly female and mental health was more 50:50. Anthony describes his time in mental health as dealing with crisis situations on a regular basis; dealing with aggression, suicide and having to chemically and physically restrain people.

Anthony describes an egalitarian gender division of nursing labour, where everybody was expected to do the same job. However there were demarcations associated with male and female body practises, eg. caring for women’s periods and men’s genital hygiene and heavy manual work, eg. lifting, carrying, and dealing with aggressive or dangerous patients.
Anthony is aware that as a male nurse his sexuality is questioned. He is aware of the homosexual tag that comes with the territory of being a nurse. Anthony has experienced the label of homosexual at work, comments from patients like: ‘most male nurses are homosexual aren’t they’. He has also experienced negative consequences from other males. He believes that men in general are unable to comprehend why men would want to be a nurse. He provides an example:

*When I first started nursing I was working as a labourer at BHP and when I said I’m leaving and I’m going nursing, the sort of comments were: that’s a bit weird why are you doing that? This was amongst a group of people who were probably 50% immigrants, and most of them were uneducated. They were a bit taken aback and really unable to understand, they couldn’t form a real concept of what you were doing, it was so foreign to their thinking. I guess other people have just had this oh gee how can you do such a job and I don’t really want to know anymore. They are a bit bewildered by what a male is doing in nursing; I guess is one of the sorts of reactions I get too.*

Anthony considers the major stereotype of nurses is that of homosexual and sexual deviant. He practises in a protective manner to prevent accusations being made against him. He is willing to allow female nurses to take over when female patients object to men’s care ‘in order to avoid the situation’. He labels his practice as being ‘professional’. By being professional he avoids any misinterpretations of his actions. He describes being professional as:

*[Being professional] includes doing things as per the book so that if you’re taking into account all their privacy issues. I guess their own personal, being aware of their own personal space and not overstepping marks that they may have sort of indicated to you. Some people are easy because they’ll be right up front and say gee I’m not used to having a male nurse around. Other people would not necessarily be direct about it, but would certainly let you know that they felt a little uneasy. Other people were blasé and just accept whatever was going and happy to get some sort of treatment regardless of whom it was. As to how you read it, just the usual sort of body language that people use, whether it be facial expression, whether it be pull away if you touch or relax*
Anthony never felt vulnerable in DD.

They were very much dependent on everyone to do lots of things for them and they weren’t didn’t have the intellectual capacity to be able to really make charges against you or claims so you really didn’t have any fear there. I was a bit naive thinking that if you’re doing the right thing people will see that you’re doing the right thing and all will be well but that doesn’t isn’t necessarily always the case.

He is acutely aware of the potential dangers of his current position. Anthony is a community mental health worker who visits clients in their homes. He feels vulnerable going into a female’s home when she has a mental health problem. He states:

In this particular line of work where you’re working in the community you’re dealing with the general populace. The fear I have is as a male going into the home of a lone female and what that may mean if that person decides to make some sort of claim. We’re put in a situation where people would be able to make accusations most days, to claim something about the way you’ve acted and really all you’ve got to protect yourself is your good reputation over an extended period of time and that’s about it. That does concern me and I’ve brought it up at different managerial levels but no one ever really wants to address it because it is in the too hard basket. What do you do, do you send out two people to see somebody because that’s the only alternative?

Cathexis - Male Domination through Sexual Relations

Sexual relations are a way that Anthony is able to maintain domination over his partners. Anthony has been married twice, both relationships ending following his extra marital sexual affairs. Anthony is exclusively heterosexual, not having any male-to-male sexual relations. He has had many sexual relations; monogamy has not
been his project. He puts this down to the ratio of males to females in nursing and the subsequent temptation. For Anthony marriage is a contract, not life binding and can be broken at any point. At the time of marriage Anthony had feelings of love for his partners, yet he was not willing to invest energy in maintaining his relationships. He shows no signs of remorse or guilt regarding his active demolition of his relationships.

Anthony married young at the age of 20 years. When he met his wife she was working as a secretary. She was 17 at the time. She was planning to do nursing and subsequently completed her general training. They were married for 6 years. He claims that the marriage failed as a result of his infidelity. He had no children from this relationship.

Anthony remarried to a younger person and had two children, a daughter who is now 18 and a son who is 13. This marriage broke down ten years ago when his daughter was 8 and his son was 3. He blames the pressures of being away for work as the precipitating cause of his failed marriage. They lived 25km away from town and when he worked he would stay in town over night. His feelings of disharmony, disillusionment and loneliness were the catalyst for extra marital sexual relations. Anthony was not committed to one sexual affair; he slept with multiple women over a period of time.

Anthony loves his two children. He has played an active role in their early childhood. When his daughter was born he took an active and equal role in her care, working on a part time or casual basis. They had no family support; his parents were elderly and lived far away, her mother was dead and father worked. After the marriage breakdown Anthony had minimal custody, and he withdrew from an active parenting role. He shows a sense of remorse and guilt about this.

Anthony’s social network has predominantly consisted of male health care workers. He claims that their views of men in nursing are different to the general population’s. Anthony enjoys and prefers male company and friendships. He has typical male
interests, sport and cars, and enjoys being one of the blokes. He finds it difficult to
develop platonic friendships with women, yet he has no trouble in finding sexual
partners. He does not trust women as he has been burnt by so many; in particular his
wives and colleagues. This does not mean he does not socialize with women, he
does, but he finds it more difficult to develop friendships. The social activities with
the blokes are more organized, usually associated with sport, golf or cricket, where
with women they are not formal and are more difficult. It is as if Anthony prefers
social situations, predominantly with men, where there is no emotional involvement
and emotional cost.

An example of gender difference in social activities is in the playing of sport. During
his training the male nurses would socialise at lunch, playing cricket. This was a male
activity; females didn’t want to play. Anthony states that it is difficult to play
competition sport whilst doing shiftwork because you cannot guarantee your shifts.
Organized sport was one arena where male domination could be maintained. The
males substituted this with sport during lunch. He states:

*When you start in a job where you’re doing shift work and it involves weekend
work and night work, it’s very difficult to maintain some sort of regular
sporting activity. The people who continued to do some sort of sporting activity
in the job were very few and far between. I guess all the guys were always
looking for something to do, something physical to do and you didn’t get the
opportunity to do it away from work, we made the most of the chance to do
something at work.*

Anthony sees the public image (media produced) of male nurses as being the
incomplete man, the sensitive new age guy or the gay nurse. He believes you never
get the real person, somebody that is well rounded with more to their lives than just
nursing.

Anthony had the starting point of his construction of masculinity in a typical working
class family with plenty of male role models: father, older brother, religious brothers
and an all-boy’s school. He is masculinized with typical male tastes, sport, drinking
and women. He commenced traditional male work: auto electrician apprenticeship and then labourer for BHP. In part he moved to BHP to escape the country town. Unlike other participants, nursing was not a foreign concept for Anthony. Some of his schoolmates’ fathers were mental health nurses at the local asylum. He entered nursing with two of his mates whom he was living with.

The construction of masculinity in Anthony’s life course resembles a project of patriarchy. He has constructed social practice in order to reap the benefits of hegemony, especially in the areas of power, sexual and production relations. Nurses’ working conditions and their unwillingness to take collective action frustrate and hurt Anthony. Anthony has no power in his work life and struggles against female authority. He blames female managers for being unjust and the root cause of his poor working conditions.

Concluding Thoughts
There are no limits to the variability in the configurations of masculinity. Both Derrick and Geoff are gay, but both have different starting points, locations and influences, constructing their masculinity differently. The construction of masculinity in Anthony’s life is a project of male dominance, whereas in Michael’s life, the project is one of gender equality. These four case studies demonstrate the multiplicity in the pattern of social practice that configures masculinity, but at the same time similarities in the trajectories of the construction of masculinity can be drawn.

Derrick and Anthony both had their starting points in a working class family, where there fathers played an absent role other than a token appearance. Both men developed a traditional masculinity and were hurt by being a nurse. Anthony in particular had difficulty with female authority. Both Geoff and Michael lost their mothers early in their lives and were starved of emotional attachment. Both men experienced violence, physical or through neglect, from their fathers. Yet these men developed quite different trajectories in the construction of their masculinity. Michael had strong attachment to his sisters and developed a strong sense of family. He is active in the care of his own family and epitomizes an unconventional masculinity.
Geoff symbolizes a traditional masculinity, working in iconic masculine institutions, but contradicts this through his strong religious convictions and homosexuality.

Chapter 8 presents the results of the collective analysis, where all the case studies were re-analysed in groups to explore similarities and differences, to understand their collective locations.
CHAPTER 8
Gender Structures and Types of Masculinity

Introduction
This chapter presents the results of the second phase of the analyses where all the individual case studies were re-analyzed in groups to explore similarities and differences in the trajectories of male nurses in varying social locations. These collective analyses of the participants are presented under the headings of the four gender substructures: production, power, emotion and symbolism, which were used to inform the analysis.

Life Course and Career Patterns
The majority of men had the starting points for their construction of masculinity in low income or working class families. Warwick was the only participant raised in a family where their income was dependent on social welfare. Fifteen of the men were raised in working class families where their parents did unskilled manual work. The fathers of Andre, Darren, Alex and Ralf work(ed) in factories or on construction sites as unskilled or semi-skilled manual labour. The fathers of Ken and Brad began as factory workers but have now moved into lower management. The fathers of Richard, Samuel, and Anthony also work in unskilled jobs in retail, trucking and carpet laying, respectively. Six of the participants’ fathers worked in skilled jobs. Both Derrick and Michael’s fathers were butchers, Geoff and Ricky’s fathers work in the emergency services, Paul’s father was in the army and Scot’s father was a nurse.

Warwick’s father was a motor mechanic but died when Warwick was nine years old. After his parents’ divorce when he was six years old, Warwick’s mother, with whom he and his brother lived, became reliant on social welfare for income. Warwick’s mother never had a paid job.

Of the 15 men of working class background, seven had working mothers in paid labour. The majority of these worked part-time as unskilled labourers. Brad, Ken and Geoff’s mothers worked part-time as a seamstress, a secretary and a barwoman respectively. Paul and Richard’s mothers did the occasional unskilled jobs, such as
cleaning. Scot’s mother was a nurse who worked part-time permanent night duty. Ricky’s mother worked full-time as a manager of a retail grocery store. Derrick’s mother worked occasionally, unpaid, in her husband’s butcher shop.

Five participants - Andrew, Adam, Simon, Warren and Greg - had their starting points in middle class families. Both Andrew and Adam’s fathers were country doctors and their mothers were nurses. Both mothers gave up paid work when they got married. Simon’s father had a partnership in a small business that he managed and his mother did not work in paid labour. Warren and Greg’s fathers were teachers; Warren’s father was a high school career advisor and Greg’s father was a principal at a country primary school. Warren’s stepmother was also working as a full time teacher. Greg’s mother worked part-time as a cleaner.

The income and work arrangements for these men’s families were conventional in that the fathers of most of the participants were the major income earner for the family. Exceptions to this were Ricky’s mother who was employed in a higher paid position compared to his father, and Warwick’s mother who was receiving a single mother’s pension.

Seven of the 21 participants as children experienced family breakdown or loss of a parent, either through death or divorce. Ricky, Warwick, Warren and Derrick’s parents divorced when they were 5 years, 6 years, 8 years and 16 years of age, respectively. As previously stated Warwick’s father died 3 years after the divorce when Warwick was 9 years old. Both of Derrick’s parents died before he was 19 years of age. Ricky lived with his mother and stepfather following the divorce but had regular contact with his father. Warren lived with his father and stepmother following the divorce and only had infrequent contact with his mother as she remarried and moved interstate. Geoff, Alex and Michael experienced a loss of a parent when their mothers died due to illness when they were 3 years, 7 years and 9 years of age. All the fathers remarried soon after. Warwick’s mother also found a partner following his father’s death. Warwick, Geoff and Alex had negative relationships with their subsequent stepparents.
Eight of the participants experienced childhood hurt and pain from their parents, either as a consequence of marriage breakup and the preceding domestic arguments between parents, or childhood abuse, in the forms of physical violence or physical and/or emotional threats. Geoff, Warwick, and Samuel grew up in very volatile families where there was a lot of alcohol use and physical domestic violence, often directed towards them. Derrick, Michael, Ralf, and Adam experienced very cold, negative relationships with their parents. There was not a lot of love in these households. Warren, whilst not directly abused, was affected by the bitter divorce of his parents.

With the exception of Ricky, Richard and Warren, the fathers of the men were absent from their lives during their childhood. Despite some fond memories held by a few informants, they do not recall their fathers participating in their daily lives, except for the conduct of discipline and punishment. As adults none of these men, with the exception of Ricky, Richard and Warren, have close relationships with the fathers.

Despite some cultural differences between the informants, the similarity in the family backgrounds of the men is striking. Most of the informants were from working class families where abstract labour was the major source of family income. The fathers of the men were absent from their daily lives during their childhood. Many of the participants were starved of positive emotions by their parents and many have endured sustained familial emotional trauma caused by parental divorce, death of a parent or parental neglect and abuse. As adults most of the informants continued to have poor relations with their parents, especially their fathers. Perhaps nursing offered these men an emotional safe haven, an outlet for emotional expression articulated through the care of others and where the rewards are positive emotional ones that have been lacking in their lives. Nursing has assisted these men in being upwardly mobile, providing a chance to escape their oppressed personal situations.

Derrick, Ralf, Geoff and Simon describe themselves as being gay. Derrick and Simon are currently in long-term relationships; Ralf and Geoff take part in occasional sex, without any firm commitment to an individual. The other 17 participants are
heterosexual. Sixteen of these are married, 13 to working nurses. Ken, Samuel and Anthony are currently in their second marriages. Warwick is also a divorcee and is not currently in a relationship. Four of the participants - Ken, Warwick, Samuel and Anthony - were married before the age of twenty-one years. In addition, Ken, Samuel and Warwick had their first child within their first two years of marriage. In fact for Ken and Samuel the pregnancy precipitated the marriage. All four men were divorced before they were thirty years of age. Both Ken and Samuel have had no contact with their children (a daughter each) since the divorce.

After leaving school 7 of the 21 participants went straight into nursing (Darren, Richard, Brad, Geoff, Ricky, Simon and Greg). Seven men entered the labour market into manual work. Ken, Anthony, Samuel and Scot commenced apprenticeships prior to commencing nursing. Ken, Samuel and Anthony left their apprenticeships because they disliked it, and Scot failed to complete his due to a down turn in the housing market and the subsequent liquidation of his employer. Alex, Andre and Warwick left home at the age of 18 years and worked as unskilled labour for income.

Six participants – Derrick, Michael, Andrew, Ralf, Adam and Paul - had commenced tertiary studies in degrees other than nursing prior to doing nursing. Ralf was the only participant who had completed a degree prior to doing nursing, in his case a Bachelor of Law. Adam and Paul, after completing their nursing training, went back to university to complete the degrees they had previously commenced. Sixteen of the participants have attained tertiary qualifications, 12 have tertiary qualifications in nursing. Eight of the twelve participants with tertiary qualifications in nursing completed them as a pre-registration qualification. Andrew, Scot and Greg have not attained any tertiary qualifications. Greg had done 2 years of a surveying degree but did not complete it.
Table 24: Participant Demographics – Age, Position, Area of Practice and Year of Entry into Nursing

<table>
<thead>
<tr>
<th></th>
<th>Age in years</th>
<th>Position held</th>
<th>Area of nursing practice</th>
<th>Year of entry into nursing</th>
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<tr>
<td>Warwick</td>
<td>44</td>
<td>NUM</td>
<td>Critical Care</td>
<td>1978</td>
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<tr>
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<td>1990</td>
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<tr>
<td>Darren</td>
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<td>RO</td>
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<td>1985</td>
</tr>
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<td>Ken</td>
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<td>Operating Theatre</td>
<td>EN1986</td>
</tr>
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<td>Midwifery</td>
<td>1990</td>
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<td>Brad</td>
<td>36</td>
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<td>1984</td>
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<td>1971</td>
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<td>1985</td>
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<tr>
<td>Michael</td>
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<td>1984</td>
</tr>
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<td>Ralf</td>
<td>61</td>
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<td>Aged Care</td>
<td>1996</td>
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<td>Scot</td>
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<td>Ricky</td>
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<td>DDON</td>
<td>Aged Care</td>
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<td>Greg</td>
<td>41</td>
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<td>1979</td>
</tr>
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</table>

Note: RN= Registered Nurse; CNS= Clinical Nurse Specialist; CNE= Clinical Nurse Educator; CNC= Clinical Nurse Consultant; NUM= Nursing Unit Manager; ADON= Assistant Director of Nursing; DDON= Deputy Director of Nursing; HSM= Health Services Manager; NO= Nursing Officer; RO= Research Officer.

Table 24 outlines the positions occupied by the participants at the time of being interviewed. There is evidence from the interviews that the career paths of the majority of informants were planned and calculated, though the trajectories and the reasoning varied. Warwick, Brad, Andrew and Darren early in their careers chose either intensive care or emergency nursing. These men were attracted to critical care nursing as it offered a stable and world-wide labour market and a male dominated masculine environment, which requires the use of scientific knowledge and technology.
For Warwick, Brad, Andrew and Darren, critical care (ICU and emergency nursing) allowed them to use their masculine privilege (masculinity, male presence) to leverage more respect and, for some, increase their value in the labour market. Being associated with a masculine specialty, where they differentiate their work characteristics as technical and scientific, rather than the traditional feminine nursing characteristics, such as nurturing and caring, assists in the prevention of being labeled un-masculine and homosexual. The scientific knowledge gained by working in this area of nursing allowed them to challenge the power structures within nursing and with medicine. These men, with the use of critical care nursing knowledge, were willing to challenge doctors, usually junior medical officers, on clinical decisions based on clinical (scientific) evidence. This provides a political means of contesting power relations with medicine, as the dominant hegemonic form over nursing.

Warwick, Brad, Andrew and Darren have been upwardly mobile in the labour market resulting from their specialty choice. None of these men was in direct patient care positions. All have moved up the scale to management or clinical nurse consultant positions. One exception here is Simon – who is now semi retired. Simon worked in ICU for over 16 years, most of it part-time. Over that time Simon’s position in the nursing labour market remained constant. He was not ambitious and was not seeking promotion. He did enjoy, however, the privilege scientific (or critical care) knowledge afforded him.

Samuel, Ricky and Ralf deliberately chose the specialty of aged care nursing as it provide them with a fast track to a prestigious management position. In the aged care health sector registered nurses occupy senior management roles, a position of power over the residents in their care and semi skilled assistants in nursing who predominantly provided the care. Ricky after two years of working in aged care and less than five years nursing experience, after a relatively short period of time post registration, is a Deputy Director of Nursing of a large nursing home. Ricky deliberately moved into aged care nursing as a strategy to fast track his career. This was also the case for Samuel and Ralf.
Alex, Scot, Anthony and Greg all entered nursing through mental health training. At the completion of schooling all directly entered mental health as a result of the mental health institution in the country town they resided in. In these towns it was acceptable for men to do mental health nursing as the local mental health institution was a major source of employment. For Anthony and Alex, general nursing was not available in the early 1970’s, both had been refused entry into general nursing as a result of their sex. Warren entered mental health nursing after completing his Bachelor of Nursing; his best clinical experience was in mental health. Both Anthony and Scott have remained at the same level of nurse, clinical nurse specialist, for the past 20 years. Both engage in patient care. Greg and Warren on the other hand have moved to Clinical Nurse Consultant and Nurse Educator roles. Mental Health nursing has the longest tradition of men working as nurses and has the largest proportion of male nurses. Men are seen to have an advantage in mental health nursing due to the potentially violent and volatile nature of the work; making it an acceptable place for men to work.

Richard, Adam, Alex and Michael early in their careers specialized in midwifery and/or paediatric nursing, perceived ‘feminine’ specialties. Adam, Alex and Michael at the time of the interview worked in paediatric nursing, but both Michael and Alex had previously been midwives. Richard is currently a midwife but had previously been a paediatric nurse. Unlike the other participants these men did not benefit from their specialty choice. These men were a minority in a less masculine specialty. They were highly visible and open to criticism. The major obstacle for these men was combating the sexual deviant and paedophile stereotypes. Michael and Richard’s midwifery practises were different from female practice, highly visible. However, unlike the positive minority status that Williams (1995) describes for men in nursing, Richard and Adam failed to achieve a prestigious position. Alex left paediatrics to work in the more ‘masculine’ specialty of the emergency department where he was eventually recruited back to paediatric nursing to a senior position.

The specialty areas of practice and career paths deliberately chosen by Ralf and Derrick offered them safety from homophobia and homophobic practises. Derrick has
predominantly worked in sexual health and HIV and AIDS. Derrick’s work has been in renowned specialty HIV wards or units; therefore the majority of staff and patients were homosexual. Derrick’s initial interest in HIV and AIDS arose from his involvement in his local rural AIDS council, which he used as a ‘de facto gay scene’. At the time of commencing nursing, Derrick had little family, both parents had died. He previously lived in a major industrial city with his parents and after their death he moved to a rural town in the Northern Rivers, renowned for its alternative lifestyle. As a young homosexual male he felt safe living and working in this town, a similar safety that the specialty of HIV and AIDS offers. Derrick cannot remember any work-related incidents where his sexuality was an issue.

Ralf, despite initially wanting to work in ICU, has worked consistently in rehabilitation, palliative and aged care. He has deliberately positioned himself in specialty areas of practice where he feels safe from homophobic advances. The people under his care were more likely to be older, and were unlikely to be adolescents or young adults. As a result he feels less likely to be threatened. He currently holds an assistant director of nursing position in a large nursing home where he is in charge out of business hours.

Consistent with the findings of previous research on the gender division of labour in nursing (Heikes 1991, Williams 1992, Williams 1995, Evans 1997) many of the participants have structured their career choices to maximize prestige and power. In the case of Warwick, Brad, Andrew and Darren and to a lesser extent Samuel, Ricky and Alex, their specialty nursing choice was orchestrated to minimize the effect of being labeled un-masculine and consequently homosexual and to maximize remuneration, career progression and promotion opportunities. Derrick and Ralf on the other hand have chosen career directions that offered them safety from homophobia.

Three patterns of career progression were identified: upward progression (n=10), sideways movement (n=7) and stagnation (n=4). Participants who are upwardly mobile have progressively moved up the career path into positions that are not
directly involved in patient care, unless in an area of specialty expertise, and have a
degree of local power and authority. Brad and Derrick have recently moved into
health service management positions. Warwick, Michael, Ralf and Ricky hold nurse
management positions. Alex and Andrew are Clinical Nurse Consultants, and Warren
and Andre are nurse educators.

The career progression of seven participants has been sideways. In these cases the
participants may have held similar positions to those stated above but their
progression to more senior positions stalled or they have moved horizontally to
similar or equivalent positions. Both Paul and Greg are Clinical Nurse Consultants
(CNC). Paul was previously a nurse academic prior to moving to his current position,
which he has occupied for the past 5 years. Greg’s career has slowly progressed,
however he has had several horizontal moves. He has industry qualifications and
worked in Mental Health, Aged Care and General Nursing. He held a CNC position
in another health service prior to moving to his current position, which is equivalent.

Both Anthony and Scot are regional community mental health workers. Anthony had
previously been employed as a clinical instructor for a regional university prior to
moving to community mental health nursing. He has been a community mental
health worker at the same level for the past 10 years. He has transferred to a similar
position once in this time due to institutional restructure. Scot was previously a
nursing unit manager in a major mental health service. The closure of this institution
led to him being redeployed at a lower level. After moving to the country, he worked
as a RN in an aged care dementia unit prior to getting his current position in 1995.
Employment opportunities for both Anthony and Scott are limited due to living in a
regional area.

Darren has had several horizontal moves. He has been a CNC for three different jobs
and has recently moved to a research position at the same level. Richard has been
working as a midwife for the past 9 years. He attempted to be an independent
midwife working in private practice, however due to insurance difficulties he had to
move back to the public sector. Geoff’s career has taken many turns, most in
completely different directions. He has worked as a RN in the operating theatres of a women’s hospital, as a rural and remote nurse, a nurse in the Navy and now the Army. All of these changes have been horizontal. A turning point in his career was his current position where he advanced to the position of Captain, giving him some authority.

Four participants’ careers have remained stagnant or have stalled. All four men continue to work in clinical positions in health institutions on rotating rosters. Simon held the same CNS position in a major tertiary hospital for 18 years prior to semi retiring. He is now working part-time in a small private hospital. Adam has previously worked in nurse education and has a diploma in nurse education. Despite this he has worked for the past fifteen years as a CNS in the one institution. During this time he has unsuccessfully applied for promotional positions. He continues to work shift work on a rotating roster. Samuel had some success in career progression early in his career, reaching the position of deputy director of nursing in an aged care facility. However due to institutional restructures he left and moved into critical care in a tertiary hospital. Here he worked for 15 years, leaving this position due to a depressive illness. He now works on a casual basis. Ken works as a CNS in the orthopaedic subspecialty of the operating theatres in a small private hospital. He has worked in this position for the past 5 years. Prior to this he worked in the operating theatres in another private hospital. Ken dislikes nursing and the work he does. Ken has no formal qualifications in his specialty area of practice and he refuses to do further study; both are obstacles for career advancement.

An examination of the effect of education, family and social backgrounds on career progression reveals no obvious pattern in this sample. Two influences on career progression that were identified were the timing of marriage and parenthood, and location. Ken, Samuel and Warwick had children early in their careers. During this time they were focused on providing for their families, working extra shifts and doing agency work. They were inhibited in undertaking further study or activities that may have assisted in career progression. Horizontal progression occurred in their careers as a result of life style choices as in location of the family. Four of the
informants moved to rural locations for family reasons; they wanted an alternative way of life other than major city living, a move which provided financial security as a result of smaller mortgages. These participants believed that their children would benefit from this move, though they knew that their own opportunities for career advancement were limited. Those participants who have had successful career progression are either single without childcare responsibilities like Derrick, Ralf and Warwick, or started their families later in their career like Warren, Brad and Ricky, or have supporting wives who take on the major child care responsibilities like Alex, Andrew and Michael.

**Production Relations**

Consistent with the findings of previous research on the gender division of labour in nursing (Heikes 1991, Williams 1995), men were over represented in positions that were perceived to be masculine and scientific in orientation and these men tended to benefit from their minority status. However, several informants challenge the notion that all men in nursing benefit from their minority group status. Several of the men were willing to participate in an equal division of domestic work and child-care and were engaged in the more female dominated aspects of nursing work, such as emotional labour. Gender stereotypes and nursing structures (policy and gender relations) inhibit men in doing certain areas of nursing work and push men towards perceived masculine areas of nursing.

Eighteen of the participants worked full time, Simon and Ralf worked part time, and Samuel worked on a casual basis. All were registered nurses, yet Darren and Brad were not working in nursing positions. Geoff worked in the army as a nursing officer. Fourteen of the participants worked Monday to Friday office hours, 8am to 4pm. Simon, Richard, Samuel, Ken, Ralf and Adam worked shift work. As in the national statistics for men in nursing, this group is over represented in management, with 6 participants occupying management positions (AIHW 2003). Ricky was a deputy director of nursing and Ralph was an assistant director of nursing in the aged care sector. Derrick and Brad are health service managers and Warwick and Michael are nursing unit managers in public hospitals.
Consistent with the findings of previous research on the gender division of labour, the incomes of the married men were greater than their spouses'. Of the 16 married men, 11 were the major income earners for the household, though their spouses were in paid work. Nine of the spouses worked part-time, 6 of the spouses worked full-time and one worked on a casual basis. As previously stated, 13 of the participants were married to registered nurses. Michael’s wife was an occupational therapist who worked in her own private practice run from home. Andrew’s wife was a teacher and Warren’s wife was a child-care worker. Both Samuel and Adam’s income was less than their spouse’s. Ken, Andre and Richard earned the same as their spouse. It is worth noting that Samuel, Adam and Ken have no children with their current partners. Samuel and Ken do not provide financial support for their children from previous marriages.

As stated previously, Derrick and Simon are in long-term gay partnerships. Neither of their partners are nurses. Simon’s partner works in the hospitality and travel industry and earns considerably more than Simon. Simon lives comfortably in a house that he owns with his partner in the wealthier eastern suburbs of Sydney. They have no major debts, affording Simon the opportunity to be semi retired. Derrick’s partner is an accountant and they live in a house they have recently bought in the lower mountains. Both Geoff and Ralf are gay but are not in any current relationships. Geoff lives alone in a rented unit overlooking a Sydney beach. Ralf owns a house in Sydney’s Southern suburbs. Ralf does not rely on his nursing income as the primary source of income. Ralf was previously a solicitor and had sufficient savings and capital to afford him a comfortable lifestyle.

**Unpaid Routine Domestic Work**

The majority of participants were willing to take part in routine unpaid domestic work. Whilst a gender balance in the division of labour associated with routine domestic work was not achieved in the majority of cases, the married men in this study appeared to take a greater share of routine housework compared to married men in other Australian and overseas studies (Dempsey 1997; Dempsey 2000). Most of the married men in this group had negotiated set workloads or routine tasks for
which they were responsible, such as cooking, washing, vacuuming and bathing the kids. Despite this, a gender division in the amount and allocation of work existed, with the majority of men responsible for less than half of the routine domestic tasks and predominantly being responsible for 'non-routine' or 'sporadic' tasks like mowing the lawn and gardening. This is consistent with other studies done outside of nursing (Dempsey 1997).

Three informants lived alone and were responsible for all their domestic work. Simon and Derrick lived in gay relationships and in both cases they took on more than fifty percent of the routine domestic work.

Child Care

Sixteen of the participants have children. Derrick, Ralf, Geoff, Adam and Simon have never had children. Ralf has in the past been solely responsible for the care of his nephew when he came to live for 4 years. He now lives with and cares for an older man who has autism. Both Ken and Samuel have children from a previous marriage and have not been active in childcare. Nor have Ken or Samuel contributed financially to the care of their children. Neither Ken nor Samuel have seen or made contact with their children for a significant period of time: they are absent from their lives. Consistent with the findings of Nicholls and Pike (2002), major contributing factors to the father/child relationship in these cases were time and distance, which were a consequence of poor parental relations. Child access visits were restricted in time and frequency and were made difficult by the relocation of the child interstate in Ken's case and internationally in Samuel's case.

Over the past decade in Australia there has been an increase in men's participation in childcare. Despite this, there remains a disparity between men and women, where men spend less time than women performing childcare tasks, take less responsibility for childcare and are less likely to perform the more tedious routine childcare tasks, such as bathing and dressing (Dempsey 1997, Dempsey 2000). In contrast to these studies, the fourteen informants with children in this sample were very active in the care of their children and were willing to take responsibility for their care. When their
partners were at work, the participants were the primary care givers. The wives of the informants predominantly worked in opposite, out of hour shifts, allowing the participants to care for the children, preventing the need for paid childcare services. These participants believed they were as capable as any woman in caring for their children, taking on the responsibility for all the necessary tasks, such as feeding, toileting, bathing, cleaning, putting their children to bed, getting them ready for school and escorting their children to school and sporting activities. These men were proud that they could care for their children as well as their partners could.

Five informants altered their work practices to become more active in childcare. Warwick, despite being divorced, arranged his work so he could care for his children every weekend. Richard took 9 months paternity leave after the birth of his daughter and Michael took 12 months long service leave after the birth of his second child, both becoming the primary caregivers. Richard later worked permanent night duty so he could care for his daughter before and after school. Anthony gave up full-time work and went part-time so he could share in childcare. Darren changed jobs, to a less prestigious position, so he could work closer to home and could provide childcare rather than relying on others.

It is possible that nursing equips these men with confidence and childcare skills, empowering them to actively participate in childcare. Richard and Michael were midwives, formally having the qualifications, knowledge and skills, possibly more qualified and confident than their wives, to care for their newborn babies. Yet, despite these men sharing a greater load in childcare compared to other men and demonstrating a high level of competence in childcare activities, as a group the wives of the men in this study carried a higher load in childcare than the men did. This is consistent with the findings from previous research on shared care families (Dempsey 1997).
The Division of Labour in Nursing Work

In this sample there are clear patterns in the gender division of labour in nursing work. The gender division of labour in nursing work is based on a set of rationales that are not necessarily coherent: sex differences in the physical body (creating a gender division of labour in physical work); sexualized body tasks; the prevalence of emotional labour; and the element of domestic work in professional nursing practice. I will examine physical body differences and sexualized body tasks here. As with many analyses of this type, not all areas fit into discrete structures, an example of this in this study is the location of emotional labour and emotions of labour processes. For the purpose of thesis congruence, the discussion on emotional labour and emotions of doing domestic work are presented later under the analysis of cathexis.

Physical body difference

Eleven of the participants described doing more physical work, like lifting and other manual labour tasks, than their female colleagues. It appears that female staff commonly asked male nurses for assistance in tasks requiring strength like lifting patients in preference to asking female colleagues. Ken, for instance, was encouraged to work in the orthopaedic operating theatre as it was perceived to be heavy and more physical.

Another pattern of work based on physical difference is shown by Andre, an oncology and haematology nurse, who on occasions was required to give chemotherapy on behalf of his female colleagues. The point here is that women of childbearing age who want to fall pregnant are not allowed to give chemotherapy for a period of time prior to falling pregnant. It was perceived that Andre, being male, did not require the same consideration and therefore was free to give the chemotherapy. (Although the chance is remote, this placed Andre at a higher potential for complications associated with chemotherapy exposure.)

It appears that the sex division of labour associated with body differences was not associated with fitness or musculature. The participants who did not have a well-developed muscular body were equally required to participate in this division of
labour. This placed the participants in a position where their bodies were at risk of injury. Most of the participants claim to have suffered from wear and tear injuries, usually back and muscular injuries. The threat of injury and levels of physical work were a major concern for Simon, Ralf and Adam, all of whom are in the later stages of their working life.

**Sexualized body tasks**

In addition, all the participants described a sexual division of labour associated with sexualized nursing tasks, i.e. nursing activities associated with sensitive, sexual or private body parts. In many cases male nurses were not allocated female patients with gynecological or urinary problems. Women requiring urinary catheterization were allocated to female nurses. Both Alex and Andrew noted that all women patients who presented to the emergency department with injuries associated with domestic violence, and women with threatened miscarriage, were always allocated to female nurses.

The informants believed that there is no real reason why they could not care for these patients. However, patient preference and comfort with female nurses was used to justify this gender division of labour. The informants noted that this was not necessarily the case for male patients. The number of male nurses does not permit the allocation of male patients to male nurses. It appears that there is a disparity in sexual nursing tasks, where it is generally more acceptable, professionally and by the public, for female nurses to conduct personal tasks on the opposite sex than it is for male nurses.

In this sample of men there are several contradictions in the division of labour. In some ways these men challenge the contemporary gender divisions of labour. With the exception of Samuel, Ken, Simon, Ralf and Derrick, these men are actively engaged in the care of their children. They are willing to take on the responsibility of primary care giver and in some cases construct their work to allow them to engage in childcare. Nursing equips these men with skills that gives them confidence to care for their children; they view themselves as being equal to any female in the ability to
care for children. They are willing to contribute to housework, but like most other men, they do not undertake an equal share. Whilst they are willing to engage in domestic work in their private lives, and are proud of this, the domestic nature of nursing work challenges their male identity and their positioning in the gender order. Most of the informants have constructed their careers by choosing ‘masculine’ specialty areas of nursing practice, highly scientific and technological, where male bodies are an advantage. At the same time they distance themselves from the view of nursing as domestic work. The exceptions to this are Michael, Richard, and Adam and to a lesser degree Alex, who continue to work in perceived ‘feminine’ specialty areas of nursing practice. Michael, Richard and to a lesser degree Alex are also the most active in child care and engage in an equal division of housework.

**Power Relations and Authority**

In the experience of the respondents in this study, men’s power and authority in nursing was limited and where it existed had a “fringe” character. Despite the fact that many of the participants in this study lacked power and authority, a few men had significant power over female nurses. Male-dominated power relations in nursing are generally local in nature, that is, they only hold dominance over nurses (usually female) who are directly subordinate to them. When it comes to the ability to make health service strategic or policy decisions, and influence other health professionals and patient medical care, male nurses like females are generally subordinate to other disciplines; especially to the male-dominated medical profession.

*Intra-nursing gender power relations*

As previously identified, Derrick, Brad, Ralf, Ricky, Warwick, and Michael are managers who hold local authority. Warwick and Michael are nursing unit managers who are responsible for the daily running of functional nursing units. A number of their responsibilities include the quality of nursing care, staffing levels, occupational health and safety issues, the purchase and maintenance of equipment and budgeting, within their nursing units. Their positional power allows them to make decisions that affect those under their authority. However this only extends to other nurses, who are predominantly women. They have little or no ability to influence broader health
service decisions. Warwick and Michael are accountable and report to senior nurse managers, who in both cases are female.

Warwick and Michael are aware that they occupy a position of unequal gender power, where Michael's entire staff, and most of Warwick's staff, are women. They are aware that accusations of gender discrimination might be made against them and they actively attempt to prevent it. Both men socially isolate themselves from their staff so they are not accused of using their position of power for heterosexual gain. They limit the number and type of social functions they attend, avoid having lunch with their staff and avoid humorous and playful situations at work. Both men claim to be cautious when asserting their authority, especially in the use of their physical body, use of language and the volume and tone of their voice. Neither Warwick nor Michael has had claims of gender discrimination made against them.

In contrast, Derrick is a manager of a health service and has significant power. Derrick is responsible for the provision of a service across an area health service and has authority over a variety of health care workers, including three senior medical officers. He has the power to make policy decisions and provide service direction. Derrick reports directly to the chief executive officer of the Area Health Service, currently a male. Derrick's position is unique; his position is usually reserved for medical officers. Unlike Warwick and Michael, Derrick doesn't see the need to socially isolate himself from his staff, as he has a diverse staff mix, with a more equal male to female ratio.

Brad is also a health service manager but does not have authority over staff. Brad is a project manager in a major tertiary hospital and is responsible for auditing surgical services for quality assurance purposes. He has the ability to make recommendations for health service policy and practice, but does not have the authority to implement change. Brad has the responsibility of reviewing the work of other health disciplines. He does not have the power to alter their practice directly, but can influence practice indirectly through hospital processes (committees and review panels).
Ricky and Ralf are nurse managers in aged care facilities. Ricky is a Deputy Director of Nursing and Ralf is an out-of-hours facilities manager. Both are responsible for the provision of nursing care in an aged care residential facility and staffing issues. Ricky has the added responsibility in local nursing policy development. Unlike Warwick and Michael, Ricky and Ralf have significant local power and do not have the same sense of caution in their authority. This may partially be the result of being responsible for a labour force that is unskilled or has basic training and skills. They have more autonomy in management and do not have the same power relations with other health disciplines.

Relations with female supervisors

All informants with the exception of Brad and Derrick are supervised and accountable to female managers. Most have good relations with their current supervisors. But all participants have had difficulties with previous managers requiring some form of ‘political’ action. Many participants have had to combat collective power arrangements developed through female social networks.

Simon, Andre, Darren, Samuel, Scot, Ricky, and Paul have all experienced what they perceive to have been negative sex discrimination after applying for promotion. Simon describes the time he applied for a Nursing Unit Manager position in the hospital where he currently worked; at the time he was acting in the position. After being notified he had an interview, and prior to the interview date, he had learnt that a female nurse had been appointed to the position. When he challenged the female Director of Nursing she informed him that he would not get the position. Andre also applied for a senior position, though in a different institution to the one where he was working. He had an interview that, on his account, went well. He was not successful in getting the position; he was told that his reference from his current manager was unsatisfactory. On confronting his manager she admitted to ‘sabotaging’ his application. Paul told a very similar story.

Many of the men describe informal female social networks, which were used by women in nursing to maintain authority and power. Paul describes a female social
network where senior nurses select members of the network for promotion. He claims that the network not only disadvantages men, but also seems to disproportionately promote lesbian women. Alex and Anthony provide hostile accounts of such networks. When Anthony was undertaking his general training (converting his mental health registration) he had an incident on his second placement. He challenged the Nursing Unit Manager (a female) and was sent to the Director of Nursing. He was found to be correct in this case. However, six months later Anthony was asked to leave his position. The NUM from his first placement had written a very poor evaluation of his work despite providing him with positive feedback at the time. Anthony states that the report was dated after the incident on the second rotation. Anthony also noted that the two NUMs were related and he believes conspired to get rid of him. Alex had a similar situation where a night supervisor, someone he had seen once in eight weeks, had written a poor clinical report on him. He believed that a network of managers deliberately orchestrated the report. Whilst these at times hostile accounts are depicted by the informants as being factual, there is no evidence that can verify these accounts. This is a limitation of the interview method.

**Combating power differences**

The informants in this study described two forms of action in gender politics that were open to them. Firstly, as individual gendered practice, the informants describe a process of confrontation, directly questioning authority and asking for a justification and, if needed, justice. When a resolution was not forthcoming to their satisfaction, the men resigned. Darren provides an example of this when he resigned after he inquired about the position in which he had been acting for 2 years and wanted to be made permanent. The informants believed female nurses who were equally marginalized were not willing to take such action.

Secondly, as collective action, these men were highly involved with the nurses’ union. Both Alex and Anthony at different times in their career were active executives of their local branch of the NSW Nurses’ Association. Samuel, Adam, Ken, and Simon had called on the Nurses’ Association to represent them against
perceived injustices by female nursing managers. In these cases union representation was used to counter perceived personal threats made by nursing management and to provide collective support and action if needed. In the cases of Anthony, Samuel and Adam the union was successful in procuring their entitlements. These men decided to leave their jobs due to damaged relations with the institution despite the acknowledgement of injustice. In the other cases the union was successful in mediating a solution to the disputes.

Support for the nurses’ union varies amongst the informants. Richard and Brad blame the union for the poor working conditions and pay for nurses. They believe nurses are generally weak at collective action and the union is politically mute. Other informants do not share these views about the union, while agreeing that nursing conditions and wages are insufficient and are comparatively lower than the other health professions.

Medicine-nursing power relations
According to all the informants a hierarchy of power and authority exists across the healthcare disciplines. Despite having reasonably cordial relations with doctors there is a power differential between medicine and nursing. All believe that nursing is the lowest of the disciplines, that nursing lacks autonomy in practice, power and authority. Medicine was identified as the most powerful discipline, occupying the position that decides policy and health service direction. Nursing and therefore individual nurses are directly affected by such decisions, but are rarely in a position to make them. At the individual level these men are frustrated at the inability to practice autonomously and at the lack of recognition and respect from other disciplines such as medicine. Legislative restrictions on nursing practice (eg prescribing medications and diagnostic tests) contribute to the perceived power difference.

Scot provides us with a typical example. Scot is a rural community mental health worker with over thirty years experience in acute mental health nursing. His supervisor is a nurse manager located in a different service, but he is also accountable
to the director of the mental health service, a psychiatrist. Scot’s role requires him to liaise with local psychiatrists, general medical practitioners and acute hospital facilities. He provides crisis assessment and intervention and follow-up care for individuals with mental health problems. In one example: he interviewed a patient known to him and was concerned about a change in the patient’s condition and concluded that the patient required an immediate change in drug management. When he contacted the general practitioner to inform him of this assessment he was ignored and reminded that he was ‘only a nurse’. The general practitioner was not prepared to take his professional assessment at face value. Out of concern for the patient Scot contacted the patient’s psychiatrist who in turn contacted the general practitioner to inform him of the required changes that needed to be made to the patient’s drug therapy. It is clear that medical-nursing power relations vary at the individual level. In this case the psychiatrist took Scot’s assessment at face value and supported his recommendations, based on his nursing status. However this was not the case with the general practitioner. Similar stories were heard from Richard and Michael about midwifery and obstetric practices, Andrew about the emergency department, Derrick about HIV and AIDS, and Warwick, Darren and Brad about intensive care.

The relation between nurses and junior medical officers is particularly fraught. There are numerous stories from the participants where junior medical officers ignored the nurses’ professional advice despite their level of specialty expertise. There were many examples where junior medical officers attempted to assert their authority over the informant and put them in a domestic servant role, e.g. getting them to clean up after procedures. This was not tolerated by any of the participants.

Strategies of politics

In order to engage in clinical decision-making and deal with the power differences between medicine and nursing, the informants engaged in inter-professional and gender politics, using strategies such as intellectual reasoning and negotiation, appealing to the boss to create embarrassment, collective practice or solidarity, and retribution.
Both Andrew and Scot describe a process of negotiation where through interaction with the medical officer they question the reasoning behind the decision the doctor has made. By examining the rationale behind the clinical decision and offering an alternative action, the nurse empowers the doctor to make the correct decision, in the eyes of the nurse. Andrew calls this process 'playing the game'. The trick, as Scot puts it, is to make it palatable for the medical officer to swallow, by attributing the alternative suggestion to the research literature or to an expert. Andrew claims the interaction needs to be couched in a way that the doctor claims ownership of the final decision. In most instances these men will not directly challenge medical officers unless the patient is in potential danger.

Alternatively, when the informants were dealing with junior medical officers (intern, resident or junior registrar) or in Scot's case above, a general practitioner, they stated they would go over the head of the junior doctor and directly contact the consultant medical officer. The purpose of this action was to embarrass the junior medical officer, to 'knock them off their pedestal'. This form of action, however, had risk for the nurse and was dependent on the relationship between the consultant and the nurse. The nurse could easily lose face if the case was not substantiated.

Anthony, Scot and Warren describe mental health care as requiring a collaborative team approach. These men describe having a very close professional relationship with the psychiatrists where there is mutual respect and appreciation. However, when a medical officer failed to respect the clinical competence of the nurse, the nurse might employ a strategy of retribution to demonstrate their worthiness. Scot described a situation where a registrar, after a request from an experienced nurse, refused to write an order to chemically restrain a potentially violent patient. This, in the informant's eyes, placed the nurses in unnecessary danger and showed complete disrespect for them clinically. The nurses in a form of collective practice set the registrar up by allowing him to continue in what they believe was naïve practice, allowing him to place himself in a potentially dangerous situation with a patient. They would only engage with the medical officer when he required 'rescuing'. If retribution as a form of politics is to work, it requires solidarity amongst all the nurses. According to the informants, retribution as a form of gender politics is used
as a last resort.

**Cathexis and Relations of Emotion**

Consistent with the patterns of power and authority relations, which are generally subordinate or limited and locally displaced, relations of cathexis and emotion are also for the majority limited. The majority of informants describe themselves as being socially isolated. They heavily rely on friendships and emotional ties with other nurses, usually female. Despite these similarities, there are clear patterns of emotions and desires across the sample of informants. The patterns will be presented under the following themes: Social and sexual relations; Emotions towards nursing and nursing labour processes; and Emotional labour.

**Social and Sexual Relations**

Two distinct patterns of emotional and sexual relations emerged from the case studies. Several men described a pattern of emotional ties to women where they prefer and develop strong friendships with females. However, several obstacles inhibit or make it difficult to develop such friendships. The second defining pattern of cathexis is where several men hold more traditional masculine interests and prefer friendships with other men. These men were more likely to treat females, in the past at least, as sexual objects.

Richard, Warwick, Brad, Derrick, Alex, Scot, Simon, Samuel and Andrew had very strong social relations with female nurses. Fourteen of the sixteen married informants are married to nurses. Despite having strong emotional ties with female nurses and having a preference for female friends, Andre, Warwick, Michael and Adam have difficulties in developing friendships with female nurses. The difficulty lies with the inability to socialize outside of the work environment. Andre, Warwick, Michael and Adam are married and find it difficult to socialize with other women. This is not due to a lack of desire but is related to the social consequences of infidelity and workplace gossip. These men refer to social norms that assist female-to-female friendships and inhibit male-female friendships. In addition, Michael and Warwick are Nursing Unit Managers with some authority over female staff, making it more
difficult for them to develop friendships. Michael provides a dramatic illustration. It is a tradition for his staff (all female) to go away on an informal social weekend. During this time they go out for dinner and afterwards would go to someone's room to continue. Michael expresses discomfort about entering a female's hotel room, especially when they have changed into their night wear and continue to drink. As a result, Michael now declines to go on these trips, which further socially isolates him.

In addition to having strong friendships with women, usually female nurses, Derrick and Simon relied on gay networks for the development of friendships and sexual relations. Derrick in his late teens relied heavily on the local AIDS council, a mainly gay scene, for the development of his friendships. Simon utilized a narrow network of friends to which he was introduced by an old partner. In both cases these men are in long-term relationships, but are not committed to monogamy. It appears that both men have separated their emotional ties from their sexual relations, where sex is for pleasure but not linked to an emotional commitment. Simon claims that this is part of the gay culture and is an understanding amongst the players.

Brad, Alex, Warwick, Michael, Adam, Greg, Scot and Simon expressed difficulty in socializing and developing friendships with men outside nursing. These informants described a lack of interest from other men in nursing, and they found it difficult to reach common areas of interest. The label of being a male nurse cuts off discourse, possibly as a result of the associated homosexual tag. As a result communication breaks down and momentum stops. These men network with women and prefer social relations with women. Being a nurse socially isolates these men from other men. This is partly due to other men's lack of interest in the work of nursing, partly as a result of the small numbers of men in nursing, which means they are unlikely to be working with other men. These men rely on nursing and female nurses for access to social networks.

Samuel, Ken, Darren, Andre, Brad, Anthony and Andrew have more traditional masculine interests and have very strong male friendships external to nursing and related health services. These men still express a desire for more male friendships.
Despite being married to female nurses, their female nurse network is not as strong as the first group’s and they do not heavily rely on their female networks for social relations. It is interesting to note that Ken, Samuel and Darren have had very poor relations with female nurses and nurse managers. Ken and Samuel view friendships as expendable. They don’t have many friends and they make new ones as their lives go on (usually from work) but they make no attempt to keep the friends from the past.

Many of the informants have had multiple sexual relationships. Andre, Darren, Brad, Alex, Andrew, Ken, Anthony and Samuel had slept around, playing the field as they put it; however most have been monogamous since being in relationships. Exceptions to this were Anthony and Warwick who did have sexual affairs whilst married, where extramarital sexual affairs led to their marriages breaking down. Both men divorced. Unlike Samuel and Ken, Anthony and Warwick remain cordial to their ex-wives, whereas Samuel and Ken’s relationships with their wives have fully broken down and are hostile. I sense that Ken and Samuel view marriage as an expendable commodity; once it dries up and becomes too difficult, it is easier to leave than work on it. In their earlier years Andre, Darren, Brad, Alex, Andrew, Ken, Anthony and Samuel viewed women as sexual conquests, commodities that were traded in for new brands. Andre, Darren, Alex, Ken, Anthony and Samuel were not willing to commit to long-term relations but were after sexual ones that remained on the surface. These men were not committed to one partner, often having multiple sexual relations with different women at the same time. In these cases women were used as objects for male sexual pleasure.

*Emotions towards nursing work and labour processes*

The strongest emotions expressed by the participants during the interviews were those of frustration and disappointment. Brad, Darren, and Derrick are frustrated at the inhibitions nursing creates to career advancement and power relations. Many of the participants were angry at the continued devaluing of men who are nurses. Many of the men, particularly Ken, Samuel and Adam, say they were hurt most by female nurses. Ken, Samuel, Adam, Darren, Simon, Ricky, Paul, Andre and Anthony all
consider they have been victims of sexual discrimination, either through false claims being lodged against them or through obstacles to promotion. Most of the men have claimed to be given a hard time by female nurses, especially earlier in their careers, where they have had to out-perform their female counterparts in order to be accepted as a legitimate nurse. The feelings of frustration, disappointment and hurt created by the profession and the public images of nursing expressed by these men, the phenomenon I have titled *Professional Injury*, will be fully examined in Chapter 9.

As previously identified several of the participants deliberately chose career paths that were perceived to be 'masculine' and socially more acceptable for men, which separated them from the domestic nature of traditional nursing work. For many of the men, the domestic element in nursing work was demeaning. Andre, Richard, Brad, Derrick, Michael and Geoff all stated that nursing work was viewed by others as being lower order, contributing to the nursing stereotype of 'handmaiden' and power inequalities between nursing and the other health professions. Whilst all the informants believed that caring and domestic duties were essential to nursing labour processes, they believed these duties did not solely define nursing. However, the inability for nursing to define itself in any other way, coupled with the lack of public discourse to express what nurses do, contributes to these gendered stereotypes.

Brad’s specialty choice, critical care, stemmed from his embarrassment at doing domesticated nurse work. He viewed critical care as technical/scientific, where ward work was viewed as “handmaiden”. Brad has a view that the domestic nature of nurse work is tied to the subdued female role. Brad considers this results in nursing being low on the health profession hierarchy, and he is ashamed of doing it.

Similarly, Andrew highlights a difference between male and female nurse care priorities. Andrew believes that males focus on the patient and their physiological needs, where as females have a tendency to focus on the environment and domestic work. This causes conflict where male nurses are perceived to be slack and non-caring. Many of the informants stated that they have at some period in their career been under critical management gaze (in all cases female) due to perceived poor performance of domestic duties. There was a sense that men nurses had to prove
themselves as nurses when they first started as RNs. This came from both nurses and from outside the profession. According to Brad, the "older nurses" would pick on his practice due to his lack of attention to domestic work, for example, not emptying the catheter bag or sputum suction bags every 4 hours. To counter this Brad uses technical/scientific knowledge and clinical skills, to gain respect from other disciplines. The demonstration of this knowledge gained him entry as a member of the medical team.

*Emotional labour*

The men in this study identified a division of labour associated with emotional work – the management of emotions for the good of others. Unlike work in many male dominant occupations, nursing work requires emotional labour (James 1992, Smith 1992, Phillips 1996, Staden 1998, Bolton 2000) - "the induction or suppression of feeling in order to sustain the outward countenance that produces the proper state of mind in others, the sense of being cared for in a convivial and safe place" (Hochschild 1983: 7). In nursing the nurse’s control of emotions (emotional labour) is exchanged as a product in the provision of care to patients. A ‘good’ nurse is able to display (through surface and deep acting) appropriate emotions for a given episode of patient care. There is an expectation and willingness that male nurses would provide care in the same vein as female nurses. In addition, men in nursing are expected to manage aggressive and violent patients - more consistent with the role of debt collectors in Hochschild’s (1983) classic study.

Like the airline attendants in Hochschild’s (1983) study, nurses’ work involves the management of their emotions in order to provide ‘care’ of others (James 1992, Smith 1992, Phillips 1996, Bolton 2000). There have been many attempts at defining caring in a professional nursing context and differentiating it from private care in a domestic setting. The provision of care in a nursing context is a complex issue “encompassing a range of human experiences in feeling concerned for, and taking charge of the well-being of others” (Graham 1983 13). James (1992) defines care as the interplay of the component parts of organization (planning and organizing skills), physical labour and emotional labour (Care = Organization + Physical labour +
Emotional labour). The provision of physical care to patients occurs simultaneously with organization and emotional labour. The informants in this study noted that even simple nursing activities, such as giving injections or attending to pressure area care, can cause pain or hurt in patients and requires some management of their own feelings. Similarly some nursing activities invoke feelings of disgust or embarrassment, for example foul smelling wounds requiring dressings, or dealing with intimate body tasks e.g. washing people’s bodies or providing hygiene to menstruating women or dealing with body products such as vomit, shit or pus. These physical care activities require the nurse to manage their emotions in order to maintain the patient’s well being (Lawler 1991).

Emotional labour, as previously discussed, is intrinsic in the provision of every day nursing care. It is most prominent in areas of nursing practice where caring for the dying and mentally ill occur (Smith 1992). All the informants, with the exception of Ken and Geoff, currently work in positions and areas of nursing (cancer nursing, aged care, palliative care, HIV and Aids, mental health, midwifery and paediatrics) where emotional labour is essential in the provision of patient care. Ken deliberately chose a nursing specialty (operating theatre) with the least patient contact, where he doesn’t have to engage with the conscious person and therefore do emotional labour. Geoff is an army nurse, a captain in the Australian Army, and is in a predominantly managerial role where minimal emotional labour is required. However, unlike Ken, Geoff has formerly worked in areas requiring extreme levels of emotional labour, for example, in an abortion clinic and in remote indigenous settings.

Even as nurse managers, Warwick, Derrick, and Michael engage in emotion work, but not necessarily in emotional labour. In emotional labour it is the emotional activities of nurses that become the profitable product. Nurse managers do not provide care to patients, therefore do not exchange emotions as a product. Despite this these men continue to engage in the management of their emotions for the good of others.
Michael is a nursing unit manager of a paediatric ward and he struggles with the implementation of organizational change and the impact it has on his staff. Michael is aware of the negative impact this change has on his colleagues and the resistance he will face from them. Despite his own opposition to the change, he manages his emotions (anger and distrust of the organization) in order to ‘put on a brave face’ and present the change to his staff in a positive manner (as put to him by the organization). He is willing to ‘cop the abuse’ from his staff and get on with it. As mentioned earlier, Warwick is conscious of being the manager of predominantly female workforce, and he is concerned that being male, if he raises his voice or speaks in certain tones, it will be interpreted as harassment. Warwick continually monitors his emotions, especially when he is angry or disappointed, and alters his persona so as not to cause negative emotions in his staff. Despite the desire to interact with their staff on a personal level, i.e. engaging in humour or pranks, both Warwick and Michael refuse to, as it could be interpreted as behaving in a sexist manner. In these cases their personal desires are often suppressed, they manage their feelings and act in an alternative manner for the good of others and their own professional safety.

The biggest division of labour in emotional work in nursing claimed by the informants is in the management of aggression and violence. The participants stated that they were often allocated the patients who were potentially violent. Several of the participants believed that it was their duty to step in when a patient was becoming aggressive. These men state that in order to deal with aggression and violence, they have to suppress feelings of fear, apprehension, and excitement and act in a calm but decisive aggressive manner themselves. Darren describes putting on a front to show the aggressor that they too mean business. Both Darren and Samuel believe women are more likely to be abused by aggressive people and males are more of a deterrent, preventing an escalation of violence. Darren is willing to use violence in order to defend himself. He describes using a zero tolerance policy that includes using physical force against aggressive and violent patients. However, most participants did not approve of the allocation of aggressive patients along gender lines.
Symbolism

After examining all the case studies there appear to be two distinct patterns of relations of gender symbolism. Ken, Andre, Ralf, Darren, Brad, Anthony and Samuel hold contemporary patriarchal representations of gender, that is, they view women (particularly female nurses) as conforming to traditional feminine roles and attributes, legitimizing the “demeaning” domestic nursing work as being “women’s work”. I will call these men the “traditional” group in terms of gender symbolism. Contrary to this, Richard, Warwick, Michael, Scott and Alex embody alternative possibilities for men. I will call these men the “progressive” group in terms of symbolism.

The traditional group symbolize gender as conforming to traditional gender roles and attributes, where the object of the project is to maintain masculine domination and place women in a subordinate position. This is in part constructed through language. The language used by informants to describe men includes “mechanically minded”, “straight-shooters”, “say as it is”, “call a spade a spade”, “confronting”, “protector”, “father figure”, “advocate” and “manager”. In contrast the language used by these informants to describe females is less assertive and less socially desirable and includes words like “weak”, “compromising”, “ongoing conflict”, “flock around”, “create smoke screens”, “passive”, “domesticated”, “too emotional” and “sexist”. These informants identify differences in sex roles, and act to reinforce them. Anthony for instance justifies the position of men in mental health nursing and men’s role in dealing with aggressive patients:

...girls play with dolls and knitting, whereas men grow-up wrestling and playing rough, making them more suited to physically restraining patients.

These men believe nursing renders them powerless, with a very limited ability to influence and make health care and policy decisions. Despite a general respect for nursing from the wider community, the informants believe the public representations of nursing and the lack of a discourse that adequately defines nursing and nursing work, renders nursing subordinate to other professions. The stereotypes these men identified include that of “handmaiden”, a servant for the doctor, who takes orders and direction; and secondly, as a sexual deviant, “pervert” or “poofter”.
These informants see a man as ideally the 'breadwinner'. However, due to perceived low pay and hard working conditions for nursing, this role is not fulfilled. As a consequence the nursing union is viewed as being 'piss weak'. As nursing and union membership is predominantly female, the informants blame females for the current working conditions, where they view women as being 'weak', 'compromising', 'bend under pressure' and where 'female nurses are not prepared to toe the hard line'.

The traditional group view the domestic side of nursing as women's work. These informants think there is a gender difference in care work: they see women as focusing on their feminine roles, the environment and domestic duties, and males as focusing on the physiological needs of the patient. Brad attributes femininity to all nurses, regardless of sex, and believes that men who do not attempt to leave clinical nursing or adopt a more masculine job are 'weak and lack courage'. Brad changed his work to a more masculine role. He is a person who feels damaged by his chosen profession, using language such as 'pity', 'shackled' and a 'bloody nurse'. These men clearly view femininity as a weakness, something that men should avoid. Their association of nursing with femininity subordinates them unless they reconstruct their position by rejecting nursing work.

With the exception of Ralf, these informants represent themselves as being only heterosexual. Darren, Ken and Samuel all reinforce the hegemonic project of compulsory heterosexuality through action and language. They uphold the heterosexual protest, vigorously defending their sexuality with homophobic language like 'poofter' and 'faggit'. If needed they might make a violent protest against any accusation - Darren had pinned a gay male colleague against the wall and threatened to 'bash his brains out' if he touched him again. This occurred after the gay man poked Darren in the bottom with a pencil.

The progressive group, by contrast, offer alternatives to the dominant forms of gender representations. These men identify multiple possibilities for men. They believe that people create their own gender arrangements, through choice, and believe in gender equity. As a result these informants portray other men as being very
narrow and 'closed off'. These men do not portray women or femininity in complete opposition to masculinity, but include traditional representations of femininity within an alternative masculinity.

A good example of this is Michael, a paediatric nurse. Michael has a clear view that people create their gender arrangements, where women and men could both choose to stay home and raise children. Michael hates the stereotypical images in advertising portraying men as inadequate in traditional female activities such as childcare and home domestic work. He states:

*I like to demonstrate that I don’t fit into their expectations or their little boundaries for what men are able to do. I like to break those boundaries and do different things.*

Michael likes to challenge the traditional images of men and masculinity. For instance he takes home-cooked (cooked by himself) morning tea to work for his staff. He has a strong desire for gender equity, which includes men’s rights. This is exemplified by his annoyance during his kid’s upbringing where in public toilets there were mothers’ rooms from which he was excluded and he was forced to change his son’s nappies out in the plaza. Gender neutrality is his goal, for example, attempting to change mothers’ groups to parenting groups.

The progressive group view most men as being emotionally distant, closed and fixed. As a result they see other men as being distant and unable to relate and be close to their children. However this is not the case for them.

*It’s that aspect of caring I suppose, people don’t see that males can care as much as females cause basically men are never meant to be that sensitive. I tend to disagree because I think I have a different idea of what a man is than other men. I just look at my brothers-in-law who are all tradesmen and their idea of what a man would be is different to mine. They even find it difficult being very close to their children because of the way they have to open themselves up a bit. I don’t have that difficulty because of the choice I made earlier on in my life to do nursing and to be able to deal with people you had to give a*
bit of, a lot of yourself, otherwise you weren't successful. It's that I think people see as a weakness. I see it as a strength because it's something you can do that they can't. (Alex)

They see a difference in the way women and other men communicate, where women communicate and network at a personal emotional level and conventional men are more superficial:

The [male] conversation's not flowing; it's always based around football and sport. It's never personal sort of stuff and women network really, really well together and talk really, really well. Men don't do that kind of stuff, relate their feelings about things and even just how they feel about their children and caring for their children, there's no language for [other] men. (Michael)

The analysis of symbolism provides one of the strongest patterns of differentiation amongst the case studies. Whilst there appear to be two definitive patterns of gender symbolism in this sample, traditional and progressive, the boundaries of these patterns are not fixed. For example, Richard, Alex, Scot and Warwick held a similar view of the 'breadwinner' role for men. However, they accepted that this was not possible and were willing to share equally the role and responsibility with their spouses. Unlike the others, they did not shift the blame for poor pay conditions onto women. Similarly, Darren and Brad liked to challenge some traditional notions of masculinity especially in childcare, but held strong views about sex roles. A contradiction identified is that of Ralf who held very strong views of sex role conformity but is gay and therefore does not take part in the heterosexual protest that Darren, Samuel and Ken so vigorously display. Several informants, Derrick, Geoff and Simon, were intermediate between these groups in their representations of gender. They neither portrayed a strong belief in traditional representations of gender nor did they contest these views.
Conclusion: Three Patterns of Masculinity

The foregoing analyses of the gender substructures allow us now to differentiate specific patterns of masculinity in these life histories. Three patterns of masculinity were identified in this sample of men. I will call them broken men, complicit men and soft men.

These forms of masculinity are not watertight categories where an informant always fits neatly into one form. They are more fluid; participants at different locations and in different historical moments may have performed social practices drawn from different masculinities. Nevertheless they are clearly identifiable in current patterns of practice. They are summed up in Table 25.

Table 25: Patterns of Masculinity

<table>
<thead>
<tr>
<th>Gender Structures</th>
<th>Patterns of Masculinity</th>
<th>Broken Men</th>
<th>Complicit Men</th>
<th>Soft Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production Relations</td>
<td></td>
<td>Traditional gender division in domestic work.</td>
<td>Active participation in domestic work. Not an equal division of labour.</td>
<td>Moving towards equal gender division of domestic labour.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoids participation in childcare</td>
<td>Unequal participation in child care.</td>
<td>Equal participation in childcare.</td>
</tr>
<tr>
<td>Power Relations</td>
<td></td>
<td>Holds no professional power.</td>
<td>Actively constructs career to gain power.</td>
<td>Does not actively seek power or authority.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Holds local professional power and authority, and seeks external power.</td>
<td>Cautious in asserting authority.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor relations with female authority.</td>
<td>Confronts power inequalities and perceived abuses of power.</td>
<td>Confronts power inequalities and perceived abuses of power.</td>
</tr>
<tr>
<td>Cathexis and Relations of Emotion</td>
<td></td>
<td>Emotional ties to men; hurt by women</td>
<td>Mixed emotional relations</td>
<td>Emotional ties to women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expendable friendships and sexual relations</td>
<td>Multiple sexual relations</td>
<td>Monogamous</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Embarrassed by domestic nursing work</td>
<td>Embarrassed by domestic nursing work</td>
<td>Accepts domestic nursing work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoids emotional labour</td>
<td>Engages in emotional labour</td>
<td>Engages in emotional labour</td>
</tr>
<tr>
<td>Symbolism</td>
<td></td>
<td>Traditional</td>
<td>Traditional</td>
<td>Progressive</td>
</tr>
</tbody>
</table>
The social practises that inform the masculinities of broken men and complicit men are broadly similar, but differ in patterns of power and cathexis relations with women. Hegemony is the project for these men, but hegemonic power, production and symbolic relations are not maintained. Ken, Samuel, Anthony and Adam embody a “broken” masculinity. Their careers have failed and they perceive women to have failed them. Ken, Samuel and Anthony married young, had a family at an early age and divorced not long after. They are hostile to their former partners and take no responsibility for the care of the children from these relationships. Ken, Samuel and Anthony did traditional male labour (boiler maker, civil engineering and metal foundry labourer) prior to entering nursing. Adam did three years of a Bachelor of Arts degree before entering nursing. Ken, Samuel and Anthony avoid the perceived feminine nursing work. Ken chose a nursing specialty that doesn’t require emotional labour or domestic work. Samuel chose a specialty where he could quickly be promoted, had a position of authority and did not have to do domestic work. Unlike the others Adam chose a highly feminine specialty in the form of paediatric nursing, he felt this was a safe option. These men have had several run-ins with female nurse managers, which have required union intervention. They have had difficulty in accepting female authority and conforming to the practises of a female workplace. Their careers have stalled. Ken has attempted to get out of nursing by applying to the army but has been unsuccessful. Both Ken, Anthony and Adam briefly left nursing, Ken worked for a surgical supply company, Anthony left to become a forestry worker and contract fencer, and Adam as a cartoonist. Ken is in a position he hates; but he cannot leave his current position without losing his clinical nurse specialist status. Samuel feels let down by his female managers; he felt exploited and placed in a dangerous position. Anthony and Adam felt victimised by their female managers. In the main these men have had positive friendships with females but were also deeply hurt by them. They prefer the company of men and prefer male friendships. Ken, Samuel and Anthony have traditional male tastes such as motorbikes, cars and sport. Adam prefers classical music and fine arts. Ken, Samuel and Anthony have in the past exploited women sexually, through infidelity. These men hate nursing or are severely injured by it; they are “broken men”.
Derrick, Darren, Brad, Andrew, Andre, Ricky, Paul and Ralf embody a “complicit” masculinity where the project is to maximise their benefits through promotion and improved working conditions. These men have constructed their careers in ways that lead to promotion and better working conditions. They have chosen nursing specialties that emphasise scientific knowledge and technology (HIV/AIDS nursing, critical care, oncology), promote them to positions of authority (aged care) and remove them from the perceived feminine and domestic aspects of nursing work. These men are hurt by the social limits that the title of “nurse” places on them. They are embarrassed by doing the domestic aspects of nursing work and see it as demeaning. Derrick, Brad, Ricky and Ralf are managers who do not engage in nursing work. Darren is in a non-clinical research officer position. Only Derrick holds significant power, the ability to influence health service policy, direction and delivery.

Unlike the broken men, Derrick, Darren, Brad, Andrew, Andre, Ricky, Paul and Ralf, in the main, have positive relations with female managers. They do not have ongoing disputes or require intervention from the union. These men view nursing as being subordinate, the lowest in the hierarchy of the health care disciplines, and this is the impetus for them to be promoted to non-nursing positions. It is their experience that nursing and therefore nurses are treated as medicine’s handmaiden.

The married men in this group engage in unpaid domestic work, but it is not an equal division. They concentrate on outside work such as mowing the lawn and gardening and they participate in some specific delegated (by their partner) housework jobs. They also participate in childcare where they take responsibility for the children when the wife is at work but they do not engage in an equal share. When the wife is at home she resumes the responsibility for these duties.

Like the men in the broken masculinity group these men strive for male friendships, yet they feel isolated. The numbers of men in nursing and shift work limit their ability to make male friends. They maintain masculine interests but find it difficult to engage with other males. They find being a nurse prevents them from developing
relations with men because the other men have no common point to generate discourse. In their view, the label of "nurse" subordinates them to the common public representation of what a nurse is and does, which in their eyes is the feminine and domestic nature of nursing work. These men maintain strong relationships with females, usually nurses they have worked with. However these friendships do not form their major social networks.

Symbolic relations are one substructure where patterns were similar for broken men and complicit men but were different from the soft men. The men who embody the broken or complicit masculinities hold stereotypical representations of gender. They define gender as stereotypical roles, the male breadwinner for example. They blame their female peers for the state of their perceived poor pay and working conditions, claiming that women are weak and are unwilling to fight. These men attempt to conform to traditional notions of masculine identity. To the men who embody a "soft" masculinity, women are represented as equals and stereotypical notions of masculinity are thought to limit the possibilities for men.

Richard, Michael, Scot, Alex and Warwick embody masculinity where the project is equality. Compared to the other men, these men share an equal division of the child caring arrangements and a more equitable share of housework, albeit at varying levels amongst the informants. These men have taken paternity leave and/or have constructed their work so they can be the primary child carer and have moved their employment location in order to benefit the family. In these cases the men's careers have come second to their family. With the exception of Scot, these men work in areas of nursing that are typically viewed as feminine and are dominated by women. These men have very strong emotional ties with women, where relations with women are their preferred social networks. These men are more comfortable with women and are able to engage in female discourse.

As previously stated, these patterns of masculinity are not fixed categories, with defined boundaries. Nor are they exhaustive. This is exemplified by the difficulty in locating Simon and Geoff into one of the patterns of masculinity. Both cases are very
complex with many contradictions. In many ways Geoff resembles a complicit masculinity, working in very iconic masculine institutions such as the military. Geoff's life is full of contradictions, for example his strong religious convictions, his preference for male lovers and choices in some areas of nursing (abortion clinic and remote indigenous nursing). Geoff has traditional masculine tastes, sport and drinking, and his sexuality remains in the closet so he can engage in male social networks, which he perceives to be essential for his career. In different periods of his life, Geoff personifies a missionary, helping those who are less fortunate. At other times he engages in highly masculine practice, such as in warfare. Simon is also gay, with a complex life trajectory. Simon worked in more masculine areas of nursing practice, such as critical care and anesthetics and recovery. Simon does not embody the same desires or drives as the complicit masculinity group. He is content to be a part-time worker, with no career ambitions. Simon wants to be happy without the stress that accompany upward career movement. In many ways Simon resembles a soft masculinity. He does not hold traditional male tastes, and he is not one of the blokes. He prefers female social networks but has been deeply hurt by them. Simon primarily engages in a relatively closed gay social network, which provides security and comfort. Whilst Simon engages in equal domestic work his project is not one of gender equality. In the past Simon has both been subjected to and benefited from hegemony. He has been complicit to the position of women in society.
CHAPTER 9
Cautious Carer:
Professional Injury and Male Nurse Care

Introduction
In this chapter two themes derived from the data are presented. The first theme, ‘Professional Injury’, examines the negative emotions these men hold towards nursing and the causes of these emotions. The second theme, ‘Being a Chameleon’, examines how the informants perform masculinity in order to provide care to their patients. The themes presented in this chapter are an extension of the structural analyses presented in chapter 8. Professional injury became evident as a sub-theme of the analysis of emotions or cathexis, where professional injury occurs from the interplay of gender and the social construction of identity. For this theme I applied the work of German critical theorist, Axel Honneth (1995). At the core of this work is the concept of identity and its relationship to the social processes of recognition. In the later theme the work of Butler (1990; 1993) and Buchbinder (1994) informs my analysis of how male nurses deal with the contradiction between stereotypes of nursing and representations of the dominant patriarchal masculinities.

‘Struggle for Recognition’ – Axel Honneth
Honneth (1995) draws on the work of Hegel and Mead, in particular the tripartite distinction among three relations of recognition as social prerequisites for identity formation, in developing a social theory of (dis)respect. Honneth proposes that it is through reciprocal intersubjective recognition, through dynamic interrelationships, that self-awareness is acquired and the moral progress of a society is developed. Honneth (2001) employs the concept of ‘recognition’ to establish a concept of moral injury, where injustice requires an element of denial or refusal of recognition, that is, not having one’s understanding of oneself recognized and accepted.

Honneth summarizes his approach as follows:

The possibility for sensing, interpreting and realizing one’s needs and desires as a fully autonomous and individuated person – in short – the very possibility of identity formation – depends on the development of self-
confidence, self-respect and self-esteem. These three modes of relating practically to oneself can only be acquired and maintained intersubjectively, by being granted recognition by others whom one also recognizes, that is, through relations of mutual recognition. These relationships are not ahistorically given but must be established and expanded through social struggles. The struggles are moral in the sense that the feelings of outrage and indignation driving them are generated by the rejection of claims to recognition and thus imply normative judgements about the legitimacy of social arrangements. (Honneth 1995 xi)

In this sense, identity formation occurs through stages of internalization of socially standardized interactions of recognition (social recognition relations). It is in social forms of interaction regulated by normative principles of mutual recognition that identity formation occurs (Honneth 2004). Without mutual recognition, disrespect and humiliation occurs, damaging an individual’s identity.

At the core of obtaining a personal identity, Honneth places three corresponding principles of recognition: affective care (love), legal equality (law) and social esteem (achievement). With regard to the concept of love, Honneth is concerned about those personal relationships of love and friendship, that facilitate the development and maintenance of self-confidence, in that one has the capacity to express one’s needs and desires without fear and abandonment. With regard to the principle of law, Honneth is concerned about the recognition of respect for “status as an agent capable of acting on the basis of reasons, as the autonomous author of the political and moral laws to which he or she is subject” (1995 xv). In this sense self-respect is mediated by patterns of interaction organized in terms of moral and legal rights. Finally, social esteem is concerned with being valuable; having something unique that creates individuality and self-esteem.

In an article titled “Recognition or Redistribution?” Honneth (2001) provides a phenomenological analysis of a moral injury. Here he offers a differentiation of an injustice, a moral offence, with a mere misfortune, where the former requires a denial
or refusal of recognition. Based on the three principles of recognition Honneth (2001) differentiates three kinds of disrespect. The first occurs when primary social relations as in the family, love and friendships, deny affective recognition, acceptance and encouragement. According to Honneth (2001 49) love forms the precondition for the development of all other aspects of self-respect, and as love is outside the control of individuals it cannot be simply transferred to other interacting members. The second form of disrespect occurs when there is a denial of rights and social exclusion, where individuals suffer in their dignity as they are prevented from exercising the moral and legal rights of a citizen in their community. The third form of disrespect occurs when individual achievements or forms of life are devalued, limiting an individual’s sense of self-esteem, through lack of ‘solidaristic’ acceptance and social regard of their abilities. It is the three principles of respect that provide the conditions of social interaction that assures dignity and integrity.

Honneth offers a way of examining respect through the examination of social recognition relations. The following analysis does not provide a comprehensive examination of the three principles of recognition, but a generalized assessment of professional respect through the stories of the participants. In the main, the theme Professional Injury examines the third form of disrespect outlined above.

Professional Injury - ‘Disempowered, disrespected and put down on a daily basis’

For the majority of the informants nursing offered a path that lifted them out of an oppressed situation, providing stable employment and educational opportunities that otherwise were not available to them. This was certainly the case for Warwick, Anthony, Samuel, Alex, Andre, Darren, Simon, Geoff, Scott and Ken. With the exception of Andrew, Adam, Simon, Warren and Greg, these men were from working class families. Samuel, Alex, and Geoff had their starting points in a violent location. Nursing provided these men an out. They became upwardly mobile. For Michael, Adam, Andrew, Derrick and Paul, nursing offered an alternative path; these informants had attempted university but either failed or were unhappy with their
choice of course. Nursing provided these men with stability and a continuation in education.

Despite the initial class upward mobility nursing offered these men, the mobility was limited and being a nurse blocked further advancement. These men were frustrated and hurt by the profession and the public images of nursing that subordinates them as men. It is repetitive interaction with others, regulated by normative principles of mutual recognition, that creates a lack of self-confidence and self-esteem in these men.

*Just a nurse*

Most of the participants were dissatisfied with their position in the labour market. Brad, Alex, Derrick, and Darren exemplify the hurt that being a nurse causes them. All the informants refer to themselves as ‘just’ or ‘only a nurse’. The continuous symbolic meaning that the title nurse offers these men is one of worthlessness, both in the social arena and in the labour market.

According to Brad, to be a male nurse has negative isolating consequences, the ‘*gay stigma*’ or ‘*sex deviant*’. Close friends ‘*pity*’ him due to the nature of his work. Brad is embarrassed by the domestic nature of nursing work. Brad believes that nursing is a feminine profession, which ‘*holds you back*’ (socially and career) but once you are free of the ‘*shackles (nursing label) it’s amazing what you can achieve*’.

When Darren first entered nursing, like Brad, his friends ‘*gave him a spray*’, ‘*ribbing*’ him about doing nursing. He copped flack about the possibility of being a homosexual. He combats this with overt denials. In the beginning he was viewed as ‘*just a nurse*’, but over time they have accepted his choice of career. Darren acknowledges that this shift in attitude may have contributed to his career progression, as he moved away from the domestic side of nursing work. He explains: *Interestingly enough the way in which they see, not only based on what I’ve done but also the further away I am from nursing, the more accepting it seems to be. The tone of the conversation and the interest in what you are currently*
doing is three fold when you are indicating to them that you are stepping away from that bum wiping, pan pushing, testicle washing type process, because that is the way people perceive nursing as just handmaiden cleaning up stuff and that is it. So based on that I would say that with my friends of the past I can generate much more work related discussion when it is work discussion away from nursing as apposed to actual nursing. You talk about nursing, you talk about filthy wounds, shitty bums, real messes that most people in the general population don’t want to talk about, don’t want to listen to and have no interest in.

Brad makes direct comparisons between nursing and medicine based on the level of production (financial rewards), the hierarchical standing of the health professions and societal respect. Brad, Darren, Alex and Derrick claim that society doesn’t have the discourse to understand what nurses do nor to understand the differences between levels of nurse (CNE, CNC, NUM). They see a nurse only as what is portrayed on television, such as in “All Saints”. They consider that the images of nursing stem from a lack of nursing discourse, hindering the mass communication of what nursing really is. As a result, feminine and religious images of nursing prevail. The public feminine images of nursing subordinates them as men. This is further explained by Alex:

I think it all comes to worth. Being a builder and building a house is worth more than being a nurse, even though people have a good opinion of nurses. They don’t understand what goes on. I think they see it as a closed, cloistered sort of; it’s more like a religion than a job. It’s a calling and that crap still persists, the old calling. I think people don’t understand nursing and because they don’t understand it it’s just a job really. It’s very difficult for them to talk about it and to enter a conversation about it because they don’t understand the nuances involved in it.

Brad adds:

Sometimes you just don’t bother sharing the experiences of your day because you just know that people haven’t got the capacity to take it on board, they’ve
got no frame of reference to deal with the information. Someone came into emergency with a hole in his or her skull and we had to pick the bits out of their brain, you know people just haven’t got the frame of reference to actually know what to do with that information.

Derrick claims that as a clinical nurse he was ‘disrespected, disempowered and put down on a daily basis’. Here he was referring to the power dynamics between the health professions, especially between junior medical officers and nurses. Derrick claims that in specialty areas like HIV or sexual health, nurses become highly specialised and may have a higher level of knowledge. However, the title of nurse, and the legislative limits to nursing practice, subordinates him professionally. Derrick states:

It’s very hard to accept some smart young thing that comes up and they’re the doctors, so they know and you don’t. You may be a clinical nurse specialist and have worked in the field for years but you don’t know anything because you’re only a nurse.

Both Brad and Darren have chosen to change out of nursing work, to a more masculine occupational role. Brad’s current position is a project officer in health service management. Whilst this position has no direct power to hire and fire, the position offers Brad a higher degree of importance and social standing. Brad exemplifies a person who feels damaged by his profession. The language he uses such as ‘pity’, ‘shackled’ and ‘bloody nurse’ illustrates this.

Industrial conditions, in particular pay for nurses, were a major frustration for Brad, Darren and Derrick. The career structure for nursing provides a limited pathway for financial reward, responsibility, autonomy or an improved social standing. Brad attempted to improve the situation by joining committees and working parties but to no avail. He believes that nurses do not have a voice, that ‘there is a total disregard of the nurse’s opinion’. Brad was frustrated because his peers and friends made twice as much money as he and with less effort and responsibility.
Darren used the way he dressed and acted to gain a higher standing by being mistaken for a doctor. By wearing a tie, Darren was often mistaken for a doctor by the patients, and some nurses and doctors who were unfamiliar with him. There is a public perception that doctors are male. Darren also approaches patients with other nurses, usually female, and the interaction between the two mimics that of nurse-doctor relationship.

*My knowledge base, the way in which I utilized the situation as a teaching and learning process may have also confused them [the patients] based on my ability with language, medical terminology, that they may have confused me with someone a little higher up and therefore any one higher up than a nurse in this place has to be a doctor.*

Despite the success in gaining this respect, the title of nurse automatically lowered his standing. He claims that he always corrects patients when they address him as doctor and this gives him a lower standing in their eyes.

Brad, Alex, Derrick, and Darren have all advanced in their careers. Brad, Derrick and Darren no longer work as nurse clinicians, after being ‘promoted’ to management or project management positions. Brad, Derrick, and Darren actively constructed their careers in order to progress and improve their standing in the labour market. They planned their specialty area of nursing practice and educational opportunities to provide them with leverage. For these men the only way to achieve success and advancement was to be promoted out of nursing and to lose the title of nurse.

*Trapped and nowhere to go*

Nursing has offered some informants a means to succeed in the labour market. For others, obstacles were placed before them, trapping them in a position within the nurse labour market where they were unable to progress. Ken symbolizes the extreme case, where he has no ability to move from his current position. He is hurt by the profession and is angry.
Ken hates nursing. Ken feels trapped in a profession he finds 'tedious', 'boring' and 'run of the mill'. There is 'no money in it'. Nursing is 'just a job', not a career; he describes it as a 'God awful existence' and he wants to 'get it over with'. Ken finds operating theatre nursing, his current work 'boring', 'onerous' and 'routine'; he is 'sick of doing it'. Yet he is trapped. He is aware that if he was to change jobs he would start at 'the bottom of the heap' again, something he is not prepared to do. Ken is a clinical nurse specialist, an industrial classification that only pertains to his current position and is not transferable. Ken has no post-basic qualifications, no operating theatre nursing certificate, making him less desirable in the nursing labour market.

On three occasions Ken attempted to leave nursing: once before he entered the bachelor of nursing degree when he enrolled in a bachelor of rural management; the second time when he took up a sales representative position for a medical supply company which lasted less than six months before he was sacked; and a third time when he attempted to join the army. On the first occasion when he enrolled in a bachelor of rural management he was newly married with a child, a marriage he now despises. During this time he felt it would be easier to do his bachelor of nursing since he got advanced standing for his enrolled nursing certificate. When he was sacked from the representative sales position Ken blamed his boss, claiming he didn’t get on with him. On two separate occasions Ken unsuccessfully attempted to join the army. The first time was straight from high school. He was rejected on this occasion because he was overweight and had acne on his back. The second time was during the bachelor of nursing degree. On this occasion he was 'deemed unworthy for the army', 'a bit slow' and 'has a problem with authority'. Ken was deeply hurt by this.

Ken recognizes that to change career or job means further study, a compromise he is not willing to make. Ken’s past experience with university was one that he is not prepared to repeat. During this time Ken was working full time and trying to study full time. He was trapped in a marriage he was looking to get out of. Ken in part blames the institutional demands of being a student for placing exceedingly difficult demands on him and his marriage. Ken states this was 'the most agonizing time' of
his life. He ‘hated every minute of it’ and ‘will never go back’.

Ken has been let down by the profession. He feels he is the victim. After graduating from university he commenced work as a registered nurse at a private hospital in the north shore area of Sydney. During this time he had experienced several episodes of what he calls sexual harassment. He was ‘always in the boss’s office’; she was giving him a ‘hard time’. Whilst he did not disclose all the details supporting his claim during the interview, this was a definite feeling he experienced. He provides us with one account where he was disciplined because of a comment he made in the operating theatre where he was asked: When do you most feel like a cigarette? Ken’s response: After sex. A female nurse made a complaint and the disciplinary process was implemented. After union action was instigated, the disciplinary action was stopped and the complaint was withdrawn. Yet Ken continued to feel victimized. He adds:

…the fact the way they treated me… they give you all the crap lists or just the general way that they speak to you. The tone, the manner, the content, or just totally ignoring you in the tearoom. They have their little cliques, their own little in groups. The north shore girls, all their husbands were doctors, lawyers, engineers and I was a scumbag male nurse. I was the lowest of the low.

Ken is an iconic case, epitomizing deep hurt and entrenched anger directed at the profession. There were several informants who experienced similar situations and expressed similar feelings as Ken but did not show the continued hurt and anger. For example, both Warwick and Samuel were married young with children, then struggled as they attempted to support their families on a nurse’s wage. Warwick attempted to do his midwifery certificate in Scotland but failed to complete it, which he now regrets, as a result of financial hardship on his family. Ken’s, Samuel’s and Warwick’s marriages failed early in bitter circumstances. Samuel, like Ken, fails to have any contact with his family. In these men’s eyes, nursing and the failed marriages are linked. The pressures placed on them, from the financial strain caused from a nurse’s wage and consequently the need to do extra work, to meeting the
needs of the family, coupled with the strain of study, placed undue stress on their relationships. Both Ken and Samuel were trapped in relationships that they did not want. Both married as a result of getting their respective girl friends pregnant.

Ken, Warwick, and Ricky attempted to get out of nursing by working for medical supply companies as sales representatives. In each case the informant left nursing following a negative relationship with [female] nursing managers. They felt trapped in their position and felt that more could be had financially in a sales position. However, in each case the sales job lasted a maximum of 12 months, all informants returned to nursing.

Like Ken, many of the informants (Andre, Anthony, Darren, Simon, Ricky, and Paul) consider that they have experienced discrimination by female nurse managers, which created barriers to their career advancement. Andre’s Nursing Unit Manager deliberately, in Andre’s eyes, gave him a poor reference when he applied for a promotional position outside the organisation. Whilst doing his general training Anthony had received an unfair negative performance report from a nursing manager which was used as leverage to force him to leave 6 months before he was due to complete his certificate. Darren was in an acting Clinical Nurse Consultant position for 3 years, and when he approached his manager to discuss it being made permanent she told him that he would not be given the position. Simon had applied for a NUM position, was interviewed and found out afterwards that the female Director of Nursing had appointed someone to the position prior to his interview. Ricky was refused study leave to do a three-day College of Nursing clinical education course and was told that he would never receive study leave. In each case the informant became trapped, unable to advance as a result of perceived discrimination. Unlike Ken all these informants left their jobs and recommenced their careers in another organisation.

Broken down: careers and mental health

Both Samuel’s and Adam’s careers have had significant disruptions, eventually breaking down. Both Samuel and Adam have required treatment for stress-related
disorders, Samuel being diagnosed with depression and Adam experiencing a ‘nervous breakdown’. Both informants blame nursing and more specifically nursing management (in both cases, women) as contributing factors. The pressures from nursing work, relations with female nurses and in Samuel’s case, threats of violence, contributed to these.

Samuel has had to combat hostilities and violence since his early childhood. His father was a ‘drunk’, very volatile and violent, often directing aggression at Samuel. After completing his HSC, Samuel commenced a bachelor degree in mechanical engineering, a sandwich course requiring employment. During this period Samuel was physically abused and at times bashed by a senior apprentice. Despite complaining and reporting the abuse to management no action was taken. Samuel left after twelve months, failing to complete his degree.

During his nursing career Samuel reports having a few instances of sex discrimination. On one occasion during his midwifery training Samuel was accused of being drunk whilst on duty. A senior midwife had mistaken the smell of paint fumes with alcohol; he had been spray-painting his car prior to coming to work. A formal complaint against Samuel was not made; rather rumours and accusations were spread through female nurse networks. Samuel felt ‘abused’ and ‘humiliated’.

Samuel has had to challenge such networks in order to clear his name. In addition to direct conflict with colleagues, he has lodged formal complaints with management and has used industrial means through union involvement on two separate occasions in order to combat discrimination.

Samuel’s depression occurred after fifteen years of service in the one institution as a critical care nurse. Samuel felt ‘disappointed’ and ‘unsupported’ by the employing organization, where they ‘continuously breached confidentiality’ and in his eyes didn’t meet their ‘obligations’. Samuel highlights two instances that contributed to his depression. Firstly, he felt ‘vulnerable’ and ‘compromised’ when he was sent to ‘special’ a violent psychiatric patient in the emergency department. Despite protesting his discomfort and lack of expertise in the area to management, he felt he
was ignored and unnecessarily placed in a potentially violent situation without sufficient resources. Secondly, on a separate occasion Samuel was physically threatened by a wardsman. Despite complaining and reporting the incident to management, no action was taken. Samuel felt that they (management) didn’t care. Samuel was hurt because he felt betrayed by management, women whom he had known and worked with for many years. He adds:

* I don’t think being male helps. There is too much opposition. I think you’ve got an entrenched culture of nepotism, a lesbian culture that is very hard to crack, difficulty in terms of gender bias, and there’s double standard. I toughed it out for a long time and I’m no longer willing to tough it out. It’s not a level playing field. I wouldn’t encourage people to be a nurse.*

Samuel left this position, and went to another state for six months with a view to relocate his life. He has since returned to Sydney and currently works on a casual basis in a different hospital two to three shifts a week.

Adam, like Samuel, has had difficulty with and feels let down by female management. Unlike Samuel, Adam encountered emotional problems early in his career. Adam had gone to an all-male boarding school and when he commenced nursing he felt inept in socializing with women.

* I was shy and very, very awkward with mixing with girls... it was easier in nursing that you were a ship’s crew... in it together... in that way I wasn’t relating to them as girls.*

Adam describes himself as ‘inadequate... very lacking in self-confidence... very self critical’. He blames this on a ‘very unstable upbringing’, lacking in emotional attachment. Adam associates the women in authority in nursing with his mother, ‘a very overbearing figure’. He states:

* Ironically my mother was a very strong, overbearing figure and here I was coming into nursing where the person in charge was usually an overbearing person.*
Early in his career Adam found nursing to be very ‘hierarchical’ and ‘regimented’. All through his career he felt an intruder. He did not belong. After twenty years in nursing Adam continues to have difficulties fitting in with the other staff. Adam has difficulty expressing himself and his emotions and portrays himself as aloof and indifferent, socially inept. This creates difficulties for him at work with other staff, particularly the younger staff that he does not relate to. Adam describes his suppression of feelings as an advantage in nursing.

I'm not inexpressive but we [referring to his wife] don't talk a lot about our feelings, we sort of have a more osmotic thing, but as personalities we don't express ourselves a lot and in fact that's how I've survived in nursing a lot as well... I'm conscious that since I've been very young that I don't express or that I repress my feelings and I've felt in some ways that that's a good thing in nursing... if you let feelings get to you too much ... you wouldn't survive in nursing.

His career had been transient, appointments lasting about 2 years before he moved on to the next job. In most cases he left as a result of a breakdown in relations. Twelve months after graduating Adam was forced to resign following two minor clinical incidents. He felt this was unjust, but it was at the height of his illness and he did not have the energy to fight the claims. Whilst he did not accuse the institution of discrimination, he did believe his relationship with the sister in charge was the main contributing factor. He felt she 'picked' on him. Adam became unemployed, on the dole for twelve months. Adam became incapacitated, suffering from severe panic and anxiety attacks. With the support of his partner (now wife) Adam went back to nursing in a hospital. Adam’s career continued to suffer from strained relations with staff and conflicts with female management, both at a large tertiary hospital in central Sydney and another pediatric hospital. Adam has altered the early pattern of transience - he has been in his current position, CNS in pediatrics at a Sydney hospital, for 15 years. Despite attempts to advance his career, it has remained stagnant. On two occasions Adam has applied unsuccessfully for promotional positions. On both occasions Adam claims colleagues, who campaigned against him, betrayed him.
In both Adam’s and Samuel’s case the starting points in their construction of masculinity contributed to personal difficulties. This in turn contributes to the unraveling of their career. For Samuel it was his violent past, for Adam it was emotional detachment during childhood. Both men were ‘damaged’ prior to commencing nursing, vulnerable to breakdown. In both cases affective recognition was not satisfied, leading to a lack of self-confidence. Nursing and management structures provided the occasion for their downfall. In both cases, the lack of compassion, consideration and at times victimization by female nurses and managers lead to these men’s breakdown. Both men felt betrayed, unsupported and victimized by women within nursing.

For many of the participants, their rights to earn a fair income and working conditions are denied as a result of a lack of respect and recognition of their status. For them being a nurse limits social status and therefore limits their rights to earn an income. In addition, legislative limits to nursing practice further inhibit their social status, preventing autonomy and handicapping their ability to bargain. Such limitations reinforce the view that nurses compared to other disciplines are not morally responsible agents. This is further exemplified in the comparisons of autonomy of practice in medicine with nursing. It is through interactions organized in terms of moral and legal rights that dignity and self-respect are mediated.

The male nurses presented in this theme lack social esteem. Social esteem is a consequence of mutual respect, is grounded in being valued where values are endorsed by a community. However, for nursing such normative values are gendered. For many, social interaction reinforces the negative values of being a nurse, for example, interactions with medical officers, and other health professionals and patients reinforce the limitations on the scope of nursing practice, career opportunities and income generation, and the reinforcement of negative stereotypes. These men felt disrespected as nurses, leading to a move out of nursing or a disassociation from nursing itself.
Being a Chameleon – Sexual Identity, Performance Masculinities and Men’s Caring.

In this section of the thesis I will highlight how men as nurses engage in nursing care practises. As argued in chapter 4, nursing is idealized as feminine as a result of culturally constructed essentialist views of gender identity. Nursing discourse, the use of language, the name of “nurse”, its construction and meaning, contribute to the feminization of nursing. Words such as “nurse”, “sister” and “midwife” all signify the female form.

As a result of nursing, and consequently the nurse, being culturally constructed feminine, and the cultural appropriation of hegemonic norms (the idealization of exaggerated heterosexual gender norms), male nurses are subverted. The nurse, as an “I” (a being), is a social construction of the subject (the individual), whereby the nurse, regardless of sex, is constructed feminine. Here, I am drawing on the work of Butler (1993) and Buchbinder (1994) to highlight the difficulties of men as nurses and the strategies (or more correctly performance) they use to overcome these.

Butler (1990), in her book Gender Trouble, defines gender as performative. In this sense, gender is not a fixed set of attributes in the form of a stable identity; but is constituted in the stylization of repeated bodily acts through time. It is through the regulation of these acts that phantasmatic and phallocentric social norms are constructed. Such gender norms are illusionary and can never be internalized, but are political constructions propagated as identity and ideology (Butler 1990, 179). Butler (1990, 180) writes:

That gender reality is created through sustained social performances means that the very notions of an essential sex and a truer or abiding masculinity or femininity are also constituted as part of the strategy that conceals gender’s performative character and the performative possibilities for the proliferating gender configurations outside the restricting frames of masculinist domination and compulsory heterosexuality.
Male nurses in dealing with male and female patients, in particular when performing intimate body care of patients, appear to be in a stalemate. All informants describe the binaries of male/female, masculinity/femininity and heterosexual/homosexual as the biggest obstacle in the delivery of patient care. Within the binary systems each term is dependent on the existence of the other, the meaning of the system depending on cultural, political, social and historical determinants (Buchbinder 1994, 3). As nurses, these men are perceived to be in opposition to the cultural representations of the dominant masculinity, therefore are labeled as effeminate. As a result, the label of homosexual is applied, the consequence of the binary system default – man–feminine–homosexual. However, this does not hold for all patients. When caring for many female patients the man/masculine/heterosexual binary systems creates a sexual block to patient care. On the one hand being a nurse and its meanings places men in a counter position to the dominant patriarchal ideologies, a homosexual position. On the other hand, in the eyes of some females, male nurses still occupy a patriarchal masculine identity, a heterosexual position. This conundrum places men in a tenuous position when trying to make the nurse-patient relationship work.

To overcome the gendered idea of nursing, male nurses have to produce many counter or oppositional gender performances. The gender performances of male nurses are not fixed dualities, that is, a masculine act or a feminine act, but are fluid and tailored to individuals, located in a specific space and in an historical moment. The informants of this study describe a performance that is culturally ‘sensitive’ to the individual in their care. Brad describes the act as being a chameleon, the ability to change colour (a metaphor for performance) to suit either the cultural ideology held by individuals or a counter position to the ideology, depending on the need. Brad explains:

I think there’s got to be a self-defensive component to it but I think as a nurse the range of people, the range of situations, the full spectrum of humanity passes before your eyes. You make your own assessment of that on a daily basis and things such as homosexuality/heterosexuality and male/female gets broken down. You work in and amongst it, backwards and forwards from it every day of your life. I don’t know if it’s a male nursing thing in particular but
you do develop the ability to adjust to the environment that you’re in. You learn the art of mimicry particularly if you want to be perceived as something other than what nursing is supposedly considered to be. You very quickly learn to present yourself in different ways. A chameleon thing.

When caring for men, most of the informants stated they perform in ways that ensure that they were identified as heterosexual, by performing in a way that represents the culturally dominant masculinity, that is, in a traditional “blokey” or “macho” way through the use of language and mannerisms. Sam stated: “I talked about blokey things; surfing and cars” (he was building a hot rod). However, the performances described by the informants ranged from simply “playing the man” to acting the “homophobe”. It was not uncommon for the married informants to talk about their wives or children as a ploy to be identified as heterosexual. Samuel adds:

Well the way I explain it, you’re a male nurse, you have two genders to look after. With the males, there was that problem with the homophobe, so you had to get over that in terms of establishing that you weren’t going to threaten them, in terms of their phobia. So you had to get over that, so you established a little bit of to and fro conversation and generally at the end there was no opposition. I talked about bloke things. Enough not to be challenged all the time.

Derrick, Simon, Ralf, and Geoff all perform in order to disguise their homosexuality. For all purposes Geoff remains in the closet, and has sculpted his body to fit the military heterosexual mould. Unlike Derrick, Simon and Ralf, Geoff is tall, has highly developed musculature, and is not softly spoken. Geoff epitomizes the military man. Derrick, Simon and Ralf are more the ‘stereotypical’ gay man, softly spoken and smaller framed. These men perform or act in similar ways to the other informants so that their sexuality is not identifiable. Derrick explains:

A good friend of mine that I trained with who was straight, people always assumed he was gay and I was straight. I think it’s just very much a matter of adaptation. I always remember specifically if you had a four-bed bay of older men, you just, you adapt to their way of being. Whether that’s my personal
style or whether that's something that a lot of nurses do, I can't say, but you'd certainly try and work out their method of communication, their way of being and whilst not denying yourself and your own individuality, fit in as much as possible to make them feel comfortable with their disease process and what they were going through, fit in with being able to have some sort of relationship with staff and still maintain yourself. I guess it was a tight rope of walking along and working out that balance...you get used to keeping yourself a bit hidden in a way because that's just basic common sense. You don't want to get harassed or bashed even though that wasn't such an issue in a place like that.

Brad describes a situation where a gay colleague with whom he worked in Sydney's southern suburbs did not represent the local masculinity and exhibited stereotypically gay mannerisms and language. As a result he had a “hard time”, being the center of jokes and ridicule, and patients rejected his care. This provides an example of how the constructions of masculine identities are positioned in locality and time.

I suppose coming from a very strong “blokey” culture area you became a bit more socially attuned to how to behave within that culture, so you know how to be culturally appropriate, but this guy who had come from the inner city, was blatantly gay and had this particular way of presenting himself. He just didn’t fit in. He didn’t know how to be culturally appropriate and it generated a lot of jokes.

To avoid occupying a social position vulnerable to homophobic scrutiny Darren and Ken take a tougher and more aggressive role. They admit to using homophobic discourse to denounce homosexuality. Language such as “poofster” and “faggot” were terms used to reinforce their own heterosexual orientation. Darren provides a good example of this:

The eighteen to twenty five age group. If you go into them, you can tell, if they haven’t directly said it to you, their body language is actually saying that they are uncomfortable with you being there. And at that point I will say “look mate if you think I am a fagot then think again. I am married with children and if
anything I'm a homophobe". I like to alleviate that concern and anxiety because in some cases these homophobic teenagers from the Sydney southwest are very, very concerned about these things and it can elicit a huge stress response for them where it can actually encourage inappropriate aggressive behavior where it is not needed.

Darren provides examples of aggression and violence towards another male nurse when pinched on the arse. After being pinched Darren turned and slammed the male nurse, a colleague of several years, against the wall and pinning him there with his forearm under the chin. Darren deliberately made a spectacle, to out the nurse to ensure the nurse would be ridiculed for his inappropriate sexual advances and to demonstrate his own heterosexuality.

In many cases it is the counter performance, the ability to perform in a way that dispels or counters the heterosexual position of the dominant masculine identity that provides the greatest anxiety for the informants. Most of the informants state that it is rare for male patients to refuse their care, but is more common for female patients to refuse. Female patient preference for female nurses is especially true if the nature of the care is intimate body care (wash, touch and clean bodies) (Chur-Hansen 2002; Lodge, Mallett, Blake and Fryatt 1997). This is particularly evident in obstetrical or midwifery nursing where the nature of care is intimate. In an ethnographic study about women’s’ perceptions of having a man nursing student attend them during labor and postnatal care, Morin et al. (1999) found that most women were accepting of men. Those that refused cited reasons that were sexual in nature. In part, the counter performance requires the representation of a ‘soft’ masculinity, the display of the feminine qualities of nurses, in order to dispel the binary system in which the male nurse is located as man/masculine/heterosexual.

Those informants who care for women have developed strategies and have structured nursing practice to combat the threat of being labeled a sexual deviant. Paul, a palliative care nurse, claims that to care for women and perform intimate body tasks he needs to be ‘in touch with the person at their level’. Here he is referring to ‘getting
to know' the patient and performing the [gender] identity that is culturally sensitive for the individual. It is the patient's ideology of masculine identity, the patient's construction of the male nurse, that is sensed and interpreted by the informants and then performed through nursing care. Paul explains:

*I have always felt extremely comfortable in being/getting in touch with a person on their level. Physical touch is a major part of my communication of being there for someone, of caring for them. But I'm very sensitive, if there's any sense that that's not received, I'll take it away immediately and I think I've only got that wrong a couple of times. Once was when I went to hold someone's hand and they withdrew it. When I reflected on that later, it was probably that it was very early, she didn't know me very well, it was very early in the interaction.*

Touch is a very important and intimate method of communication for Paul in his nursing practice of palliation. He is aware that touch is a form that communicates feelings and can be misinterpreted by the receiver. As a result, he is cautious in its use. Paul distinguishes a difference in the locations of his touch for men and women. When caring for women Paul uses more intimate forms of therapeutic touch, for example, holding hands and hugging. Contrary, when caring for men Paul rarely uses touch in a therapeutic form. He explains:

*I don't use touch with males very often. Gee that could be misinterpreted couldn't it? Often a hand on the shoulder rather than a holding of a hand, or sometimes just a touching of the upper arm if I want to convey a connection, be assuring, or a sense of being here for you. I use those sorts of strategies for males more often.*

In a few cases, institutional policies and procedures reinforce the sexual deviant stereotype of men nurses through the implementation of sex segregation of nursing care. Scot, Anthony, Warren and Greg, all mental health nurses, describe nursing policies that require male nurses to be accompanied by women when entering female patient dormitories. According to Scot, male nurses were not permitted to be alone with women patients. During the seventies and eighties, in the institutions where Scot
and Anthony worked, men were not permitted to work in female wards. More recently, these segregation policies have become more relaxed, creating a degree of anxiety in these men since the sex segregation policies provided a degree of security. Both Scot and Anthony feel more ‘vulnerable’ to allegations of sexual impropriety in their current positions. As community mental health workers they are concerned about going into women’s houses alone. Scot states that ‘it boils down to his word and reputation if sexual allegations are made’. Andrew also described sex segregation policies in the emergency department where male nurses are not permitted to perform physical assessments on female patients without a female escort.

Those informants who participate in the care of children have described the added obstacle of being labeled pedophile. For Simon, Alex, Adam and Michael the real threat of being labeled a pedophile is part of daily nursing practice and counter performances are incorporated into their care. Like those men who care for women, these men refuse to provide body care to paediatric patients without the company of a parent or another nurse.

**Male nurse care**

The informants of this study clearly describe nursing care strategies they employ to overcome the sexualization of their care. Strategies such as communication, explanation and information, maintaining privacy and minimizing touch and care, all contribute to ensure their sexual safety. These practice strategies were standard, used to care for both male and female patients, to combat both the homosexual and heterosexual deviant stereotypes.

The informants in this study learnt early in their career the importance of communication when providing care. Prior to touching the patient, a full step-by-step explanation of the procedure is given, outlining every step and a rationale for it. Informants commented that it is through explanation and patient education, that ‘trust’ between the male nurse and the patient is developed. Gaining the patient’s informed consent or permission prior to performing care and preventing any
ambiguity or surprises through giving clear explanations of the procedure, is essential
to developing and maintaining patient trust. Michael, a former midwife explains:

Taking the time to make sure that they understood what would be happening,
that there would be a vaginal examination and what that involved. I would
need to have access to parts of their body that they wouldn’t normally give to
other people... touching their stomach and looking at pads. I needed their
permission to move into areas where there were lots of boundaries and where
they weren’t used to having people pry. It was making that very clear that this
was an expectation of them and this was what I would be needing from them,
almost with them participating through the process. So making that very clear
was a means of protecting myself; I guess also breaking down that element of
surprise for them; there would be no surprises. They knew exactly what the
process would be. I would try and explain a lot at the beginning, but it would
be as you went through as well. Okay we’ve reached this stage, now we’re
going to be moving on to... this will be happening and then that will be
happening. I found education and explanation was really important. I was
always very aware, I think more so than my female peers, I was more in tune
with respecting their rights as customers because of that gender barrier and in
some ways I felt that I needed almost to demonstrate that I had an
understanding of what their bodies were going through and what they needed.

In addition to clear communication, maintaining patient privacy was identified as
being important in preventing accusations of sexual (heterosexual or homosexual)
misconduct. The informants describe only exposing and touching those body parts of
the patient that was required for the intervention. Unnecessary body exposure,
unnecessary touch, or performing care when it was not necessary, were identified as
possible causes of patient distrust. Where possible and where the patient was capable,
the informants encourage the patient to participate in their own care.

I only do what’s necessary and protect privacy. I am in tune to the age group
and of what you’re doing. At my age I am mindful that an adolescent doesn’t
need a full examination if she’s got a sore foot. If it’s a threatened limb well
yeah you might have to check her pulse. (Samuel)
Alex, Michael and Richard state that they relied on clinical symptoms as indicators for intervention. For example, both Michael and Richard, in their midwifery practice, explained that they did not routinely conduct vaginal examinations on women during delivery, but rather conducted them only when patient’s clinical signs indicated it.

_Vaginal examinations are something that I’m very conscious of not doing them unless absolutely necessary and in fact doing very little, doing none if I have to or could get away with it. I am always very conscious of not invading personal space and always drawing that line._ (Richard)

This practice was seen by female midwives to be dangerous. Both Michael and Richard claim their practice to be best practice. Michael explains:

_Threatening for them. They [female midwives] found it a dangerous sort of practice in terms of leaving women too long in second stage, not doing lots and lots of VE [vaginal examinations]. Clinically I felt and I still believe that you don’t need to VE a woman a lot. Just by listening to them and what their body’s doing, you can pretty much work out where they are in their labour process. I was fairly confident in my approach in that way. I was very rarely wrong. Physically they would perform to where they were, you would get used to the symptoms and the signs of their labour and you’d sort of be able to tell where they were and they [female midwives] found that very threatening. I didn’t find they [female midwives] would use their knowledge and experience around labour. They wouldn’t listen to a woman. There was a high epidural rate, a high caesarean rate and it was very much a very high intervention rate. They relied very much on obstetricians to make decisions rather than being midwifery-centered practice._

All the informants identified the age of the patient as a major component of their own vulnerability when caring. They were more wary of teenagers and young adults. When caring for women requiring invasive examination or when providing care to adolescent girls, all the informants declared they would insist on a witness. In most cases this was a patient relative or advocate, or a female nurse. Alex states:
I find in most things that I do I never put myself in a position even today where I’m open to any sort of suggestion of my practice and that’s a protective thing. Well I do a lot of intrusive stuff as far as bowel motions and if I’ve got a few 13, 14, 15 year old girls, I’ll always make sure I’ve got a female staff member with me when I do things. I think that’s reasonable because it doesn’t matter what you do these days, you have to be very careful with your practice and seeing people of the opposite sex privately.

This was also true for some male patients. Michael as a paediatric nurse explains:

*I’ve actually had vibes from young male patients who are I guess overtly exploring their sexuality and I felt were maybe had had a gay or another male to male encounter. There were times when they made me feel uncomfortable, then I would go and get someone else as well.*

All the informants stated that they use their ‘gut feeling’ and if they ‘sense’ an uncomfortable feeling between them and a patient, they would always ensure a third person would be present, usually a female nurse. The participants were unable to describe how they became aware of the unease, the ‘gut feeling’, claiming they used intuition. Michael explains:

...if I didn’t feel comfortable with someone, if I went in and did the initial history taking and started to go through and explain what was going to happen, if I started to get bad vibes or bad feelings from that woman then I would go and get someone to come in with me. If it was a husband and wife and I felt a good rapport with them, they were confident with me, and they seemed happy and comfortable with the situation then I would just practice on my own. I wouldn’t feel the need. And that would be intuitive, it would just be something that I would feel. I’d be assessing their reactions; their responses and you can pretty well tell how people are responding to you. If they trust you or don’t trust you or are uncomfortable with you, you can read that in their body language and the way they speak to you, the tone, the intonation they give you in answer. If I didn’t feel comfortable then I’d go and get someone else.
Conclusion

As previously discussed, identity formation occurs through stages of internalization of socially standardized interactions of recognition (social recognition relations). It is social forms of interaction regulated by normative principles of mutual recognition that identity formation occurs (Honneth 2004). The men in this study are continuously reminded of their professional identity, one that is neither masculine nor as ‘normal’ nurse. For this sample of men, social interaction in the form of nursing practice and limited work conditions reinforces the ‘oddity’ of their work choice and the gender conflict their choice creates.

The conflict of being a male and having a masculine identity and the culturally constructed nurse as feminine creates a state of confusion in their identity. The need for these men to take precautions and perform (masculinity and nursing practice) in various safe ways to avoid being labelled a deviant, demonstrates a lack of recognition by others that they are ‘true’ nurses. Without mutual recognition, disrespect and humiliation occurs, damaging their professional and gender identities.

In this study, the ability of the informants to do nursing and provide care is dependent on the way they ‘do’ gender, that is, they have to be perceived to be performing the masculine identity that best represents the individual patient’s ideology of what it is to be a man, which is set in a particular location and time. In addition, they have to counter the representations of the male nurse, whether it is homosexual, paedophile or heterosexual deviant. Respondents develop workplace strategies for overcoming effects of gender stereotypes that may hinder their nursing work.
CHAPTER 10
Conclusions: Contradictions and Tensions

This study was undertaken with a view to examine the social practises that configure masculinities in the lives of male nurses. In this, the final chapter, I reflect on the findings of the study and on the methodology, and propose directions for future research.

Since nursing is constructed as a feminine occupation, I thought it essential to the full understanding of men’s experiences of nursing that a study of gender characteristics be included. Thus a quantitative cross-sectional survey of male nurses, female nurses and male engineers was undertaken to determine the differences in the self reporting of gender characteristics. The results of the survey illustrate how society (as represented by these samples) culturally constructs professions as gendered institutions. Essentialist definitions of gender and normative sex roles were used by the engineer and to a lesser extent the female nurse samples to justify nursing as a female profession. Tensions are created for male nurses by the contradictions of the social configuration of nursing as feminine and masculinity as identity. Stereotypes such as the homosexual tag, being lazy, being focused on technology and not caring, occur for male nurses as a result of the contradictions between sex, gender identity and being a minority in a profession culturally constructed as feminine.

Consistent with other studies, the results of the comparison of self-descriptions of psychological sex characteristics do not support the notion of sex-specific characteristics. All three groups were different for the Expressive Orientation component and no difference was found across the samples for the Instrumental component. Whilst more female nurses were sex-typed feminine and scored higher on the Expressive component compared to both male nurses and male engineers, more male nurses were sex-typed feminine and androgynous, and scored higher on the Expressive component compared to male engineers. Such differences partially support the notion that male nurses, compared to other males, do possess personal attributes consistent with the ‘feminine’ occupational demands of nursing.
This thesis aims to explore male nurse subjectivities with a specific focus on how broader socio-political ideologies and the internal (re)structuring of contemporary nursing shape middle-class occupational masculinities. With the use of life history method, I examined the lives of 21 men, where power, production, cathexis and symbolic relations were analysed. The male nurse, this study shows, is not a single construct as is reported in previous research. Rather, male nurses can occupy multiple masculinities. Three patterns of masculinity were identified in this sample, these being broken masculinity, complicit masculinity and a soft masculinity. I would now like to provide a summary of each of these masculinities.

Those men who represent the broken and complicit masculinities are the same who are hurt by being a nurse. Hegemony is the gender project for these men; however, this becomes challenged by the cultural constructions of nursing. Hegemonic power, production and symbolic relations are not able to be maintained. Female authority, low pay, and the gay stigma threaten their masculine identity. This study is consistent with the studies by Heikes (1991) and Evans and Bly (2003); found when men who engage in a female profession, non-hegemonic relations of masculinity are enacted, resulting in a perceived “spoiled identity”. The struggle to maintain a positive masculine identity results in practises that project a masculine identity (Villeneuve 1994, Evans and Bly 2003). This is very clear in the practises used to deny the homosexual tag, for example, participants referring to their wives and family in conversations and displaying homophobic honour with their use of derogatory language such as “faggot” and “poof”. Like male nurses in previous studies (Williams 1989; Williams 1992; Evans 1997), these men chose specialty areas of nursing considered more legitimate for men. They are less likely to engage in duties of a domestic nature, or which require high levels of emotional labour and intimate body care. The men in complicit and broken masculinities deliberately choose specialty areas of practice that require technical or scientific knowledge, and are perceived to be the most prestigious and better paying, like managerial roles. In so doing they distance themselves from enacting the feminine and project a masculine identity.
Those men in the complicit masculinity are able to manage their structural advantages in order to move up the career ladder. These men are motivated by their compromised masculinity, and struggle to maintain a positive masculine identity. As MacDougall (1997) claims, it is the traditional masculine men in nursing who achieve positions of power, achieved by suppressing their caring instincts in order to maintain their masculine role. They are supported by the gender arrangements within the family; an unequal gender division of labour in their favour. Whilst nursing was initially a means for upward mobility, an escalator of sorts (Williams 1992), the brand ‘nurse’ for the complicit men became a glass ceiling, inhibiting their career opportunities and advancement. Despite the level of achievement for these men within nursing, they are subordinated by the position of nursing in the social order. These men strive for status and authority but are limited by being a nurse. These men therefore look outside of nursing to give them further leverage and upward mobility.

Unlike those showing complicit masculinity, the broken men were unable to continue to be upwardly mobile. These men failed in career advancement and social relations with women. These men project a masculine identity through aggressive gender politics and dominance, both within the family and at work. All but one of these men had failed relationships, and all have had industrial disputes with female managers. Like the working-class men in Donaldson’s (1991) study of manual labourers, these men had no power and authority at work, and patriarchal relations were the key feature of their domestic arrangements. These men dominate sexual relations, having extramarital sex, and they dominate production through an unequal division of domestic labour. In contrast to the men in Donaldson’s (1991) study, the men in this study were willing to engage in militant union and industrial activity. Unlike the case for labourers, nursing positions are abundant, therefore, they are not heavily reliant on their current position of employment, as employment can be found elsewhere. These men feel ‘let down’ by their female managers and have been deeply hurt by nursing, so much so that it has in some cases impacted on their mental health. The men in broken masculinity have unsuccessfully attempted to leave nursing. These men identify themselves as victims, subordinated by female managers and the tensions created by the contradictions of nursing.
The men in the soft masculinity offer us an alternative way of being. These men are not hurt by nursing in the same way as the other masculinities. They do not experience the ‘spoiled’ identity created by the contradictions of masculinity and nursing, and do not project a dominant masculine identity. Rather, these men embody a “soft” masculinity, where women are represented as equals and stereotypical notions of masculinity are thought to limit the possibilities for men. They enjoy being a nurse and doing nursing work. They are willing to work in specialty areas of nursing where nursing labour processes are highly emotional and involve intimate body care. These men prefer female social networks, even though they experience structures that restrict their access, limiting their work related social capital.

**Recommendations for Future Research**

*Learning to Care*

As Judith Butler (1993) puts it, gender only comes into being with the stylization of repeated bodily acts and that it is through the regulation of these acts that social norms are created. This study found that in order to provide care, male nurses symbolically perform gender to suit the ideology of their patients. This opens up an interesting possibility for ethnographic research to explore the phenomena, and to examine how male students learn how to do this, and what are the consequences if male nurses fail to achieve this. Only a few studies (Okrainec 1994; Paterson et al. 1996) have been conducted that investigate male nursing students’ experiences in learning to care. I suspect, in the main, nursing education, and in particular the teaching of nursing practises, are provided in a genderless way. There is a need for educational research and curriculum review to examine how nursing education prepares male nursing students for the provision of nursing care.

*Social Capital*

This study highlights the social isolation of some male nurses and the inability to crack the social networks of females. The findings of this study that male nurses are socially isolated are supported by several studies in North America (Floge and Merrill 1986, Heikes 1991, Williams 1995, Kelly et al. 1996). Evans and Blye (2003), in a recent statement of an important view of gender and nursing, claim that the socialization patterns of male nurses are practises that maintain a masculine
privilege. They suggest that male nurses engage in “boundary heightening practises” where they distance themselves from female colleagues in order to fit in with a masculine group of men, with whom they share similar interests and experiences, and from whom they gain support. This form of camaraderie serves to attain and maintain masculinity and to reinforce their claim to power under patriarchy (Evans and Blye 2003).

This study found two patterns of emotional relations, of which one supports Evans and Blye’s (2003) arguments. Samuel, Ken, Darren, Andre, Anthony and Andrew have very strong male friendships and traditional masculine interests. What is interesting is that Samuel, Ken and Anthony have not been advantaged in their career by their masculine alliances, yet their sense of masculinity is protected and reinforced. However, there are many men in this study who do not engage in “boundary heightening practises”. In fact the men who engage in soft masculinity prefer female friendships and social networks. This second pattern of emotional relations contradicts Evans and Blye’s arguments.

What is not acknowledged in the literature is the agency in femininity that excludes men from female social networks. This study shows that the exclusion of males from female networks reduces their access to social capital. For the majority of the informants, nursing social networks are their major form of social capital - “networks of social relations that are characterized as norms of trust and reciprocity, which lead to outcomes of mutual benefit” (Stone et al. 2003, 1). The term social capital is used here to examine the informants’ ability to develop social relations, accesses social networks and use these social connections in order to get ahead. Further research is required to examine social capital in nursing and the social practises that may exclude men from this social capital.

The Political Position of Women in Nursing

Nursing, for many years, has been a bastion for women, where female knowledge and women’s work has been legitimized and celebrated. Historically, when career options for women were limited, nursing was a location where women could advance in a career. Nursing has provided minority women, single and lesbian women, a location
where they could be upwardly mobile. As more men enter nursing, the political position of women in nursing may be threatened. Research is required to explore the impact of an increasing number of men entering nursing on the political position of women in nursing.

Some Thoughts on Method

According to Connell (1991), in order to study historical change in masculinity, methods are needed that elucidate practises, and contradictions in practises, which are situated in time. Such methods should “draw on personal experience and on social interactions, collectivities and institutions” (Connell 1991: 143). This study demonstrates how life-history method reveals structural fact at the same time as personal experience. This study investigates the construction of masculinity in the lives of male nurses in the context of their lives. Such life history accounts have led to an understanding of the stages, critical moments and transformations in the processes of the configuration of masculinity, and how individuals are enabled or constrained by structural position (Messerschmidt 2000). Indeed, life history method has been of great importance in the study of masculinity (Messner 1992; Connell 1995; Dowsett 1996; Messerschmidt 2000).

Although life history method provides rich sociological data, it has its limitations. For example, the life story can never be told in its entirety, nor can its context be fully documented. In reality, the researcher recounts part of the story. As biographers we are restricted by text in the telling of someone’s life, therefore, the life of “real” people can not be fully documented (Denzin 1989). As Denzin argues, autobiographical and biographical forms are incomplete literary productions. As Plummer (2001) puts it, life stories come through many blurred sources and can take many forms. The topical life story, as used in this study, is used to throw light on a highly focused area of the life. This study does not aim to grasp the fullness of the person’s life, but aims to examine social practises and gender relations within the life.
Further questions with biographical methods are the issues of truth and fact. In life history method there are possibilities that the respondents may lack memory of key events and/or issues, or may mislead the interviewer altogether (Messerschmidt 2000). Yet this can occur in all social research. It is impossible to determine if these men’s interpretations of accounts are factual, though judgements can be made about consistency and credibility. On the other hand, as life history examines respondent’s stories as lived at the time they are being told, the interpretations as they stand are real in an immediate sense. If an author or teller of a life story thinks something existed and believes in the existence, its effects are real (Denzin 1989; Plummer 2001). In this study it is the commonalities across the participants’ accounts that provide support for their validity.

During the conduct of this study, I was always conscious of the ownership of the life stories. I am privileged to be the custodian of these men’s stories and I am mindful of the damage that could be done with the mis-use of the knowledge gained from their stories. For this reason I continuously remind myself of the following ethical issues: confidentiality, honesty, deception, exploitation and hurt. Confidentiality of all subjects and significant others has been maintained by replacing the names of individuals and places with pseudonyms. For particular individuals, their specialty areas of practice, locations, and timing of events have been altered. Care was taken so that the meanings of the stories weren’t altered by the changes. Apart from these alterations, I have tried to be honest in the telling of their stories, and where appropriate I have used the participants’ words to demonstrate their intended meanings.

I would now like to turn to the method of analysis. In this study I used Connell’s (2002) four-dimensional model of gender (power, production, cathexis and symbolism) as a framework for the structural analysis of the case studies. The difficulty experienced with this model was one of boundary. Nursing work and labour processes often intersect other gender substructures. An example of this is in the case of emotional labour, where emotions and sexuality are symbolically manipulated in the performance of body work, and sold as labour. The men in this
study symbolically performed gender when providing care for their patients. In addition, power relations (or the lack of power) and production relations - working conditions and the nature of nursing work - are main sources of anger, hurt and injury (emotional relations) in these men's lives. Whilst each substructure provides a reference point for analysis, they are not discrete, but are dynamic and interact with each other.

The difficulty experienced with the use of Connell's model of gender was locating specific parts of the analysis where the data cuts across gender substructures. An example of this was in the location of emotional labour processes. In this thesis, the analysis of emotional labour in nursing work is presented under relations of cathexis, but could easily be placed under relations of production. Similarly, the analysis of sexuality, or more correctly the enactment of heterosexuality in performing nursing work could be located as either relations of production or relations of cathexis. This is more of an issue of the presentation of findings rather than a question of analytical method. However, the complexity and multiplicity of social practice does not always neatly fit discrete gender substructures, rather cuts through or across them.

Closing Remarks
This chapter brings an end to the long journey I have travelled in a quest to extend the understanding of the lived experiences of male nurses, and the patterning of social practice that configures masculinities in their lives. Whilst this study highlights patriarchal practice in some informants, it also offers an alternative way of being for male nurses. Being a male nurse brings with it contradictions and tensions. In my mind, the way forward for nursing, and the meaningful recruitment and retention of men into nursing, is through challenging hegemonic masculinity. Rather than nursing campaigns appealing to the "real man", which aim to legitimize hegemonic masculinity in nursing, public campaigns need to be developed to demonstrate the alternative ways of being, especially the 'soft' alternatives in masculinity. In order for male nurses to be fully accepted, both traditional hegemonic masculine identity and ideology, and the representation of nursing as feminine, need to be deconstructed and alternatives presented.
References


Appendix A: Human Ethics Approval for Survey Study

11 March 1997

Dear Mr Fisher,

The Human Ethics Committee at its meeting on 3 March 1997 considered your protocol:

Title: Sex-Role characteristics of male nurses

Ref No: 97/3/19

It was the Committee's opinion that there were no ethical objections to the project being undertaken.

The procedures outlined in the protocol must be adhered to.

Please note, the Subject Information Sheet and Consent Form must be on University of Sydney letterhead and must include the full title of the research project and telephone contacts for the researchers.

The following statement must appear on the Subject Information Sheet:

Any person with concerns or complaints about the conduct of a research study can contact the Secretary of the Human Ethics Committee, University of Sydney on (02) 9351 4811.

Approval for the protocol is given on the understanding that you will return the "Report Form - Monitoring of Research", which will be provided by Committee, as a progress report on your research by no later than 30 April 1998.

Approval has been given for one year and renewal is contingent upon the provision of the progress report.

Yours sincerely,

Dr J D G Watson
Chair
Human Ethics Committee
Appendix B: Survey Participant Information Sheet

The University of Sydney
Faculty of Nursing

Murray Fisher
Department of Clinical Nursing
University of Sydney MO2
NSW 2006 Australia

Information Sheet

You are invited to participate in a research project entitled:

"Sex-Role Characteristics of Nurses"

The study of sex-role characteristics has a well established history in psychology, however, there are very few Australian studies in this area of research and even less studies investigating the sex-role characteristics of specific occupational groups. As an experienced registered nurse I wish to gather information about sex-role characteristics from a contemporary nursing workforce, to promote informed discussion and to attempt to dispel commonly held stereotypes about male and female nurses. Your participation in this project is appreciated.

This research project is being conducted by Murray Fisher, as part of my doctorate studies. The aim of this study is three fold;
1. to determine the sex-role characteristics of nurses;
2. to determine the differences in sex-role characteristics between male and female nurses, and;
3. to determine if there are any differences in sex-role characteristics between male nurses and other male samples.

It is not the purpose of this project to make judgements regarding individual’s sex-role characteristics.

Another area in which there has been very little profession based research, is that of discrimination against or harassment of males in nursing. A secondary aspect of this research is to ascertain whether these exist.

All of the information gathered for this study will remain confidential and anonymous. No individual will be identified in this project.

Your consent for inclusion in this study is indicated by the completion of the attached questionnaire. Your participation is voluntary and you are permitted to withdraw from the project at any time without penalty or prejudice.

If you require further information, please do not hesitate to contact me on 9351 0587. If you are concerned about any aspect of this research you may contact Ms Gail Briody of the University of Sydney Ethics Committee on 9351 4811.

Yours Sincerely
Murray Fisher
Appendix C: Female Nurse and Male Engineer Survey

Questionnaire

<table>
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<tr>
<th>Instructions</th>
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<tr>
<td>Thank you for participating in this study. Please read all the instructions carefully and answer all the questions as honestly as you can, ensuring not to leave any questions unanswered. On completion of the questionnaire, return it in the prepaid envelope attached. Your cooperation is greatly appreciated. All information gathered is anonymous and confidentiality is guaranteed.</td>
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This questionnaire was distributed by the NSW Nurses Registration Board on behalf of the researcher. No names or addresses have been or ever will be disclosed to the researcher.
SECTION A

Demographic Data:

1. **Age in years:** _______ yrs

   Please Tick the correct answer.

2. **Gender:** Male ☐ Female ☐

3. **Dependants:** No children ☐ 1-2 children ☐ >2 children ☐

4. **Highest Qualification:**
   - Certificate ☐ Diploma ☐ Degree ☐
   - Grad Cert/Diploma ☐ Masters Degree ☐
   - Other ☐ specify: ______________________

5. **Sexuality:**

   Please circle the number on the line that corresponds to your sexuality, using the criteria below:

   0 1 2 3 4 5 6

   0. Exclusively heterosexual with no homosexual tendencies
   1. Predominantly heterosexual, only incidentally homosexual.
   2. Predominantly heterosexual, but more than incidentally homosexual.
   3. Equally heterosexual and homosexual.
   4. Predominantly homosexual, but more than incidentally heterosexual.
   5. Predominantly homosexual, but incidentally heterosexual.

6. **Relationships:**
   - Single ☐
   - Married ☐
   - Defacto ☐
   - Same sex partner ☐
   - Separated/Divorced ☐
7. **Position held.**
Please indicate by ticking the position in which you are currently employed. If you hold more than one position, please tick the position in which you are predominantly employed.

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**Other**

8. **Principal Area of Nursing Practice**
Please indicate by ticking the principal area of nursing practice in which you are currently employed. If you are currently working in more than one area of practice, please tick the area in which you are predominantly employed.

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SECTION B

PERSONAL DESCRIPTION QUESTIONNAIRE

The task asks you to describe yourself. Below is a list of personality characteristics. Please use these characteristics to describe yourself. Indicate on a scale from 1 to 7 how true of you these various characteristics are. Please do not leave any characteristics unmarked.

Mark 1 if it is NEVER OR ALMOST NEVER TRUE. 2 if it is USUALLY NOT TRUE. 3 if it is SOMETIMES BUT INFREQUENTLY TRUE. 4 if it is OCCASIONALLY TRUE. 5 if it is OFTEN TRUE. 6 if it is USUALLY TRUE. 7 if it is ALWAYS OR ALMOST ALWAYS TRUE.

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<td>Pleasure-seeking</td>
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</tbody>
</table>
SECTION C

This task asks you to state whether you agree or disagree with the following statements. Please use the following scale to determine your answer.

Please Circle 1 if you Strongly Disagree  
2 if you Disagree  
3 if you are Unsure  
4 if you Agree  
5 if you Strongly Agree

1. Nursing is a suitable profession for males.  1  2  3  4  5

2. Nursing is a more suitable profession for females.  1  2  3  4  5

If you agreed to this statement, what makes nursing more suitable for women?
Appendix D: Male Nurse Survey

Questionnaire

<table>
<thead>
<tr>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank you for participating in this study. Please read all the instructions carefully and answer all the questions as honestly as you can, ensuring not to leave any questions unanswered. On completion of the questionnaire, return it in the prepaid envelope attached. Your cooperation is greatly appreciated. All information gathered is anonymous and confidentiality is guaranteed.</td>
</tr>
</tbody>
</table>

This questionnaire was distributed by the NSW Nurses Registration Board on behalf of the researcher. No names or addresses have been or ever will be disclosed to the researcher.
SECTION A

Demographic Data:

1. Age in years: _____ yrs

Please Tick the correct answer.

2. Gender: Male □ Female □

3. Dependants: No children □ 1-2 children □ >2 children □

4. Highest Qualification: Certificate □ Diploma □ Degree □
   Grad Cert/Diploma □ Masters Degree □

   Other □ specify: ____________________________

5. Sexuality:

Please circle the number on the line that corresponds to your sexuality, using the criteria below:

0 1 2 3 4 5 6

0. Exclusively heterosexual with no homosexual tendencies
1. Predominantly heterosexual, only incidentally homosexual.
2. Predominantly heterosexual, but more than incidentally homosexual.
3. Equally heterosexual and homosexual.
4. Predominantly homosexual, but more than incidentally heterosexual.
5. Predominantly homosexual, but incidentally heterosexual.

6. Relationships: Single □

Married □

Defacto □

Same sex partner □

Separated/Divorced □
7. **Position held.**
Please indicate by ticking the position in which you are currently employed. If you hold more than one position, please tick the position in which you are predominantly employed.

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Admin/Management</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>Nursing Unit Manager</td>
<td>Nurse Academic</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>Asst Director of Nursing</td>
<td>Clinical Nurse Educator</td>
</tr>
<tr>
<td>Midwife</td>
<td>Deputy Director of Nursing</td>
<td>Nurse Educator</td>
</tr>
<tr>
<td>Clinical Nurse Consultant</td>
<td>Director of Nursing</td>
<td>Senior Nurse Educator</td>
</tr>
<tr>
<td></td>
<td>Area DON</td>
<td>Staff Development</td>
</tr>
<tr>
<td></td>
<td>Manager Nurse Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Area Manager Nurse Ed.</td>
<td></td>
</tr>
</tbody>
</table>

8. **Principal Area of Nursing Practice**
Please indicate by ticking the principal area of nursing practice in which you are currently employed. If you are currently working in more than one area of practice, please tick the area in which you are predominantly employed.

<table>
<thead>
<tr>
<th>Aged Care</th>
<th>Mixed Medical/Surgical</th>
<th>Women's Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical - General</td>
<td></td>
<td>Gynaecology</td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
<td>Mothercraft</td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
<td>Obstetrics/Midwifery</td>
</tr>
<tr>
<td>Endocrinology</td>
<td></td>
<td>Reproductive Medicine</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td>Mental Health - General</td>
</tr>
<tr>
<td>HIV related</td>
<td></td>
<td>Adolescent Mental Health</td>
</tr>
<tr>
<td>Immunology</td>
<td></td>
<td>Drug and Alcohol</td>
</tr>
<tr>
<td>Medical Imaging</td>
<td></td>
<td>Psychogeriatric</td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
<td>Emergency / Casualty / accident</td>
</tr>
<tr>
<td>Oncology-Generic/Haematology/radiotherapy</td>
<td></td>
<td>Intensive Care</td>
</tr>
<tr>
<td>Palliative Care</td>
<td></td>
<td>Acute Coronary Care</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
<td>Neonatal Intensive Care</td>
</tr>
<tr>
<td>Renal Medicine</td>
<td></td>
<td>Paediatric Intensive Care</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td></td>
<td>Aboriginal Health</td>
</tr>
<tr>
<td>Spinal Injuries</td>
<td></td>
<td>Community Nursing</td>
</tr>
<tr>
<td>Surgery - General</td>
<td></td>
<td>Child and Family Health</td>
</tr>
<tr>
<td>Operating Theatre/Recovery</td>
<td></td>
<td>Developmental Disability</td>
</tr>
<tr>
<td>Cardio-thoracic</td>
<td></td>
<td>Occupational Health</td>
</tr>
<tr>
<td>Burns</td>
<td></td>
<td>School Children's Health</td>
</tr>
<tr>
<td>Ear, Nose and Throat</td>
<td></td>
<td>No Area of Practice</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
<td></td>
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<tr>
<td>Orthopaedic</td>
<td></td>
<td></td>
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<tr>
<td>Plastic and reconstructive</td>
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<tr>
<td>Urology</td>
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<tr>
<td>Vascular</td>
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<tr>
<td>Transplantation</td>
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</tbody>
</table>
SECTION B

PERSONAL DESCRIPTION QUESTIONNAIRE

The task asks you to describe yourself. Below is a list of personality characteristics. Please use these characteristics to describe yourself. Indicate on a scale from 1 to 7 how true of you these various characteristics are. Please do not leave any characteristics unmarked.

Mark 1 if it is NEVER OR ALMOST NEVER TRUE.
2 if it is USUALLY NOT TRUE.
3 if it is SOMETIMES BUT INFREQUENTLY TRUE.
4 if it is OCCASIONALLY TRUE.
5 if it is OFTEN TRUE.
6 if it is USUALLY TRUE.
7 if it is ALWAYS OR ALMOST ALWAYS TRUE.

<table>
<thead>
<tr>
<th>Loves children</th>
<th>Competitive</th>
<th>Childlike</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firm</td>
<td>Casual</td>
<td>Anxious</td>
</tr>
<tr>
<td>Dependent</td>
<td>Timid</td>
<td>Devotes self to others</td>
</tr>
<tr>
<td></td>
<td>Self-critical</td>
<td>Feels superior</td>
</tr>
<tr>
<td>Patient</td>
<td>Logical</td>
<td>Boastful</td>
</tr>
<tr>
<td>Tense</td>
<td>Grateful</td>
<td>Loyal</td>
</tr>
<tr>
<td>Bossy</td>
<td>Sarcastic</td>
<td>Strong</td>
</tr>
<tr>
<td>Noisy</td>
<td>Forceful</td>
<td>Carefree</td>
</tr>
<tr>
<td>Needs approval</td>
<td>Clear thinking</td>
<td>Absent-minded</td>
</tr>
<tr>
<td>Rash</td>
<td>Weak</td>
<td>Rude</td>
</tr>
<tr>
<td>Show-off</td>
<td>Bashful</td>
<td>Sees self running show</td>
</tr>
<tr>
<td>Interesting</td>
<td>Mischievous</td>
<td>Outspoken</td>
</tr>
<tr>
<td>Appreciative</td>
<td>Responsible</td>
<td>Worrying</td>
</tr>
<tr>
<td>Nervous</td>
<td>Emotional</td>
<td>Gentle</td>
</tr>
<tr>
<td>Sensitive to the needs of others</td>
<td>Resourceful</td>
<td>Silly</td>
</tr>
<tr>
<td>Aggressive</td>
<td>Skilled in business</td>
<td>Pleasure-seeking</td>
</tr>
<tr>
<td>Confident</td>
<td>Shy</td>
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</table>
SECTION C

This task asks you to indicate whether you agree or disagree with the following statements. Please use the following scale to determine your answer.

<table>
<thead>
<tr>
<th>Please Circle</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>1. Nursing is a suitable profession for males.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Nursing is a more suitable profession for females than males.</td>
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<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
</tbody>
</table>

If you agree with this statement, what makes nursing more suitable for females?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
3. Male nurses are often stereotyped. 

If you agree with the above statement, give examples of how male nurses are stereotyped?

4. At your workplace, have you ever been discriminated against by nurses of the opposite sex because of your gender?  
   Yes ☐ No ☐  
   If yes, please describe how you were discriminated?

5. At your workplace, have you ever been harassed by other nurses because of your gender?  
   Yes ☐ No ☐  
   If yes, please give examples.

6. At your workplace, have you experienced any of the following.

   6.1 Written or printed material that put you down because of your gender or sexual preference and is displayed publicly, circulated, or put in your work space or belongings?  
      Please Tick  
      Gender ☐ Yes ☐ No ☐  
      Sexual preference ☐ Yes ☐ No ☐  

   6.2 Verbal abuse or comments that put you down or stereotype you because of your:  
      Please Tick  
      Gender ☐ Yes ☐ No ☐  
      Sexual preference ☐ Yes ☐ No ☐  

   6.3 Jokes based on your gender or sexual preference that you have found offensive?  
      Please Tick
6.4 People ignoring, isolating or segregating you because of your:

Gender
Yes □ No □
Sexual preference
Yes □ No □

If you answered yes to any of the above, could you please give examples.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
If you answered yes to any of the above statements in question 3, please indicate who were the main offenders? If there are more than one category offender, please number them in ascending order starting with the number 1 which represents the main offender.

- Same sex nurses
- Opposite sex nurses
- Other same sex health professionals
- Other opposite sex health professionals
- Same sex non professional health workers
- Opposite sex non professional health workers
- Same sex patients
- Opposite sex patients
- Same sex members of the public
- Opposite sex members of the public

If you answered yes to any of the above, please indicate how often/frequently the above occurred?

- Daily
- Weekly
- Monthly
- 6 monthly
- Annually
- Once only

Thank you for taking the time to complete the questionnaire. Your assistance is very much appreciated.
Appendix E: Open Ended Responses – Why is Nursing More Appropriate for Women?

Essentialist / Positivist view of gender
1. Women are more caring, sensitive and emotionally strong than the average male. (4)
2. Women have more affection and care built up into their system by gift of God (comparably to most men). (6)
3. Feminine instinct/protective of their perceived natural role in society. (18)
4. They have more maternal instincts than men. Women are generally tactful, diplomatic,
   females, they are more tender, understanding, caring,
5. More patient and caring. (32)
6. Women are more maternal hence more compassionate
7. Females more compassionate and caring. (36)
8. Nursing relies on the “feminine” aspects of personality: empathy, caring, feelings etc. (37)
9. Women more capable of showing greater compassion, more intuitive of a patients feelings. (42)
10. They (women) are usually more compassionate and sympathetic to people’s needs. (44)
11. Women are generally more tender, compassionate, sympathetic, gentle than men. (47)
12. Women are nurturers - men aren’t.
13. Women tend to be more compassionate and better able to cope with the personal emotional demands
   nursing places on them. (50)
14. Females tend to have more empathy for people when they are sick or in a disadvantaged or embarrassing
   situation. (52)
15. I believe women can be more compassionate and understanding of patients needs. (55)
16. Motherhood, natural instincts. (59)
17. Women are generally more caring than men. (62)
18. Women, appear to me, to be more caring than men
19. Women have a perceived tendancy for mothering/ caring and nursing has strong elements of this personal
   characteristics. (65)
20. Women generally have a more caring/ considerate approach than men. (67)
21. Maternal instinct
22. more compassionate. (75)
23. Women seem to be more compassionate towards others - empathetic. (81)
24. More compassionate. (82)
25. Generally women are more sensitive to the needs of others than men - probably due to the mother instinct.
26. Females tend to be more patient, caring and understanding of people, particularly when they are sick. (90)
27. Women appear to be more compassionate. (93)
28. Women tend to be more compassionate and tender
29. More caring. (101)
30. Women are often more aware of others needs and are more sympathetic and approachable.
31. Females, generally, have a more caring nature. (104)
32. Women are generally more compassionate
33. Females usually have the interpersonal characteristics required to be very good nurses. (107)
34. They provide a more caring approach
35. They have a greater capacity for “caring” and nurturing. (116)
36. more caring and empathize
37. Women are more conscientious, patient, sympathetic, warm and tender than men. (118)
38. They have an apparent ability to help people to relax. (123)
39. Instinct (124)
40. Females can be more understanding and caring for others with their maternal instincts. (128)
41. the inbuilt “mother-instinct” of females
42. Women are more compassionate, understanding, gentle hands and have motherly instinct. (131)
43. Females are kind, gentle and make things better. (133)
44. More caring in nature than men
45. women have a greater tendency for nurturing and caring
46. Women are generally more patient and care for others
47. Women are more compassionate and caring. (149)
48. Perception that women are more sensitive and caring. (150)
50. Women have softer personalities and are more caring. (151)
51. They are more understanding and compassionate in the majority. (153)
52. More patient, emotional and worrying. (155)
53. Tend to be more compassionate than males.
54. Have a sense of “mother”
55. Generally more compassionate and understanding personality, greater patience
56. Feeling towards others, more patience and understanding. (160)
57. They appear to be more caring and responsive. (169)
58. Females more clearly display caring qualities
59. Mostly females are more sympathetic/compassionate than males. (171)
60. Females are usually more responsive to peoples unspoken needs (vital attribute for very ill persons. (173)
61. Women appear to be more caring and understanding. (175)
62. Women in general seem to have more of a compassionate, caring side to their personalities than most males. (178)
63. Women are more compassionate, soft handlers, more tender, and more understanding. (192)
64. Women have a more caring, “maternal” image
65. Women are more sensitive and caring, quieter, more aware of pain
66. Females probably project a more caring impression for patients. (197)
67. Women are usually gentle
68. On average, more empathy, more communicative, more able to comfort patient, put patient at ease. (202)
69. Because they are tender. (204)
70. Kindness which is natural, soft spoken, sincere. (208)
71. Women tend to be more open with their feelings ie. Compassion etc. (in my experience) I also believe they have a more nurturing ability. (213)
72. Women are evolutionally nurturers. (215)
73. More caring. (217)
74. Women are more sympathetic to an individuals needs and people feel more comfortable around women when their personnel well being is concerned. (218)
75. Nurturing gender characteristics. (219)
76. Women are generally more caring. (220)
77. As a generalisation, I believe women are more caring by nature. (223)
78. Women more compassionate as a nurse. They have better interpersonal skills than men. (225)
79. They are traditionally lovers and carers and have more patience. (226)
80. Naturally they have the ability to look after their children and the family; they are soft;
81. Motherly/nurturing image females have. Tend to have more caring/understanding nature and communicate better (in touch with feelings of patients). (228)
82. Women are more caring. (230)
83. Generally have more compassion
84. Collective women are more humane than men. (339)
85. Caring/nurturing disposition. (241)
86. They tend to be more caring and sympathetic. (243)
87. Generally more compassionate and understanding.
88. Perception of caring and gentleness. Maternal characteristics. (247)
89. More caring, patient. (250)
90. Women do care more
91. Innate feminine characteristics ie. Sensitivity, empathy, care giving. (20)
92. Natural carers / nurturers. (31)
93. Women are more loving and caring. (43)
94. I think women are more careful and gentle than men. (46)
95. It is my opinion that females are, on average, more compassionate than males. (62)
96. Natural tendency to mother - women have an inbuilt rescue tendency need to help people, more than men. (67)
97. Women are more caring, warm, and understanding of others needs. (74)
98. Women are open with their feelings. (124)
99. Women are more patient, kind, and sympathetic than men. (134)
100. Natural tendencies in women to protect. (139)
101. Males are more into problem solving than looking into the emotional needs of others. (166)
102. Females are more naturally inclined to be nurturers which is the keystone to effective nursing. (168)
103. Women are far more compassionate than men. (180)
Women are more sensitive. Females tend to be in tune to others’ feelings/needs. Women biological make-up is empathetic, compassionate, caring for others. A mother is always a mother. Women are more sensitive, understanding. Women are more understanding and warm. Also genetically have a tendency to nurture. Females are more affectionate and willing to listen to others. More caring and compassionate. Females characters seems more inclined to good nursing practice. They are more understanding. Due to the natural caring, nurturing instinct inherent in the female sex. General female make up and personality. Women have a more caring and compassionate nature. High value on the feminine part of human beings i.e. nurturing, connecting, sharing of emotions, spirituality.

Women are more nurturing than males; is like mother instinct. More caring and compassionate. Females characters seems more inclined to good nursing practice. They have a natural predication. Most females seem to be more naturally caring and nurturing than most males. Women have the maternal touch. The instinctive and gentle nature of females make them more suitable. It is by its own definition a nurturing type of profession. Females are more caring, patient, often more gentle. Females have a more nurturing nature and are more compassionate. A female may be more caring, sympathetic, motherly position, caring for injured. Innate female qualities make them better nurses in general, they tend to be more industrious and observant.

Female Sex Role
1. Women should belong in more female based roles.
2. More suited to caring role.
3. It tends to be a more female orientated role, probably based on age-old preconceptions about men’s and women’s roles in society.
4. Males are hunter/gatherers while women are more maternal hence more compassionate.
5. Tasks are more in keeping with traditional female roles and therefore females are generally more proficient in them.
6. Traditional role for females.
7. It is cultural making it more accepted in our society (blame the wars and our grand parents).
8. Their tendency towards caring as they care for children.
9. I have grown up with my mother nursing my father through a long illness and my wife nursing our children - I am not good at it.
10. Traditional and biological role of carer.
11. Females usually care - males tend not to.
12. Women are generally better at a nurturing role.
13. Men have always seemed to be steered into more manly roles.
14. Nursing is a caring role which lends itself more to female disposition - more socially acceptable.
15. Traditional role for females.
16. Predominantly seen as a female role.
17. Traditional roles still evolving.

Preference for Female Carers
1. Identity and similar experiences with people of same sex. (25)
2. Just nice to have around the wards. (28)
3. There is not total acceptance by female patients that male nurses should be involved in personal attendance eg. Showering female patients. (48)
4. Women's bodies are more complex, greater need of nursing. Women more likely to know more about women's as well as men's needs. (51)
5. When a hospital patient I much prefer women to attend to me. (64)
6. Patients are more comfortable with women nurses.
7. Females can relate to both sexes better than males can.
8. If I am sick and weak, I would much rather be looked after by a compassionate woman. (93)
9. Many women patients would feel more comfortable (I think) with female nurses caring for them. (103)
10. Men rarely object to being nursed by a female. Women often do object to male nurses. (122)
11. I never had a male nurse attend to me, but I do not think that I would like it. (209)
12. It is easier and adaptable to have female nurses for male patients while male nurses may have embarrassing situations for a female patient. (216)
13. I think many elderly find it threatening having a male nurse particularly women. (187)
14. I prefer being looked after by a female nurse. (215)
15. I know I prefer a female caring for me during labour, its a female bonding thing I think, no male could ever know what its like and that's not a sexist statement, just a fact. (318)
16. Most patients like female nurses looking after them. (350)
17. Female patients may be uncomfortable with male nurses in some situations. (194)
18. General nursing clients are more comfortable with females, particularly the older generation in nursing homes.
19. Patients are generally more accepting of females and have accepting of invasiveness of nursing carried out by women.

Female work/Division of labour
1. Seem to like nursing more than men. (22)
2. Women will do menial tasks happily - men pass them off to women. (49)
3. Women more likely to accept conditions duty etc.
4. Women are generally more caring than men. (62)
5. Traditional Professional role. (68)
6. More women seem to be interested in the skills required for nursing. (74)
7. Women seem to like it and choose it. (120)
8. Women pay more attention to minor details. (141)
9. Patience to mundane tasks. (147)
10. Salaries are such that a single income family could not depend on nursing as the source of income for main bread winner. (157)
11. Qualities in the home that are ideal in a nursing environment. (170)
12. Female nurses are much more suited to midwifery and lactation (or anything else that needs are specifically female). Male nurses are definitely more suitable if strength (physical) is required eg. Lifting heavy bed ridden patients. (198)
13. There are more women in it and they re the leaders in the profession. (212)
14. Females who want flexible/part-time job and don't necessarily want to make a career in one place can be portable. (242)
15. In many cultures women have been and still are the chief nurturers and caregivers, therefore, I feel they have a greater understanding of a patients physical and emotional needs.
16. Very good in providing pleasant atmosphere or environment e.g. more tidy in a lot of ways. (18)
17. I guess the stereotype of a nurse being a female has stayed with me;
18. Females are more prepared to get the bedside job done.
19. There are more women in nursing. (81)
20. Males are not willing to do all aspects of the jobs. Men seem to be mostly happy to sit and chat, which is nice, but for example, they would leave someone uncomfortable, incontinent and wouldn’t worry. (105)

21. Women don’t mind working on the wards doing the mundane work, eg sponges, repetative work. Men tend to like more of a challenge eg. N.U.M., or working in high dependency areas i.e. I.C.U., emergency etc. We need a lot more nurses on the wards, community etc. So this is why females are more suitable. (113)

22. P/T hours, weekends, nights when bringing up families very hard for men, such a flexible profession for mothers. (183)

23. midwifery is an area of nursing men are not meant to be.

24. Women have a different way of taking care/ nursing patients just like a plain housewife looking after the house/food/clothing etc. With men being left in the home is not as good in household chores. (265)

25. willingness to see to the details of care. (306)

26. Midwifery more suitable for women - having had 2 children

27. More widely accepted to be female dominated. (345)

28. They are more willing to put up with a lot of shit. (43)

29. Their ability to undertake and often successfully complete several tasks at once, better than their male colleagues. (55)

30. It has always been a female dominated profession. (65)

31. Because females are in the majority

32. It is already a female dominated profession

33. Contrary to the political retoric there is minimal promotional potential at a clinical level therefore easy going, accepting, tolerant nature is required to survive or the ability to come and go. Women in my experience are able to do this more readily than men. (148)

34. In my view female nurses are less questioning and more accepting of hospital policies and procedures so often have a less conflictual relationship with management. (170)

Negative Consequences
1. Females usually care - males tend not to and if they do, they are misconceited as possibly being gay - so it is difficult for males to show that side of their character. (174)

2. Society stereotyping. (164)

3. homosexual connotation. (234)

4. I feel the one of the reasons there are more female nurses to male is stereotyping. (231)

5. far too many traditionalists or feminists making us feel unwelcome. (1.9)

6. Community attitudes and the different sexual needs of men and women. (1.12)

7. Predominantly female greater support is given between the female staff. (1.21)

8. Feel that there are still expectations (societal mainly) that men will not become nurses. It is considerably easier for women however. (1.29)

9. Social conventions including salary, public perceptions / expectations. (1.54)

10. Society expectations make the professional role easier to fill for women. (1.61)

11. The stereotyped image a lot of people have towards the concept and narrow mindedness. (75)

12. Public perception and pressure. (122)

13. Public perceptions and the acceptance is that it is a female occupation and males often dominate management ie CEO who like to manage females, a rising male will have lots of problems from CEOs. (150)

14. Female nurses remain more acceptable to the public than males.

15. There still remains the old girls club network for promotions and dispute resolution. (229)

16. I love nursing but I would warn other males about the sexual discrimination that is prevalent
Appendix F: Open Ended Responses – Stereotypes of Male Nurses

<table>
<thead>
<tr>
<th>Sexuality</th>
<th>Career Driven</th>
<th>Technical vs Caring</th>
<th>Manual Handling/Deals with aggression</th>
<th>Non-achievers</th>
<th>Lazy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Often thought to be gay (Sexuality is a real issue at work)</td>
<td>1. Not career driven.</td>
<td>1. More technically able - less compassionate.</td>
<td>1. We can always fix physical aggression (referring to patient aggression).</td>
<td>1. often thought to be less intelligent/ competent/ capable.</td>
<td>1. Lazy.</td>
</tr>
<tr>
<td>2. People in general have passed comments to me like male nurses are poofers.</td>
<td>2. Often considered more ambitious ie. &quot;Ladder Climbers&quot;, more often &quot;frightened doctors&quot;.</td>
<td>2. Generally perceived as rough, less sensitive and caring. Males are seen as being aware of the big picture, but not paying attention to smaller tasks required for complete patient care.</td>
<td>2. Used for heavy work security/tough stuff.</td>
<td>2. not bright enough to become a doctor.</td>
<td>2. All males are lazy.</td>
</tr>
<tr>
<td>3. Often presumed &quot;GAY&quot;.</td>
<td>3. very driven ambitions, people who aspire to the peak of the profession without regard for others</td>
<td>3. I believe that female nurses tend to see males nurses as less competent in their roles (as nurses).</td>
<td>3. Good for lifting heavy patients.</td>
<td>3. Trainee Drs.</td>
<td>3. Not capable in some tasks as females.</td>
</tr>
<tr>
<td>4. Assumed to be Gay.</td>
<td>4. Alternately they can be viewed as being opportunistic in favour of the large proportion of females in the profession.</td>
<td>4. Trouble makers, outspoken, always take on management role.</td>
<td>4. Again from my experience males not studying for higher grade</td>
<td>4. Some people think why males not studying for becoming a doctor, but nurses.</td>
<td>4. All male nurses are lazy.</td>
</tr>
<tr>
<td>5. Anecdotal evidence suggest that society at large have stereotyped male nurses to be homosexual.</td>
<td>5. You should be a NUM or administrator.</td>
<td>5. Expected to be able to fix things, equipment etc.</td>
<td>5. Couldn't get a real job! can't survive in the man's world.</td>
<td>5. You're a bit rough.</td>
<td>5. Often regarded as lazy or unreliable.</td>
</tr>
<tr>
<td>6. Often assumed to be homosexual, although I feel that this is changing.</td>
<td>6. Thought to be out to be managers and nothing else, just more eager to achieve.</td>
<td>6. Expected to be interested in technology.</td>
<td>6. non-achievers.</td>
<td>6. Lazy.</td>
<td>6. You're a bit rough.</td>
</tr>
<tr>
<td>7. Quite often they are presumed gay and treated as such until otherwise proven otherwise.</td>
<td>7. Just in it for money and management.</td>
<td>7. males are often perceived as the dominant determining staff member.</td>
<td>7. Most elderly patients call me uncaring or</td>
<td>7. Male nurses are stereotyped</td>
<td>7. Lazy.</td>
</tr>
<tr>
<td>8. Male nurses are seen as either homosexual, effeminate.</td>
<td>8. Manager orientated.</td>
<td>7. Often thought of as lazy.</td>
<td>8. male nurses are considered less caring and compassionate. This may have more to do with lack of expression rather than of feeling.</td>
<td>8. Gay! Less masculine nurses are all in critical care, impatience and rough. Not 8. Gay or jobs within the shortest time frame.</td>
<td>8. Too lazy.</td>
</tr>
<tr>
<td>9. Public perception in particular country areas, is that male nurses are (or have homosexual tendencies) homosexuals.</td>
<td>9. Career orientated and want top jobs</td>
<td>9. Male nurses may be considered less caring and compassionate. This may have more to do with lack of expression rather than of feeling.</td>
<td>9. &quot;Men just don't understand&quot;.</td>
<td>9. You are physically strong.</td>
<td>9. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>10. In my experience male nurses are often considered and presumed to be homosexual.</td>
<td>10. Female nurses tend to think that male nurses climb the ladder quicker because of the fact that they re male, not because they deserve to.</td>
<td>10. You should be able to fix the equipment.</td>
<td>10. Better for manual handling, dealing with aggressive clients. Better in psych than general nursing.</td>
<td>10. &quot;Men just don't understand&quot;.</td>
<td>10. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>11. In my experience male nurses are seen to be gay or stupid mainly gay by the general public.</td>
<td>11. All males just want admin jobs.</td>
<td>11. Impatient and rough. Not careful. Do not focus on small details.</td>
<td>11. Male nurses are stereotyped as strong but no brains.</td>
<td>11. Hand me down doctors.</td>
<td>11. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>12. Gay/ Less masculine</td>
<td>12. aggressive and after the top jobs within the shortest time frame.</td>
<td>12. Considered more concerned with admin, technical side of nursing, computing etc. rather than people oriented.</td>
<td>12. A catch 22 question? The public (those who are unenlightened) may view male nurses as a stereotype ie., useful for certain tasks and duties. Those more enlightened see no difference.</td>
<td>12. When are you going to get a mans job.</td>
<td>12. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>13. Assumed homosexual, weak.</td>
<td>13. The girls often say that male nurses are all in critical care, psych and administration areas as a way to climb the ladder quicker.</td>
<td>13. You don't care</td>
<td>13. Not seen as hard workers anymore</td>
<td>13. Felt when are you going to get a mans job.</td>
<td>13. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>14. by public and nurses think if your a male nurse your gay.</td>
<td>14. a stepping stone to medicine/administration</td>
<td>14. Male nurses are not compassionate because men generally are not. Traditionally the caring role in society has always been done by a woman therefore men in</td>
<td></td>
<td>14. Inept at doing other professions.</td>
<td>14. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>15. I think the community to some extent sees male nurses as effeminate.</td>
<td>15. a stepping stone to medicine/administration</td>
<td>15. Male nurses are not compassionate because men generally are not. Traditionally the caring role in society has always been done by a woman therefore men in</td>
<td></td>
<td>15. Inept at doing other professions.</td>
<td>15. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>16. Whether your heterosexual or not - most people assume your gay.</td>
<td>16. Disproportionately represented in higher grade positions.</td>
<td>16. You don't care</td>
<td></td>
<td>16. Failed doctors.</td>
<td>16. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
</tr>
<tr>
<td>17. Still the old stereotype of being effeminate!</td>
<td>17. Assumed to be ambitious</td>
<td>17. Male nurses are not compassionate because men generally are not. Traditionally the caring role in society has always been done by a woman therefore men in</td>
<td></td>
<td></td>
<td>17. The girls often say that male nurses are seen to be gay or stupid mainly gay by the general public.</td>
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<tr>
<td>18. Some people still think male nurses are likely</td>
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<td></td>
<td></td>
<td></td>
<td>18. Inept at doing other professions.</td>
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</table>
homosexual.

19. In my experience nursing is usually regarded by the general public as being a less than manly occupation. My male sporting associates often joke, seem surprised or have difficulty associating me with the role (or perhaps their perception of it). When studying at uni my male relatives often referred to my course as “your trade” at the time it seemed like a feeble attempt to masculinise the profession. It was as though they were embarrassed.

20. Frequently stereotyped as being frequently homosexual


22. Homosexual /Efeminate/ Weak personality (woose).

23. Some stereotyping still goes on that male nurses are still considered to be homosexual although this stereotype is rapidly decreasing.

24. Male nurses are often perceived as a bunch of poofers.

25. Often thought of as homosexual.

26. Male nurses are occasionally associated with being homosexual.

27. All male nurses are gay and weak.

28. Probably gay.

29. As being weak, overly sensitive, effeminate and homosexual.

30. You must be gay.

31. Homosexual

32. As being gay

33. Effeminate, insecure, emasculated

34. Must be homosexual or possess feminine traits.

35. They are usually seen as soft, slightly feminine and non assertive people.

36. Gay

nursing are viewed in this category still.

15. Gravitate to Admin or icu.

16. Also mainly seen as administration or authority type jobs.

17. Wont do a good job, messy, cant be compassionate, nursing is just a stepping stone to medicine/management, only interested in technological aspects.

18. Desire to work in stressful areas of icu, emergency etc.

19. Expected to adopt disciplinary role.

20. More suited to administration which I believe is untrue.

21. Male nurses cannot be real nurses because males lack the ability to empathise, be gentle, or compassionate.

22. Uncaring, insensitive, lack the female touch, more suited to administration.

23. Stereotyped as managers and not clinical nurses.

help with the lifting”.

14. “Male nurses are handy to have about to do the heavy lifting work or to deal with aggressive patients”.

15. Used in security roles because of strength/ size

16. Always there to lift patients and do heavy work.

17. Lifting patients

18. Any aggressive act, manual handling task, awkward non traditional task, men are expected if not demanded to be there.

19. Used as the workhorse

20. Able to cope with situations

21. Given jobs which involve danger or that will benefit from added muscle. Male staff used to resolve disputes with hostile pts. Male staff used as bodyguard for other health care staff.

22. Useful to help with heavy duties eg lifting

23. Good for lifting

24. Used for heavy work.

25. Often called upon to do home visits that could be considered to be unsafe. Some times seen in a body guard male.
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<tr>
<td>37.</td>
<td>You may well be gay.</td>
<td>Still viewed by many people as all males (nurses) must be gay.</td>
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<td>38.</td>
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<tr>
<td>39.</td>
<td>I have been to parties basically getting the &quot;green light&quot; from girls I have spoken to and when they find out you're a nurse they just walk off. Some male and rarely female patients treat you as if your automatically gay. Often their whole attitude towards you changes when they find out you're married with kids.</td>
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<td>40.</td>
<td>As effeminate/homosexual.</td>
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<tr>
<td>41.</td>
<td>&quot;All male nurses are gay.&quot;</td>
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<tr>
<td>42.</td>
<td>Most male nurses are homosexual.</td>
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<tr>
<td>43.</td>
<td>Homosexual tendencies.</td>
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<tr>
<td>44.</td>
<td>Homosexual.</td>
<td></td>
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<tr>
<td>45.</td>
<td>Always gay.</td>
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<tr>
<td>46.</td>
<td>Gay</td>
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<td></td>
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<tr>
<td>47.</td>
<td>Male nurses are often stereotyped as gay, weak and effeminate.</td>
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<tr>
<td>48.</td>
<td>All male nurses (or a majority) are Homosexuals,</td>
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<tr>
<td>49.</td>
<td>Effeminate</td>
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<tr>
<td>50.</td>
<td>Men in nursing are seen as effeminate linked in the public's mind with men in hairdressing and ballet.</td>
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<tr>
<td>51.</td>
<td>Males are often called gay, bent, effeminate, etc.</td>
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<td></td>
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<tr>
<td>52.</td>
<td>However some women are called butch, dykes, leso's etc.</td>
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<tr>
<td>53.</td>
<td>Often than not people believe you are all homosexuals. Certainly the late 1960's-70 and little has really changed.</td>
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<tr>
<td>54.</td>
<td>I done my General training in 62-65 at the time there were not many males in nursing – I think there was a general feeling that male nurses may be effeminate or even gayish.</td>
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<tr>
<td>55.</td>
<td>Occasionally I've had an initial response or question from a patient or carer wondering if I'm</td>
<td></td>
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</table>
Appendix G: Human Ethics Approval for Life History Study

HUMAN ETHICS COMMITTEE
The University of Sydney
Room K4.01 Main Quad A14
Sydney 2006
Tel: (02) 9351.4474 Fax: (02) 9351.4812 E-mail: human.ethics@reschols.usyd.edu.au

Professor R Connell
Faculty of Education
A35
17/05/2002
Dear Professor Connell

Title: An exploration of the experiences of men in nursing
Ref No: 02/03/15

Thank you for your undated correspondence addressing comments made to you by the Committee. After considering the additional information, the Executive Sub-Committee approved your protocol on the above study.

The additional information will be filed with your application.

In order to comply with the National Statement on Ethical Conduct in Research Involving Humans, and in line with the Human Ethics Committee requirements the Chief Investigator's responsibility is to ensure that:

1. The individual researcher's protocol complies with the final and Committee approved protocol.
2. Modifications to the protocol cannot proceed until such approval is obtained in writing.
3. The confidentiality and anonymity of all research subjects is maintained at all times, except as required by law.
4. All research subjects are provided with a Subject Information Sheet and Consent Form.
5. The Subject Information Sheet and Consent Form be on University of Sydney letterhead and include the full title of the research project and telephone contacts for the researchers.
6. The following statement appears on the Subject Information Sheet:
   Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney, on (02) 9351 4811.
7. The standard University policy concerning storage of data should be followed. While temporary storage of audio-tapes at the researcher's home or an off-campus site is acceptable during the active transcription phase of the project, permanent storage should be at a secure, University controlled site for a minimum of five years.
8. A progress report is provided by the end of each year. Failure to do so will lead to withdrawal of the approval of the research protocol and re-application to the Committee must occur before recommencing.
9. A report and a copy of the published material is provided at the end of the project.

Yours sincerely

[Signature]
Associate Professor Stewart Kellie
Chairman
Human Ethics Committee

cc. Mr M Fisher, Department of Clinical Nursing M02
Information for Participants

You are invited to participate in a research project entitled "An exploration of the experiences of men in nursing".

Working in a predominately female (92%) profession, perceived to be doing domestic work, and the perception of nursing to be attuned to feminine personality characteristics brings into question the masculinity of men in nursing. This study aims to examine the experiences of men who are nurses with a view to investigate social practices in which relationships between male nurses and others are constructed. This research project is being conducted by Murray Fisher as part of a PhD thesis in the Faculty of Education, University of Sydney.

This study will ask you to describe your relationships within the institutions of the family, work and other social networks. By examining these relationships, social practices that construct gender relations are identified. This study will explore the issues that may place the construction of masculinity for male nurses under pressure and to identify strategies male nurses employ to overcome these pressures.

The design of this project is qualitative, specifically semi-structured interviews of 20 male nurses. The interviews will be conversation style, focusing on 7 key areas: personal/social background; professional history; daily interactions with patients, other health professions, administration and the public; image of men in nursing; difficulties/disadvantages for men in nursing; advantages for men in nursing; and their view of how the profession is changing ie., the future gender dynamics.

Participation in this study requires you to be interviewed, which will involve you talking about personal issues. The interviews will be audio taped, from which transcripts will be analysed for recurrent themes. The interview will take approximately 90 minutes. To be eligible for this study, you will have a minimum of 10 years experience as a registered nurse.

All of the information gathered for this study will remain confidential. Audiotapes and transcripts of interviews will not contain any markings by the researchers that will allow the participants to be identified. Participants' records of interviews will be named "person #1", "person #2" etc. In reporting the data, information that would lead to the identification of individuals will not be included. Only the researcher and supervisor will have access to original material. Your participation is voluntary and you are permitted to withdraw from the project at any time without penalty or prejudice.

If you require further information, please do not hesitate to contact us on the telephone numbers indicated below.

Any person with concerns or complaints about the conduct of a research study can contact the Manager of Ethics and Biosafety Administration, University of Sydney, on (02) 9351 4811.

R Connell
Murray Fisher
RESEARCH STUDY: AN EXPLORATION OF THE EXPERIENCES OF MEN IN NURSING.

PARTICIPATION CONSENT FORM

I, .................................................................................................................. (name) have read and understood the Information for Participants on the above named research study and have discussed the study with ....................................................................................

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I understand that the interview will be audiotaped.

I hereby agree to participate in this research study.

NAME: ............................................................................................................

SIGNATURE: .....................................................................................................

DATE: ..................................................................................................................

NAME OF WITNESS: .........................................................................................

SIGNATURE OF WITNESS: ..............................................................................

The University of Sydney
Faculty of Education
SCHOOL OF POLICY AND PRACTICE
Appendix J: Life History Interview Schedule

Interview Schedule
The interview will be conversation/narrative style (tell me about...) and will focus on the following areas:

Personal/Social background
- Family relationships from childhood / since entering nursing
- Family in nursing/health
- Friendships from childhood / since entering nursing
- Sexuality / Sexual relations

Narrative of Professional Life
- Job history and its meaning
- Experience of gender relations in nursing and position of male nurses - patients and families, nurses, medical officers and other professionals.

Labour process of nursing
- Daily work
- Interactions with patients, other healthcare professionals, others
- Use of technology etc

Workplace
- Management
- Industrial issues
- OHS issues
  - body issues in work
  - division of labour
  - violence, safety
  - wear and tear

Image of men in nursing
- What is/are the image/s of men in nursing?
- How are male nurses portrayed? Media, TV, Magazines, papers etc.

Difficulties/disadvantages for men in nursing
- What strategies do men use to overcome these (eg. Denial - degender nursing)

Advantages for men in nursing as experienced by them

View of how the profession is changing
- Future gender dynamics.