Inhabiting a woman's world: the experience of male general student nurses in the Republic of Ireland

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Doctorate in Education (EDD)

June 2018

Keele University

ABSTRACT

This thesis explores the experience of being a male general student nurse in the feminised world of nursing in the Republic of Ireland, where only 5% of general nurses are male. The main focus of the thesis is the experienceof male general student nurses in relation to their conceptualisations of their work, their masculinities and how they negotiate gendered identities. The research questions centred on the men's feelings, perceptions and ways of coping and therefore the overall approach was framed within a broadly interpretative perspective. Using Interpretative Phenomenological Analysis (IPA) the thesis set out to research how the male general nurses make sense of the world in which they find themselves and specifically what it is to be a male general student nurse in the female world of nursing. I carried out 10 in-depth one-to-one interviews with male general student nurses who were in their final year of training. The findings showed that the participants considered they were treated differently because of their gender. Discrimination was both positive and negative. This thesis represents a snapshot in time. It contributes to the overall knowledge of what it is like to be a male general student nurse in the feminised world of nursing in the Republic of Ireland. At the time of the thesis, there was little other research work on a similar cohort of participants. The thesis illuminates the advantages and disadvantages to being male in this world, even before they complete the programme and become registered general nurses.

CONTENTS

LIST OF TABLES

GLOSSARY

CPC	Clinical Placement Co-ordinator
EdD	Doctorate in Education
HEI	Higher Education Institution
IPA	Interpretative Phenomenological Analysis
MDT	Multi-Disciplinary Team
NMBI	Nursing and Midwifery Board of Ireland (previously *An Bord Altranais*)
OWE	Organisational Work Ethnography
RCN	Registered Children's Nurse
RGN	Registered General Nurse
RM	Registered Midwife
RNID	Registered Nurse Intellectual Disability
RPN	Registered Psychiatric Nurse

ACKNOWLEDGEMENTS

I wish to express my sincere thanks to all those people who have helped in the completion of this thesis.

A special word of thanks to the participants who gave so generously of their time and for their thought-provoking contributions. I would also wish to thank the staff in the HEIs where the participants were attending.

My then workplace, *An Bord Altranais*, was most generous in affording financial and other assistance and I am most grateful to the Board and staff for their extraordinary support. I am thankful to my community of practice: my former colleagues Dr Ryan and Professor Kearns.

I wish to thank the staff at Keele University who guided me along the path including the academic and administration staff and my earlier supervisors Dr Waterfield and Dr Whitehead. I wish to express my heartfelt gratitude to my supervisor Professor Farzana Shain for her patient support and guidance and encouragement.

I would like to thank my lifetime friend Rosary Morley who assisted with the transcribing. Sadly, she died and was not able to see the final thesis. May she rest in peace.

I would like to thank my friend Dr Rossney for her support and encouragement.

I wish to express my gratitude to Dr Karen Castle for her support during my time in the UK.

Finally, to all my friends and family and especially my mother, who listened to and tirelessly supported me on my journey.

CHAPTER 1: INTRODUCTION TO THE THESIS

1.1. OVERVIEW

This thesis sets out to explore what it means to a group of male general student nurses to be a man in a world that is traditionally dominated by women. It is contextualised within a workplace where the characteristics of being a nurse are the expected characteristics of being a woman. Being a general nurse has been, and continues to be, closely linked with being a woman, including traits such as nurturing and caring. There has also been an expectation that the female nurse would be subservient and obedient, often to the male doctor, with the male traits being seen as strength and dominance. Therefore, being a male general nurse has been, and to an extent continues to be, viewed as being 'unnatural.'

This introductory chapter gives an overview of nursing in the Republic of Ireland. It outlines my own context and my place in the research including my own relative position as insider-outsider. There is an overview of a piece of work relating to my Organisational Work Ethnography (OWE, 2007) that I carried out as part of the EdD programme. This OWE assignment formed the basis in choosing to explore the experiences of male general student nurses. Aims and research questions pertaining to the research are introduced. There is an overview of gendered identities plus feminization as the underpinning conceptual framework to the research is introduced. The methodology is briefly considered. There is an introduction as to how my research might enhance knowledge. This chapter concludes with an introduction to the thesis structure and a summary.

1.2. THE CONTEXT OF NURSING: REPUBLIC OF IRELAND

In the Republic of Ireland, nurses and midwives are governed by the *Nurses and Midwives Act 2011* (previously *The Nurses Act, 1985*, which legislated for *An Bord Altranais*: The Nursing Board). The current governing regulation and registration authority under the 2011 Act is *Bord Altranais agus Cnáimhseachais na hÉireann*: the Nursing and Midwifery Board of Ireland (NMBI, 2014). The NMBI maintains a Register of Nurses and Midwives. There are 10 Divisions of the Active Register and the total Active Register shows that males comprise less than 8% but they account for only 5% in general nursing (Refer Table 1).

Table 1: **NMBI Register Profile by Gender** (NMBI, 2014)

Division of the Active Register	Female	Male	% Male
RGN	52,249	2,908	5%
RPN	6,732	2,420	27%
RNID	4,310	468	10%
RCN	4,194	71	2%
RM	11,590	23	0.2%
Total Active Register	61,555	5,206	8%

The nursing education programmes available in the Republic of Ireland may be at pre-registration level, that is, for the person who is not on any part of the Register, or at post-registration level, that is, for the nurse or midwife who is already on one (or more) parts of the Register (Refer Appendix A). Since 2002, all pre-registration programmes are at honours degree level: commencing in 2002 with the general, psychiatric and intellectual disability nursing programmes and in 2006 with the addition of midwifery and the children's (integrated with general) nursing programmes. An applicant

applies to the Central Applications Office (CAO). This organisation caters for applications for the majority of all third-level courses. An offer of a place is determined on a competitive basis usually on the grades attained in the final second-level school examination (leaving certificate) and gender is not a factor. When an applicant for nursing or midwifery accepts a place, she/he then applies to NMBI to have her/his name placed on the Candidate Register. The number of applicants applying for nursing or midwifery has continued to show an upward trend with the percentage of men applying continuing to show variation between the five Divisions of the Register (Refer Appendix B). The number of men entering the General Nurse Candidate Register remains low at on average 5% (Refer Table 2).

Table 2: **General Student Nurses on the NMBI Candidate Register 2002 to 2010**

(NMBI, 2014)

Year	Total	Female	Male	% Male
2002	1016	965	51	5
2003	1165	1096	69	6
2004	1091	1033	58	5
2005	1088	1032	56	5
2006	1155	1090	61	6
2007	1174	1119	55	5
2008	1148	1102	46	4
2009	967	919	48	4
2010	1010	938	72	7

Registration as a general nurse affords a passport to travel the world and to work *en route*. This desire to travel is evident by the number of verification requests to the NMBI, whereby the receiving country requires verification of a nurse's registration. There are many advances and career promotion opportunities and a nurse or midwife can become an independent prescriber of medication and can work autonomously as an advanced practitioner. At the start of my thesis, the salary was comparatively competitive. Neverthelessthe number of males on the General Division of the Candidate Register has remained comparatively low, a factor that I clearly witnessed throughout the different stages of my career.

1.3. MY OWN BACKGROUND AND THE RESEARCH TOPIC

I completed 2nd level school aged 18 years intending to study English at university. During that June and July as I awaited examination results, I had a summer job working in the laundry attached to a residential centre for people with an intellectual disability and in the afternoons when the laundry was quiet I helped out on the wards. After a few weeks the Matron called me to her office asked me if I would start as a student nurse in the autumn. I laughed, thought about my place in university, and said 'Yes!' and so the scene was set for a hugely rewarding career that has oft times changed; afforded me amazing opportunities to travel all over the world, to meet some really lovely people and to have had such great fun along the way. My intellectual disability nurse (RNID) training was followed by general nurse (RGN) training and subsequently further training in different spheres of nursing.

I have taken many different paths including a BA in English, History and Philosophy followed by a MA in English where I examined the concept of self in literature. I studied Theatre and Film and got wonderful parts as a professional actress. My nursing career continued in a non-planned path. I

worked to the highest level at ward, hospital management and teaching. When I commenced the EdD programme, I was working at national and international level in Regulation and Education, where my work included an inspectorial role of education programmes both in HEIs and in the clinical setting. I also had a role in national policy making regarding education and regulation of nursing. One of the projects with which I was involved was manager of the national promotion and marketing campaign, with the main focus being to encourage school-leavers and mature people to apply for nursing at pre-registration level. The campaign was highly successful but despite gender-neutral campaigns, the number of men applying for general nursing remained little changed. Half way through the EdD programme my work role changed and I became involved in European Union nursing regulation harmonisation and later in the regulation and registration of advanced nursing and midwifery practice in Ireland.

I have travelled extensively during my career and have always been struck by the low number of men in nursing, most notably general nursing, and as juxtaposition by the proportionately high number of men in senior positions. I developed an interest in the concept of gender within nursing and the opportunity emerged to look at this more closely as part of my assignment on Own Work Ethnography (OWE: refer 1.4) which was a component of the EdD programme. This assignment was to be carried out in my own working environment or one that closely related to my work at the time. Following exploration with the EdD programme director, it was agreed that because of the then nature of my work, it would be appropriate to conduct the OWE in a HEI in which my work was closely linked. The OWE served as a pilot study for my subsequent research.

1.4. ORGANISATIONAL WORK ETHNOGRAPHY (OWE)

Part of the EdD programme was to undertake an assignment using ethnography as a qualitative methodology: “The core strategy in the field methods used in ethnography is the direct observation of naturally occurring *in-situ* actions; additional strategies include informal and formal interviewing, the collection of documents and artefacts, and the making of field recordings. The researcher’s own experiences inevitably also play a role, whether explicit or implicit” (ten Have, 2004. p 131).

I undertook this OWE in a largeHigher Education Institution (HEI) in the Republic of Ireland. From my own experiences with the healthcare systems in a number of countries I had always felt that gender had played a significant role with the nursing profession. Therefore, the main focus was to broadly look at gender within the organisation. More specifically it was to investigate gender as an issue in nursing within the organisation. I considered a number of aspects including: policy issues and gender overall; gender and nursing within the organisation; charms and challenges among male nurse lecturers by virtue of gender; and charms and challenges among male student nurses by virtue of gender. “Ethnography…attempts to build a picture of the language, relationships and social meanings used by a group of people using a common, cultural identity” (Jolley, 2013. p 172). For me to build a picture of the HEI regarding gender, I decided to look at the organisation overall and specifically at gender and nursing education within the HEI. Drilling down further, I considered that the study should explore how the male nurse lecturers and the male student nurses considered that their gender had acted in their favour or against them during their experiences as nurses. Therefore, I decided to approach the ethnography as follows:

Policy Issues and Gender Overall

Meeting with the Admission Officer in a one-to-one interview to discuss:

Policy on gender in the HEI

Gender distribution among staff

Any areas where there was an imbalance in the gender distribution among staff

Any areas where there was an imbalance in the gender distribution among students

Changes in trends among students in certain traditional gender-biased departments.

Gender and Nursing Education within the HEI

Meeting with the Deputy Head of the School of Nursing in a one-to-one interview to discuss:

History of nursing education within the HEI including gender overview at pre-registration level and at post-registration level

Statistics on gender among staff and students

Promotion and marketing campaigns carried out by the department

The gender aspect to these campaigns

The policy of the School of Nursing regarding gender.

Charms and Challenges among Male Nurse Lecturers by Virtue of Gender

Meeting with three male nurse lecturers in an individual one-to-one digital voice recorded interview to discuss:

The aspects that gender played in choosing a career in nursing and throughout that career

The challenges faced, as a man, in deciding to be a nurse and subsequently throughout his nursing career

Any advantages experienced in nursing by virtue of gender.

Charms and Challenges among Male Student Nurses by Virtue of Gender

Meeting with two groups of male student nurses, one group from 1st year and one group from 4th year in a digital voice recorded focus interview format to discuss:

The aspects that gender played in choosing a career in nursing and throughout the programme in nursing

The challenges faced, as a man, in deciding to be a nurse and subsequently throughout the programme

Any advantages experienced in the programme by virtue of gender.

I requested statistics regarding gender among academic teaching staff. These statistics needed to be considered within the recent social history of the education of men and women in the Republic of Ireland. Free-education for second-level education was not available until the late 1960s. As a result, relatively few females completed second-level education and fewer still progressed to third-level. Women who did enter third-level went into more traditionally female areas such as teaching. The marriage bar, which excluded women from large areas of the workforce after marriage, was not lifted until the 1970s. As a result of these two factors, it would be reasonable to expect that it would take time for any gender imbalance in education to be re-dressed, especially at senior level. However, by the time this ethnographic study was undertaken in 2007, I would have expected that there would be a relatively equal distribution of men and women working within the HEI system. The statistics showed that of the 1,000 plus academic teaching staff in the HEI, the gender split was 40% female and 60% male. Of the total student, population of nearly 21,000, 55% were female.

There were marked contrasts in gender distribution in some programmes within the university. An example was in those programmes pertaining to engineering and mathematics, where only 16% of the staff was female. Interestingly, in the areas of engineering and mathematics that would have

been traditionally male-dominated, 39% of the students were female. Because the intended focus of my research was nursing, I decided to look more closely at the gender statistics of students in the areas of life science and found that whereas in medicine 38% were male, in nursing it was less than 8%. In regard to nursing, the statistics confirmed for me the huge imbalance that exists in a profession that is so highly female dominated. The gender gap is clearly narrowing in engineering and in medicine. Medicine, which, like engineering would have been traditionally male, now had a significant higher % of female students. In stark contrast, nursing students remained predominantly female.

My OWE indicated that male general nurses (lecturers and students) considered that they were treated differently by nurses (and others) compared to their female colleagues. My findings clearly indicated that gender is a key factor in nursing in the Republic of Ireland. Some overall concepts began to develop from the OWE. To varying degrees, the overall concepts clearly had a gender underpinning, with the participants viewing that their gender had both positive and negative influences on how they were treated (Refer Table 3).

Table 3: **Overall Findings from OWE (2007)**
GENDER AS A FACTOR MITIGATING AGAINST MALES APPLYING FOR GENERAL NURSING
Sparse guidance to second-level school boys regarding nursing as a career: "Why would you want to go off and do woman's work" "It's a girl's job. It's not a man's job"
Laughter when males say they're interested in nursing: "I thought you were a lad's lad"
Half-joking comments by friends such as "you must be a sissy"
Perception that male nurses are homosexual
Play as a child involved the boys being the doctors and the girls being the nurses; even in role play on the nursing programme when the doctor was played by a female and the nurse by a male, it was perceived as being more humorous than when played the other way round
GENDER: NATURE OF THE WORK
Concern from others "Could you take the crap that a woman would?"
Tradition of Irish men wanting to be seen as manly and not wanting to be seen in the role as carer
Perception by society that nursing is women's work and that it requires female characteristics
Perception that nurses wheel people in and out of toilets or on and off commodes
Obedience has been a key component in nursing; men don't take well to being obedient
GENDER: SALARY
It's not a breadwinner's job
It doesn't pay to care
Salary, conditions and long hours not attractive to the man
Men prefer prestigious better-paid jobs like medicine, engineering, and physiotherapy

Table 3: **Overall Findings from OWE (2007)** continued
GENDER: POSITIVE BEING A MALE IN GENERAL NURSING
Treated differently (better) by the older patients because of the Irish tradition of the man being in charge of the family
Female colleagues perceive that male nurses are "treated differently…get away with more…blessed is he among women"
Procedures saved so that the male students could observe/participate. The same consideration not always afforded to female colleagues
No problem in males changing duty-rota but female colleagues did encounter a problem
Male doctors consider the viewpoint of male nurses more than the viewpoint of female nurses
Preferential treatment given to the supervision of the male students
Male nurses being addressed as 'Mr' whereas female nurses being addressed as 'Nurse.' Introduced to the patients as 'Male Nurse…'
Because they are in the minority, staff and patients will learn their names much quicker

Table 3: **Overall Findings from OWE (2007)** continued
GENDER: NEGATIVE BEING A MALE IN GENERAL NURSING
Initial culture shock being surrounded by so many females, especially if from an all-boys school
Feeling of being "mothered"
A lot of cliquishness, bossiness, bullying by middle-aged female nurses
Laughter when the male nurse says he's been dealt with inappropriately by female patients but support and sympathy when the female nurse says she's been dealt with inappropriately by male patients
Tendency to be put working with male patients whereas their female colleagues work equally with both male and female patients
Excluded from certain areas like gynaecology or breast care
Being called on when patients need turning or lifting and when day's work is finished 'come out crippled'
'Come back when you qualify. It'll be great to have a male to do all the lifting'
GENDER: PROMOTION OPPORTUNITIES
Proportionately more men in nurse management roles; Men have more drive; Females have different priorities; Mechanism for men to "get out of the female stuff"
Sense that female colleagues are pushing male colleagues to go for promotion "Why don't you go for that, you're a man."
As he finishes his first allocation, a 1st year student being told half-jokingly by a registered female nurse: "The next time you're back in the hospital it'll be as my boss"

The findings from OWE reiterated what I had experienced in nursing at the different levels of clinical, education and management. From this introduction into the feelings and perceptions of

male general student nurses and male registered general nurses, I began to explore this area more closely and the thesis title emerged as: “Inhabiting a Woman’s World: The Experience of Male General Student Nurses in the Republic of Ireland.”

1.5. AIMS AND RESEARCH QUESTIONS

Aims

The research aimed to find out what it was like to be a man in a female dominated world and how gender had been an influence. It explored the reactions to the participants when they first stated that they were going to enter nursing coupled with the reactions of people since they started as student nurses. It explored the masculine gender identity of the male general nurse participants and if having spent almost four years in the nursing arena, this identity had changed. The research investigated the coping strategies used by the participants to assist with integration into this other-gender world (refer 4.2.1).

Research Questions

1. In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

2. How do the male general student nurses understand their gendered identities?

3. In what ways do the male general student nurses feel that their masculinities have been reinforced and/or challenged by their professional identity?

4. What strategies do the male general student nurses use to integrate themselves into the nursing profession?

1.6. THEORISING GENDERED IDENTITIES

The traditional image of the nurse is a female in crisp white uniform and starched hat smiling angelically and wiping the fevered-brow of the sick, while being the obedient handmaiden of the male doctor. Expected characteristics of being a nurse or of being a woman have been traits of being gentle, caring, sympathetic, empathetic, tolerant, patient, nurturing and deferent. The broad underpinning to the conceptual framework of the experience of male general student nurses in this thesis is feminization. Feminisation relates to the numerical dominance of women in any profession or line of work with the consequent lowering of pay, status and recognition of the work because it is seen as women's work. Feminization is an important concept in understanding the numerical dominance of women in general nursing and the gendered characteristics of general nursing. When an occupation, such as general nursing, has a numerical dominance of females, it is considered feminized. Simpson (2009) considers that it is the "domain of women to be undervalued and work deemed suitable for men to have a higher status" (p 7). With low status comes low pay. Such concepts may well have implications for the male general student nurse in deciding to enter nursing and throughout his four-year training and nursing career.

Gender as a sociological study is relatively new and it was not until the 1970s that it became a distinct study in its own right. Up until that point sociologists tended to view the world as if it were made up of men with women's place in society as being pre-defined and in general not open to question. The study of men was seen more in terms relative to feminism and to men's treatment of women and of the role of men in perpetuating a patriarchal stance. It was not until the late 1980s that closer examination of men and of masculinity emerged.

Biology may influence us as men or as women but for this research I was interested in pursuing the social influencers on what it is to be masculine and if this masculinity changes having spent almost four years as a man working in a feminized domain. The traditional image of being a man or of being a woman in the Republic of Ireland has been one whereby the man did 'manly' things and the woman did 'womanly' things. The man was head of the family; he was the breadwinner; and he worked at 'manly' work such as farming or industry but certainly not general nursing. The woman pursued feminine jobs such as nursing and got married, and stayed at home and minded children. But 21st century Republic of Ireland presents, on the face of it, a very different vista. My research explored the social perceptions of what it is to be masculine and if masculinity is altered by being socialised within general nursing.

My research looked at the masculine identity of men in the largely female world of nursing and if such an identity had changed in the four years of being a student nurse. It explored how these men 'do' masculinity in this world of nursing. Society with its institutions and individuals and the interactions between the two, influences and supports what is meant by masculinity. Masculinity is the composite of behaviours and traits, both verbal and non-verbal that epitomizes what is the norm for a male within a specific culture. In other words, it is not feminine. Therefore "masculinities exist as both a positive, inasmuch as they offer some means of identity signification for males, and as a negative, inasmuch as they are not the 'Other'" (Whitehead and Barrett, 2001.p 16).

Gramsci (1995) uses the term hegemony to explain how the ruling classes maintained control over the working classes and Connell (2005) adopted the term to explain how a particular form of masculinity emerges as dominant and how such dominance relies on the subordination of feminism and of some forms of masculinity. My research explored the experience of the male general student

nurse in the feminized profession of nursing and the femininities or masculinities that were hegemonic in the context of general nursing.

The stereotypical image of the gay man is one of being overtly and overly effeminate. From my own experience, there is a common misconception that being a male nurse equates to being gay. The identity of being a gay man has brought with it a cultural stigmatisation but there is also a stigmatisation by the heterosexual man to the homosexual man, with the latter being in a position of subordination. "Gayness, in patriarchal ideology, is the repository of whatever is symbolically expelled from hegemonic masculinity…gayness is easily assimilated to femininity" (Connell, 2005. p 78). Connell's refers to another type of masculinity, that of complicity. This relates to the men who are connected with hegemonic masculinity but do not fully represent it. There is complicity with hegemonic masculinity and benefit to be gained from the "the patriarchal dividend, without the tensions or risks of being the frontline troops of patriarchy" (Connell, 2005. p 79).

This thesis also explores the participants' concepts of their masculinities. Within a socially constructed gender there is still the expectation that men will continue to do 'manly' things and I was interested in finding out if the participants were treated differently because of their gender and if this was exploited in any way, for example, if they were used for their perceived increase in muscle strength. Connell (2005) postulates that our gender identities are adjusted as the need arises. My research explored the degree to which male student nurses carried out such adjustments. It recognised that we are all gendered and considered the gendered nature of what it is to be a man in a woman's world. Gender is not a fixed concept and rather than 'having' gender we are more inclined to 'do' gender. The research examined if the nursing profession favours the male student nurse and if the profession itself actively contributes to continuing an inequality between men and women.

1.7. METHODOLOGY

My own position had to be factored into the research. I have been a general student nurse and have, to some degree or other, been involved in the field of nursing for many years. Therefore, I had an insider's view but I was not a male and from that perspective I was an outsider. Using the methodology of Interpretative Phenomenological Analysis (IPA) I set out to try and understand what it was like to be a male general student nurse. I needed the insider's perspective (Conrad, 1987). But I also needed to "stand alongside the participant, to take a look at them from a different angle" (Smith *et al*, 2009. p 36). Therefore, I was both insider and outsider. I needed to both represent what the participants said and to interpret what they said. I needed to be both empathetic and questioning. I brought to the research my own subjectivity and declared this from the outset anddrew on my own subjectivities as a woman who is a nurse and my own experiences in the nursing profession. Notions of using the researcher's own subjectivities are important. David (2002) in her reflections on her own journey from childhood to being an academic is an example of where one's own voice is central and incapable of disregard. In keeping with the overall methodology of IPA, the voice of me as researcher, as subjective, had to be considered and not disregarded. Central to IPA is the voice of the researcher. So when the participant interpreted his experience and related it to me, then I, in turn, as the researcher, needed to interpret what he said. In this regard I got closer to understanding the participants experience and therefore the need for the use of the "I" in the study.

The research questions were about feelings, perceptions and ways of coping (Refer 1.5). Therefore, the overall approach needed to be based on a broad interpretative perspective. The specific methodology used was that of IPA. The methodology of IPA focuses on trying to understand the experiences of others in a given situation and how they make sense of the world in which they find

themselves. In addition, it is about the researcher making sense of what the participant is saying with the participant making sense of what it is to be a male general student nurse in the female world of nursing. Therefore, it is a 'double hermeneutic' (Smith and Osborn, 2003). IPA is a 'bottom-up' as opposed to a 'top-down' approach and is inductive in nature. Participants are the experts when it comes to their own experiences and therefore those recruited for my research were male general student nurses in the Republic of Ireland. I considered that IPA as a methodology fitted well with my research. As a methodology, IPA endeavours to make sense of the participant's world by combining both description and interpretation (Willig, 2001). It is "descriptive in that it attempts to present an account of subjective experience…IPA is also interpretative as it acknowledges the researcher's role in creating a thematic account" (Quinn and Clare, 2008. p 375). I needed to find out as closely as possible what their experiences were but I also could not disregard my own experience as a female nurse who had worked with male students throughout different areas of my career.

I chose male general student nurses in the Republic of Ireland. Some research had been carried out with male nurses in other countries, but at the time of undertaking my study, I was unaware of any such research having been carried out with male general student nurses undertaking the honours degree programme in the Republic of Ireland. The data collection method was one-to-one, face-to-face semi-structured interviews with 10 male general student nurses who had completed two clinical placements during their internship, which is the fourth and final year of the programme. The participants attended two HEIs in the Republic of Ireland.

The analysis is the second part of the double hermeneutic and is therefore interpretative and subjective in nature. It must be transparent with verbatim accounts from the participants' world-view. The account is idiographic but counterbalances the specific from a participant to that shared with

other participants. Each interview is analysed prior to analysing the next interview. The analysis comprises reading and re-reading an interview several times. The analysed interview is reduced into emergent themes based on verbatim accounts. In order to get as close as possible to the experiences of the male student nurses, I, as the female nurse and researcher, needed to rely on verbatim accounts of the participants. The emphasis of verbatim accounts in IPA met this requirement very well. At the analysis stage, the researcher does not reference any literature until the analysis is complete.

1.8. CONTRIBUTION TO KNOWLEDGE

The research was a snapshot in time: Spring 2009 and Spring 2010. It contributed to the overall knowledge of what it is like to be a male general student nurse in the feminised world of nursing in the Republic of Ireland. It explored the advantages and disadvantages to being a male in this world. The research told the story from the perspective of this minority group of men. It revealed what these male participants considered to be the work of a general nurse with its gendered nature and alignment with feminine traits. It detailed the participants' views of masculinities and the influence of masculinities on their identities. In turn it gave an account of how spending almost four years in general nursing had influenced both their masculinities and identities together with the coping mechanisms they used. The research allowed these men a vehicle for expression that they might not otherwise have had. Therefore, the research gave a gendered account of nursing from the perspective of the minority male general student in the majority female world of general nursing.

1.9. THESIS STRUCTURE

Chapter 2 ‘Men in Nursing’ details the historical context of men in nursing tracing a time from when men were in the majority in the field of caring to the current situation with world variations. The chapter examines the traditional traits of what is perceived as being a nurse and the alignment of these traits with gender.

Chapter 3 ‘Theorising Gendered Identities’ considers gender history and approaches. It examines gender from the perspective of the body and of power. It summarises the conceptual framework of the feminisation of nursingas applicable to my research.

Chapter 4 ‘Research Design’ details IPA as a qualitative approach to my research including the data collection methods and the rationale used to determine the participants. Ethical approval and access issues are detailed. There is a summary listing the seven main areas of the research and how I decided on these seven main areas coupled with an overview of the approach to the analysis chapters.

Chapters 5 and 6 ‘Analysis’ draw together the summative findings from the 10 interviews. These chapters chronicle the experiences of each participant and an interpretation of each interview with verbatim accounts from the interview is offered. Having developed emergent themes from each interview individually, I searched for connections across emergent themes. When this process was completed for each of the 10 interviews, I looked for patterns, connections/clusters, across the interviews and linked these to the seven main areas to be explored.

Chapter 7 ‘Discussion’ positions the findings to the theoretical underpinnings to the thesis with links to the literature and uses the research questions as the basis for discussion.

Chapter 8 ‘Limitations, Recommendations, Concluding Comment’ considers the limitations of the research, suggests recommendations and offers a concluding comment from a personal perspective.

1.10. SUMMARY

This first chapter ‘Introduction to the Thesis’ offered an overview of the thesis. It provided a context for men in nursing and for my position in the research. It briefly outlined the research aims and questions. It provided an introduction into gender and the feminisation of nursing as the conceptual framework underpinning the thesis. It introduced the methodology and how the research contributes to knowledge. The following chapters address each of these aspects in greater detail while exploring their position in and relevance to the thesis.

CHAPTER 2: MEN IN NURSING

2.1. INTRODUCTION

In the Republic of Ireland, men make up 8% of the total number of nurses (Refer Table 1). In the United Kingdom that number is 9% (NMC, 2013). In other EU state numbers range from 2 % to 15% (Salvage and Heijnen, 1997) while in the United Sates 9.4% (Weinberg, 2004). In addition, the characteristics and traits often cited as being important and central to being a nurse are associated with those that have been identified as pertaining to women (Evans, 2004a).

This chapter explores the rise and fall of the number of men engaged in nursing. I argue that a number of political and economic events and the emergence of certain figures in history resulted in the feminisation of general nursing with the work being viewed as most definitely not as the work of the male. The mid-twentieth century saw plans to encourage the return of men into nursing but over the past 60 years it would seem that the numerical shift has not been as intended. Following the historical perspective, this chapter explores some of the barriers that men experience in relation to nursing. Central to nursing is caring for the body or bodywork and caring for the mind or emotional labour. This chapter examines the gendered nature of caring for the body and the mind. Coping strategies used by the men in nursing in order to provide care and be accepted are considered. But just as there are barriers that the male nurse must contend with, the corollary is that the male nurse also experiences advantages and these too are addressed.

2.2. HISTORICAL PERSPECTIVE OF MEN IN NURSING

Similar to teaching, nursing was mostly a male dominated occupation throughout the early history of the Western world. Evidence of the first trained men who nursed was those who worked with the doctors during the Greek Hippocratic era (Christman, 1988. Davis and Bartfay, 2001). In the parable of the Good Samaritan in the Bible, Jesus refers to a male innkeeper being paid to nurse an injured man. Around 235 AD, a group of men was formed in Egypt, called the Parabolani, whose function was to care for the patients who had succumbed to the Black Plague (Kenny, 2008).

The first school of nursing was formed in India around 250 BC and only men were allowed to attend because women were not deemed to be pure enough (Wilson, 1997). In ancient Rome, military hospitals were staffed by *noscomi* or male nurses right up to the fall of the Roman Empire. In the fifth century the Alexian Religious Order of men cared for the sick at Edessa. The early Christian era saw the establishment of the Christian hospitals as religious organisations to accommodate the ever-increasing influx of ill people to them. These Christian hospitals were staffed by members of the male religious orders and lay male nurses. Such institutions continued to grow in number throughout the Byzantine epoch necessitating more and more lay people to become involved and to be paid, thereby leading to nursing becoming a separate occupation. With some exceptions (mostly women-related conditions and illnesses) the paid lay nurses were men. Male nurses continued to feature strongly in the care of the sick right up to the end of the 14th century. Religious orders of men continued to be formed throughout the Middle Ages, whose ethos was one of caring for the sick. Male nurses continued to have a strong presence in caring for the wounded on the battlefield and in dealing with epidemics. In fact, it was two men, namely St John of God and St Camillus, who in 1930 were named as the patrons of nursing (Thunderwolf, 2005). St John of God (1495–1550)

devoted his life to caring for the sick and St Camillus (1510–1614) developed the first field ambulance.

Men worked as nurses within the patriarchal cultures of the male religious orders and the battlefields. However, from the 1500s women were beginning to replace men in the nursing role in a number of situations. Male nurses were beginning to be seen mostly in situations where the intimate care of male patients was needed and where physical strength was needed to handle the heavy or psychotic patient (Mackintosh, 1997. Evans, 2004a). The main factors credited with the cause in the gender shift include: fewer men entered religious life but more women began to do so; some religious orders diminished or disappeared; with the introduction of a secular management, standards began to drop; with the drop in standards came a drop in status and regard; concomitant with this was a drop in pay; and the Industrial Revolution brought with it increasing well-paid opportunities for men (Christman, 1988. Donahue, 1996).

The Industrial Revolution was a significant point in history regarding the gender shift in nursing. There was an increased demand for men to work in heavy industry. This demand contributed to a reduction in the number of men entering nursing (Christman, 1988). Industrialisation was a double-edged sword bringing improved conditions and prosperity for some but for others the opposite was the case, with ensuing poverty and displacement. Governmental response was to publish the Poor Laws, differentiating between the 'undeserving poor' and those who were 'genuinely' poor (Fealy, 2006). The vista for nursing was not usually a positive one. On the occasion that nursing did occur in institutions, it was carried out by 'pauper nurses' (Miers, 2000). Nursing was considered a low status occupation to be carried out by women, who were often of dubious character. Nursing had now become a most undesirable occupation as epitomized by Charles Dicken's character Sarah Gamp. Nurses were viewed as "people of low status, little education, or uncertain honesty and

uneven temperament, who were assumed to have entered nursing because of their inability to be accepted for employment elsewhere" (Macintosh, 1997. p 233).

In the 1700s as large voluntary or charitable organisations began to emerge and with the segregation of male and female patients, so too did the segregation of male and female nurses, especially the persons in charge of the two sections. In the mid-19th century there was an increase in the workhouses that had infirmaries attached. At the same time there was an increase in private asylums. With the increase in such facilities came the need for more carers. In many instances, inmates were used to care for other less well inmates. Ward segregation continued to be the norm and the male carers were referred to as keepers or attendants rather than as nurses. Male nurses were not common during this time. Whereas men did work in the newly formed asylums, their role was more that of keepers and gaolers. O'Lynn and Tranbarger (2007) notes that it is likely that many 'man-servants' in large households also carried out nursing functions and men continued to nurse in military situations.

The Enlightenment concepts of reform gathered momentum by the mid-1800s. Coupled with notions of Enlightenment, the development of medical schools was the precursor to our modern-day hospitals. The workings of these new centres of treatment required a different approach to nursing care. In helping to realise such reforms in nursing, social reform-minded gentry both in Ireland and the UK began to emerge (Fealy, 2006). One such reformer was Florence Nightingale who is considered to be the founder of modern-day nursing. She had strong organisational ability and political astuteness. She came from a privileged background and was considered well educated. She became famous for her work during the Crimean war. She brought with her a group of nurses and trained the nurses in carrying out care in a compassionate well-organised manner with emphasis on cleanliness (Baly, 1986). When she returned to England following the Crimean war,

her reputation from her work during the war coupled with her connections, both from a social class and a political perspective, enabled her to set up a school of nursing in St Thomas' Hospital in London (Dock and Stewart, 1938). In some less modern hospitals there still remains to this day a particular ward layout called 'the Nightingale ward' including a defined space between wards to minimise infection. Her approach to nurse training was adopted throughout Ireland and the UK and indeed elsewhere in the world.

Nightingale recognised that the conditions in the organisations for the sick were appalling. Her belief was that women, not men, were better able to clean things up and improve standards. She considered that men were not suited to nursing and that it was natural disposition of a woman to be a nurse (Macintosh, 1997. Brown *et al,* 2000). In 1867, Nightingale wrote: "The whole reform in nursing both at home and abroad has consisted of this: to take all power over the nursing out of the hands of men, and put it into the hands of one female trained head and make her responsible for everything" (Dossey, 1999. p 291). In turn this added to the hierarchical structure with the educated genteel woman at the top of the nursing hierarchy.

Doctors were men and they were concerned lest Nightingale's rising of standards for nurses would cause the nurses to question their roles as subservient to the medical profession. But Nightingale assuaged their fears, reinforcing the subservient role of the female nurse in relation to the male doctor. Her restructuring was clearly embedded within a patriarchal society because the female nurses were the handmaidens to the male doctors with the latter holding the power and making the decisions. The position of the inferior female nurse in relation to the superior male doctor was a mirror image of that of the family where the breadwinner and master of the house was the man, with the woman as the person who remained at home – the servant to the master. "What emerged…was the reproduction of the wider Victorian class structure, based on preconceived notions of the

divisions of labour between the sexes and between women of different classes" (Carpenter, 1978. p 92).

2.3. BARRIERS MET BY THE MALE IN RELATION TO NURSING

Barriers faced by men in relation to nursing start with society's beliefs regarding what a girl should do and what a boy should do. This is often reflected in the career advice given to teenagers is deciding on what course to do or what work to pursue when leaving school. Barriers continue even within nursing itself. Barriers exist from a number of perspectives ranging from trying to make the decision regarding career choice in the first instance right through to the actual work arena. O'Lynn and Tranbarger (2007) developed a survey tool: "Inventory of Male Friendliness in Nursing Programs (IMFNP)." They surveyed a group of 250 RGNs in the Republic of Ireland who trained in the period from 1996 to 2004 (the diploma three-year courses). One hundred RGNs responded (Refer Table 4).

Table 4: **Summary of Results of Inventory of Male Friendliness of Nursing Programs** (O'Lynn and Tranbarger, 2007. pp 198-199)
Use of personal pronoun "she" in relation to nurse
No history of men in nursing presented
No guidance on the appropriateness of touch
Nervous that female patients would accuse male students of sexual inappropriateness during caring
No active encouragement as a man to pursue nursing as a career
Different requirements limitations for male students during obstetrics placements
Felt had to prove self because people expect nurses to be women
Anti-male remarks
Being called away to help with lifting of heavy patients

These findings showed how male nurses in the Republic of Ireland who trained in the period 1996 to 2004 considered they were treated because they were male. The findings were significantly reflected in the experiences of the participants in my own study almost a decade later.

In an Australian study investigating factors that lead to attrition among male student nurses, a number of themes emerged including: isolation; the nursing role: caring and role models; and traditional gender roles and technical aspects of nursing (Stott, 2007). The male students felt isolated and felt singled out, for example, by being the only ones asked to give a urine sample during a clinical skills teaching session or being asked to remove their shirts for a teaching session on an electrocardiograph. They spoke of being nervous talking in front of a group of women "like a pack of wolves…very, very intimidating" (Stott, 2007.p 328). The men expressed concern in fulfilling the role of the nurse including the caring role, referencing the worry about having the right 'bedside

manner.' The participants noted a lack of suitable male role models, both in the clinical and in the academic settings. Traditional gender roles were another source of bother for the male students with the stereotypical role of the nurse as female. They noted the reaction of patients to men as nurses, with the common misconception that they were doctors. As they progressed through their training, the male nurses expressed a preference for the technical aspects of nursing, with one study participant noting: "Males will go in to specialised areas more readily because they feel comfortable and it is more of a challenge" (Stott, 2007.p 331). In other studies, male nurses felt singled out, not being made feel welcome, struggling with emphasises on teaching formats geared towards women and negative experiences in relation to obstetrics and gynaecology rotations (Brady and Sherrod, 2003. Ellis *et al*, 2006. Dyck *et al*, 2009).

The idea of the male body being used or indeed ab-used, has been discussed in a number of studies whereby the male nurse is called upon for lifting or in situations where control and restraint is needed or where a confused patient needs to be cared for (Williams, 1992. Brooks *et al,* 1996; Milligan, 2001; Whittock and Leonard, 2003; La Rocco, 2007; Keogh and O'Lynn, 2007; Curtis *et al*, 2009; Simpson, 2011). The male nurses themselves perceive this physical ability in two opposing ways. Some find it demeaning and undermining in their contribution to nursing. Others use it as a means of promoting their own masculinity and of reaffirming themselves as strong men (Heikes, 1991; Simpson, 2011).

Nursing has been aligned with the female, with the effeminate, and because the effeminate is associated with being gay, there is an assumption that the male nurse must also be homosexual. Even in modern television and film, this perception permeates and the first name of the male lead in the film 'Meet the Parents' as Gaylord acts as a symbolic reinforcement that because he is a nurse

he must be gay. As recently as March 2015, the male nurse character introduced into the UK Soap *Emmerdale* is homosexual.

Nursing, perceived still as an occupation for women, is devalued in a male-dominated patriarchal society. Nursing has been, and to a considerable extent remains, stereotyped with characteristics such as nurturing, caring, dependence, and submission. These traits are in marked contrast to society's perception of male characteristics including strength, dominance and aggression. One of the role traps is that if nursing comprises traditionally accepted traits of women, then men in nursing must be homosexual. A study of 18 New Zealand men was conducted in 2003–2004 by Harding to examine the construction of the stereotype of male nurses as gay. His findings showed that the participants believed that the majority of nurses are heterosexual but in apparent contradiction, the stereotype of male nurses as gay prevailed. The findings indicated a belief that psychiatric nurses were heterosexual but that general nurses must be more than likely gay (Harding, 2007). Evans points out that the notion of equating male nurses with being gay brought about another issue. Because of the perception among some of linking being homosexual to deviant sexual practices, the male nurse can therefore be portrayed as dangerous or threatening. The consequence for carrying out nursing care on the physical body can result in problems, given the need for bodily contact and touch in the course of male nurse work (Evans, 2002).

2.4. BODY TO BODY: PHYSICAL BODY WORK IN NURSING

Women's knowledge of caring was passed down from generation to generation through the spoken word. However, with the development of the written word, the power afforded women quickly diminished. Writing as a means of communication became the exclusive domain of the priesthood, which developed a written narrative for doctors but not for the woman carer. The result was that

women's' accounts were changed or relegated to a place of little importance. Underpinning the rise in Christianity came the exultation of the soul and the corresponding distain for the body. Talk or knowledge of the body was actively discouraged. It was the man who clearly determined the role of nurse/woman. The female received the knowledge that the male considered necessary. "Priests, clerks, and then doctors strove for centuries to bar women's access to writing" (Colliere, 1986. p 96). The doctors developed, and as importantly, they documented their knowledge. Like the priests who saved souls, the doctors saved lives. Like the nuns, the nurses got on with the function of caring for the body. The nuns supervised subordinates in the giving of this care. Thus, caring for the body became a "devalued lower-order skill" (Phillips, 1993. p 1556).

A key component of what it is to nurse comprises bodywork, that is, caring for the human body. Underpinning nursing care are the activities of daily living carried out, to varying degrees, by the nurse on the patient. Such activities cover each end of the spectrum of body contact, from simple hand-holding to bowel evacuation and include: moving, lifting, washing, drying, rubbing, dressing, brushing, changing soiled clothes, injecting, taking and examining body excrement and fluids. The very essence of general nursing care relates to touch: to dealing with the body of another (and its secretions) by using one's own body. Because of the predominance of the female gender in nursing, it is considered gendered work (Lawler, 1991; Macintosh, 1997; Poliafico, 1998; Meadus, 2000; Twigg, 2006; Harding, 2008; Harding *et al*, 2008). There is a perceived danger that when male nurses touch female patients as part of the caring process, it can be misinterpreted. Participants commented that "despite it being acceptable for women nurses to touch men and women patients, it was not as acceptable for men to do the same" (Evans, 2002. p 444). In society there is the public part of the body, which is overtly on view on a day-to-day basis, but there are the private body parts, which, depending or cultural or religious beliefs, remain hidden from the public gaze. There are occasions when intimate physical touch is necessary. The nurse often has to care

for not only the public part of the body but the private parts as well. It is this touching of the private parts that can prove problematic for the nurse, and often more so for the male nurse.

Each nurse must always be aware of the effect of touch and of the potential for misinterpretation but "the use of touch is even more challenging for men who are nurses because of discourses which have 'feminised' touch and 'sexualised' men's touch" (Harding, 2008. p 28). He reports on a study on men, gender and nursing with 18 New Zealand men who were nurses and the identification of the following emergent themes: the failure of nurse education; keeping oneself safe; feminisation of touch; vulnerability and stress in using touch as part of body work; and sexualisation of men's touch.

The failure of nursing education:

The study found education was lacking in helping the male nurse deal with intimate care. This lack in education has been supported by other studies. Studies have found that the content of nursing programmes has marginalised male student nurses (Villeneuve, 1994). Male nurses expressed the need for guidance and support in the delivery of intimate care.

Keeping oneself safe:

In this study by Harding participants suggested strategies used in keeping oneself safe, including: communication, asking a female colleague to undertake the care, having a chaperone, or providing the option of another nurse. But these 'strategies' are avoiding the real issue of the male's dis-comfort in providing intimate care and is reflective of not only a flaw in the education preparation but significantly in the lack of support in the clinical setting by the registered general nurses. This effort at keeping oneself safe has been cited as a role strain that often sends the nurse from the clinical setting and certainly from settings where intimate care is required (Harding, 2008).

Feminisation of touch:

Since the era of Nightingale, nursing has been clearly associated with the female and touch is considered to be 'natural' to the female and does not come as naturally to the male (Evans, 2002).

Vulnerability and stress in using touch as part of body work:

In this theme, men expressed concern at being misinterpreted and felt vulnerable, especially when alone with a patient. Of concern was that a number of participants in the study felt that if there was an accusation of inappropriateness, that the accuser would more likely be believed. In a study by Evans, a male student nurse commented that a female colleague reported him when he put his hand on the shoulder of a partially dressed woman who was upset. In another instance, the father of a newborn baby accused the male student nurse of molestation because he was changing the neonate's nappy (Evans, 2002).

Sexualisation of men's touch:

Through the media, for example the Carry-on movies or the titillation of dressing up as a half-clad nurse, the work of nurses can be viewed as being sexualised. "Young female nurses become the objects of sexual desire: male nurses, on the other hand, are constituted as objects of sexual threat" (Harding, 2008. p 29). This gender stereotyping has led to a discourse whereby it is acceptable for the female nurse to intimately touch either the male or female patient, but it is considered not appropriate for male nurses to do so. Caring for female patients, where that care comprises touch and contact with intimate areas of the body can be especially problematic for the male nurses, who may be excluded from providing such care by female colleagues and by patients (Poole and Isaacs, 1997. Lodge *et al*, 1997. Morin *et al*, 1999. Chur-Hansen, 2002. Keogh and O'Lynn, 2007). Working in certain areas can be viewed as 'no-go' areas for the male nurses, including gynaecology and obstetrics (Williams, 1992; Abrahamsen, 2004; Evans, 2004a; Inoue *et al*, 2006). Male nurses are also concerned lest their touch could be misinterpreted as sexual abuse or molestation (Evans,

2002. Evans and Frank, 2003. Grady *et al*, 2008. Simpson, 2009). Body-to-body contact is one element of nursing care with its issues for the male nurse. The other side of the care-giving coin is the emotions or the emotional labour. A formula for care comprises: Care = organisation + physical labour + emotional labour (James, 1992).

2.5. EMOTIONAL LABOUR: NON-PHYSICAL WORK IN NURSING

Emotional labour relates to feelings and their expression or suppression to give a sense that a person is being cared for in a safe and convivial place (Hochschild, 1983). Tracing back to Nightingale's time and indeed beyond, it therefore seems more natural the women would be nurses and men would be doctors. A study by Gray (2010) explores nurses' narratives on emotional labour coupled with the gendered nature of emotional labour. The findings included: nurse definitions of emotional labour; the emotional routine of nursing; images of nursing; barriers to emotional labour; gender stereotypes; and personal perspectives on nursing and emotional labour.

Nurse definitions of emotional labour: All nurses in the study identified emotional labour as a pivotal role of the nurse. They described emotional labour as making patients feel safe, comfortable, at home.

The emotional routine of nursing: Emotional labour was seen as 'part and parcel of the normal routine of nursing.' The nurses in the study said that emotional labour made working with the patient much better.

Images of nursing: Participants considered that the image of nursing differs from group to group. They felt that patients' image of nursing was based on the traditional image aligned with the image

of the ministering angel, of the mother mothering the child. As a result, nurses felt it was necessary to put emotions into their nursing work. But some of the participants considered such an image to be fraught with difficulty and considered it sexist. They considered that such stereotypical images actually devalued emotional labour.

Barriers to emotional labour: The stereotypical images of nursing associated with the female were seen by the participants as barriers to emotional labour. The participants felt that such images did not allow for the recognition of emotional labour as a professional occupation but instead reduced it to part of a 'woman's work.' The perception of emotional labour as part of a woman's job was significant in the career choice of the participants and of where they choose to work when qualified.

Gender stereotypes: Gender stereotyping emerged among the participants. General nursing was seen as female work involving washing and close physical contact and that the women were natural emotional labourers. By contrast, psychiatric nursing was seen as being more masculine necessitating dealing with physical aggression and thereby requiring strength on the part of the male nurse. Of specific mention in the general setting was the so called 'dirty areas' such as gynaecology and maternity that were viewed as not being appropriate for male nurses (Lawler, 1991. p 213).

Personal perspectives on nursing and emotional labour: Participants reported that their perceptions of emotional labour developed over their training. They indicated the importance of storytelling in helping to develop emotional labour. This is reinforced by the work of Lawler (1991) whereby emotional labour in nursing has traditionally been in oral rather than in written format. "This largely hidden oral history is perhaps related to the invisibility of emotional labour, its uncodified and gendered nature, and its devaluation in economic and cultural terms" (Gray, 2010. p 357).

The alignment by Nightingale of the woman/mother/nurse clearly linked emotional labour to the role of the female. Emotional labour with the body is still viewed as mainly the responsibility of the female. The fall-out is that women's health in the hospital setting is viewed as the domain of the female carer and if a man was to work in such areas he would be considered gay or effeminate (Gray, 2009). But throughout their training, male student nurses must get involved with the bodywork and with the emotional labour and may often need to employ various coping strategies to give the best care and to be accepted.

2.6. THE MALE IN NURSING: COPING STRATEGIES AND ADVANTAGES

What some male nurses see as being disadvantageous, others use to their advantage, for example, using their muscle power as a strong indicator of their masculinity (Heikes, 1991. Simpson, 2011). As well as the assumption that men are strong, there is also the perception that men are good technically and again some male nurses use this perception to their advantage and use such ability to stand out as special within nursing. It is also considered that the general ability to deal with more technical areas is part of the reason why male nurses end up working in the more technically focussed areas such as ICU, CCU, and Emergency (Villeneuve, 1994). Another reason for men opting for such areas is that they avoid the routine work of the general wards with the repetition of tasks that can be considered 'dirty' work such as washing and cleaning and caring for the more chronically ill (Williams, 1992. Simpson, 2009).

Whereas there is a small number of men in nursing, the literature indicates that this small number of men occupy a privileged position in relation to women colleagues. In a patriarchal society, men attain situational dominance and are often given a privileged standing (Ryan and Porter, 1993. Villeneuve, 1994). Deliberately or inadvertently, the female nurses nurture the career of the male nurses. Reasons why female nurses may facilitate the promotion of their colleague male nurses

include that it is normal for men to be in charge and that if men are in charge then nursing as an occupation will become stronger. There is also the view that female nurses consider it inappropriate for male nurses to carry out routine nursing tasks (Williams, 1992. Evans and Frank, 2003. Simpson, 2011). How other professions within the general hospital treat the male nurse has also been reported as being advantageous. In a study by Williams it was reported that physicians treat male nurses better than female nurses and this special treatment makes for another advantage for the male nurse in the general hospital setting (Williams, 1995). The position of the male in nursing is complex, encompassing both advantages and disadvantages. Whereas a lot has changed over the history of nursing, there is still change required by society and by nursing itself to accept and embrace the notion of the male nurse.

2.7. SUMMARY

Men have a long history in the world of caring but events at a certain point in time firmly feminised nursing. Those men who do enter the female world of nursing are potentially faced with many barriers: barriers that are embedded within a gendered patriarchal culture, whereby nursing is often a reflection of society and where the stereotypical image of the nurse does not readily make room for masculinity. Caring for the physical body and for the emotional 'body' brings challenges especially for the male whose sexuality is often questioned or whose body mass makes him a handy man for lifting and for heavy manual work. Male nurses often use this muscle power and their perceived technical ability to their advantage. Their female colleagues often encourage them to go for promotion. Given the history of nursing coupled with its present mix of male and female nurses, it was apt to look at gender as an issue, either a positive or a negative one, for the male general student nurse.

CHAPTER 3: THEORISING GENDERED IDENTITIES

3.1. INTRODUCTION

This chapter considers literature on gender history and approaches. It examines whether gender is biologically or socially constructed. It explores the concept of agency but also considers that agency can change and that it cannot fully belong to a person. Following from this is the notion that the process of becoming a subject depends on discourses that the subject has never actually chosen and where gender may be a series of performative acts. The chapter goes on to consider the notion of the gendered man, initially from a historical perspective. It explores the body as an expression of masculinity going back to the man as a soldier and the muscularity of the traditional farmer and forester. Power is further explored from a hegemonic perspective looking at power over the perceived non-conformist male (Connell, 1987; 2005). This chapter briefly addresses the nursing man. The chapter summarises feminisation as the framework for my thesis.

3.2. GENDER HISTORY AND APPROACHES

3.2.1. Historical Overview

Masculinity and femininity are concepts based on gender with the prior expectation that males will be masculine and females will be feminine and that to have both types of attributes at the same time seems an impossibility (Thompson and Vertein, 2010). Gender is a construction that is influenced by history, culture and social relations (Scott, 1999). From a sociological perspective, gender is in essence about society's view of the attributes that fit in with what is considered to be masculine or feminine. Gender socialisation is enabled by our experiences from our families, through schooling,

and by a myriad of media sounds and images (Marini and Brinton, 1984). Gender is concerned with the psychological, social and cultural differences between the two sexes of man and woman. Gender is within us and within our culture. As we go about our daily lives, we are afforded opportunities of expressing our gender. It is “neither sex organs nor sex acts, but the socially constructed ideal of what it means to be a woman or man” (Coltrane, 1994. p 1). In nursing, these preconceived ideas of what it means to be a general nurse can influence how society views the nurse and by and large society equates a general nurse as being female. In the Republic of Ireland, society still views the man as doing ‘manly’ things and this does not include being a general nurse, at least not at general ward level where the nurse has to perform bodily work. My research afforded the participants the space to consider the reactions of people when each participant decided to become a general nurse. It also explored reactions from people since they commenced the general nursing programme.

Looking at the history of gender, it needs to be viewed within the context of other social constructs such as class, ethnicity and sexuality, coupled with the meaning of femininity or femininities and masculinity or masculinities. Regarding the notion of class, Karl Marx concerned himself with the relationship between the working class and the capitalist class. But he viewed the principal players in both classes as men. Women were clearly viewed as the reproducers of both the next generation of workers and of supporting the men through for example cooking food. In essence women in such a scenario were devoid of any real power. Until the 1970s, sociologists generally considered the world as if men made up societyand where, if women were considered at all, then it was a consideration of their place in society as a “natural given or, at best, thought of in terms of roles which were social but nonetheless unproblematic” (Jackson and Scott, 2002. p 1). In a sense, as general nurses are more readily considered as female, it seems a ‘natural given’ that men do not

readily fit into the role of a general nurse. My research explored society's image of what it is to be a general nurse and how this image was seen by the participants as being gender-influenced.

3.2.2. Biological or Social Constructed Gender

The idea of blue for a boy and pink for a girl still prevails to-today with balloons in the maternity hospital shop clearly differentiating between the genders of the newborns by a simple representation of colour. Clothes shops and toyshops continue to differentiate by labelling sections as Boys or Girls. In our society we continue to dress boys and girls differently and continue to teach them how to behave differently. We treat them differently and stress gender as a socially important category. In 1998 when the English footballer David Beckham wore a skirt-like garment, his appearance hit the front page of many newspapers and gained prime billing on the news bulletins. When males and females end up behaving differently to each other "we interpret the resulting patterns of gendered identity, attributes and behaviours as confirmation that they were different to begin with" (Kane, 2013. p 13). The outcomes expressed by the male and female would seem to be shaped from the moment of birth (or even in the womb with scan confirming the baby's sex) and appear to be continued in the home, in education, at work, in social life and in political life, resulting in the view of gender as being socially constructed. There is the notion that purely biological aspects such as chromosomes and hormones predetermine our gender-specific behaviour. Gender is still viewed by many as biological differences pertaining to physiological and reproductive capacities. In general nursing, for example, male nurses are still used and at times ab-used for their muscle power. My research allowed the 10 participants to consider what each perceived to be the practice of nursing, with an emphasis on what it was like for each man to be a nurse. There were many citations of where it was considered that being a man played a pivotal role of how each one was treated.

There was (and to an extent remains) a strict binary of two distinct categories bringing with it constraints for both the male and the female. However, in the last few decades, the idea of gender being socially constructed at three instead of two levels has been explored. This third level allows for "individual-level internalisation of gender expectations without relying on it alone to explain gendered outcomes" (Kane, 2013. p 14). The arguments against a belief based purely in biological terms are very strong. The levels of aggressiveness or the levels of passivity among males/females, greatly differs between cultures. Coupled with this is the argument that even if there is a commonality regarding a particular trait, it does not prove that the origin is biological but that cultural/social factors were also most likely at play. Whereas we are born with a biological sex, it is our socialisation process that moderates and controls our gendered behaviour whereby boys and girls learn sex roles and the male and female identities of masculinities and femininities. "Babies were, from the start, called either female or male-labelled by the famous pink and blue baby clothes. Blue babies were expected to behave differently from pink babies-rougher and tougher, more demanding, aggressive and vigorous" (Connell, 2002. p 76).

Bem's psychological androgyny theory contested the bipolar notion and considered masculinity and femininity to be two separate and independent concepts and thus a person of either gender can possess both femininity and masculinity at the same time. This integration of both concepts in the same person is referred to as androgyny (Bem, 1974). In order to explore gender, it cannot be assumed that masculine behaviour is displayed only by men or feminine by women. "Gender and sex are not equivalent, and gender as a social construction does not flow automatically from genitalia and reproductive organs" (Lorber, 1994. p 17).

3.2.3. Agency or Performative Gender

If masculine behaviour is not always displayed by all men or if masculine behaviour may be displayed by a woman, then social construction of gender is insufficient to explain gender. Social learning theory has been criticised for ignoring the agency of the child and for perceiving the child as the "passive recipient of social moulding" (Donehower, 1983. p 20). As human beings, we are not mere sponges who can all be conditioned. The socialisation model does not take account of a person's ability to form gender relations nor does it take into account people's ability to go against pre-existing definitions, for example, the boy who hates sports, the teenager who realises he is not heterosexual, or the girl who wants to work in a job traditionally viewed as being a man's job (Connell, 2002). Connolly (2004) comments that children's habitus can change depending on the particular social networks in which they are operating. Davies' (2002) position is that sex and gender are aspects of the social structure, created within and by individuals. This social structure cannot be separated from the individuals who comprise it. It cannot be, *per se*, imposed on individuals but its very presence constrains their individual and social actions: "These are not simply an external constraint…they provide the conceptual framework, the psychic patterns, the emotions through which individuals position themselves as male or female and through which they privately experience themselves in relation to the social world" (Davies, 2002. p 283).

Pierre Bourdieu (1930-2002), a French sociologist, was interested in the dynamics of power in society. He was concerned with the role of practice and embodiment in social life. Bourdieu (1973) notes that the agency of individual actors, changes. As people we are advantaged or disadvantaged relative to one and other, dependent upon a plethora of factors including access to power, privilege, resources and social position. Bordieu's belief was that each individual's habitus is socially constructed, developed and generated through lived-experiences within our contextual situation. Agency is embedded in enlightenment understandings of an individual whereby an individual is

seen as a free spirit whose thoughts, words and deeds are based in the principle of free and rational choice. Therefore “everyone has agency even though some clearly have more options than others” (Phillips, 2011. p 11).

Performativity is the capacity of communication not merely to communicate but it also acts an action. Judith Butler (1956 to present) is a theorist in gender studies who considers that even everyday communication is performative in that it contributes to defining identity. Therefore, identity is not just the source of verbal and non-verbal communication but it explores the construction of identity as it is caused by performative behaviours. Butler postulates what she refers to as the bind or the apparent contradiction of agency. In her theory she considers that the process of becoming a subject is based on and dependent upon discourses that a subject has never chosen. But it is this very discourse that maintains a person’s agency. Therefore, Butler contends that the agent becomes subordinate to a specific discourse and consequently subordination is a condition of agency. It is this subordination and its ensuing power that itself actually limits agency (Butler, 1997). In Butler’s thinking, the role of agency seems to have no place and it appears to result in wondering about the ability of a subject to consciously act (McNay, 2000). Gender is viewed by Butler as being performative. She argues that whereas gender might appear to be a fixed entity, it is rather a series of perfomative gestures imposed on the body in line with powerful discourses (Butler, 1990).

My research was interested in finding out what were the influencers on the participants when they made the decision to commence the four-year degree programme in general nursing. By virtue of being male, they were going against the social norms of what work a man should do and I therefore discussed with them what coping mechanisms they used in the female world of nursing. I wanted to explore how the social structure affected the participants. I wanted to find out if the male general student nurses exercised agency and if there were factors other than gender, for example, was

sexuality a factor and was there any reference to race. Performativity was also a consideration in exploring the experiences of being a male general student nurse and aspects considered included if there were displays of hyper-masculinity and if there were signs of 'script' against which the participants 'performed.'

3.3. THE GENDERED MAN

3.3.1. The Man in History

There were a number of events in history that shaped the formation of gender order and masculinities. The decline of religious dominance and its replacement with rational scientific thought afforded men the opportunity to embrace reason and discard mythology. The emergence of colonial conquests allowed for male-only projects. Another preserve of the male was the development of the city society with its large commercial emphasis that afforded men enormous power. The force for power was again the role of men in war (Connell, 2005). Most of the great figures in the world of history from the world of religion to rational thought, from the world of the city to the battlefield, from philosophy to science, were men. These great figures are well represented in the written history.

Social theory had automatically considered that the male perspective was a given, it was normative (Haywood and Mac an Ghaill, 2003). Resulting from the second-wave feminist movement, the early men's movement of the 1970s was profeminist in its philosophy. Towards the end of the 1970s, the men's movement considered that "a new sexism has been born, a sexism that thrives on male bashing and male blaming" (Clatterbaugh, 1997. p 11). This resulted in the mythopoetic men's movement of the 1980s, which hit out at feminism with a conviction that feminism had led to an emasculation coupled with an emasculating culture. "By retreating into the wilderness and by exercises in spiritual interrogation, they attempted to recuperate their own innate masculine power"

(Adams and Savran, 2002. p 5). The 1990s 3rdwave was concerned with gender in regard to questions of normativity, performativity and sexuality: “A common theme is the importance of representation and its connection with wider change, questions of change and continuity in contemporary masculinities and identities” (Edwards, 2006. p 3).

The notion of what was meant by ’man’ or ‘men’ was (and perhaps still may be) assumed to be people belonging to the male sex. Hearn notes that analysis of masculinity can find its origins in the work of the psychologists Freud and Adler whereby the adult character is not pre-determined because one is born male or female but that it emerges as a result of emotional attachments to others as we traverse the trials and tribulations of growing from child to adult. Anthropologists such as Mead placed emphasis on the cultural influences on the development of a person. These emotional and cultural influences helped form the concepts of masculinity and male sex role. By the 1970s, masculinity was taken to mean a role that mirrored certain dominant cultural values obtained through social learning from socialisation agents. Masculine values or norms were taken as, for example, aggressive, ambitious, assertive, and athletic (Hearn, 2006). The body itself is considered to be an important component in the history of masculinity.

3.3.2. The Embodied Man

In the past two decades, three theories have helped spark debate around the male body. The first two as discussed above, are around the notions of biological and social determinism. The third theory is that both the biological and the social merge to provide gender difference in behaviour (Connell, 2005). Raewyn (born Robert William: RW and also known as Bob) Connell is an Australian sociologist who developed a social theory of gender relations. This theory stresses that gender is a social structure and not merely one of personal identity. She has written extensively on the social construction of masculinity, specifically hegemonic masculinity, which sets out to explain

why men maintain dominant social roles over women and indeed any other gender identity that might be viewed a 'feminine' in a given situation. Connell provides a theory of body-reflexive practice whereby she viewed the body as both object and agent of practice. She contends that physical masculinity is subject to change and is constantly being constituted (Connell, 2005).

Connell proposes that masculinities "come into existence as people act. They are actively produced, using resources and strategies available in a given social setting" (Connell, 2000. p 20). How the physicality of the body is portrayed is of significance to many men. Traditionally the muscularity of the male body was of special significance in relation to physical work or manual labour, for example, farming. Bourdieu who had conceptualised the body as a means of 'physical capital' considered that bodies are affected by the day-to-day processes of life and as such take on different symbolic values (Bourdieu, 1986). Traditionally the conventional masculinities of the farmer were that of a strong man in every way who worked hard in battling the elements. However, this is no longer as definite in today's world and "rural masculine identities are unstable and shifting, reflecting changing gender relations and rural change" (NÍ Laoire, 2005. p 96). Another expression of the significance of the body as an expression of masculinity was the man going to war. The body in war is one that is highly controlled but also one that is surrendered. The surrender of the body and indeed the mind in a military context is given over to the next in command. But with this unquestioning obedience, the control exerted by the soldier over his own body is as important (Morgan, 1994). Other occupations whereby the physicality of the body is seen as an expression of masculinity includes forestry in Norway (Brandth and Haugen, 2007) and steel work in America (Catano, 2003).

Changes in technology, less wars in certain parts of the world, and more women getting involved in traditional male work have had the potential and indeed often the reality of the loss of the physical power and dominance of the male body. According to Whitehead, this has resulted in a crisis in

masculinity (Whitehead, 2002). In place of those work situations that defined the masculinity of the man through the physicality of the body, a whole new science surrounding the male body shape has emerged. The hyper-masculinity as traditionally expressed in the military or on the farm has been replaced by the hyper-masculinity of sport (Connell, 1987). But according to Butler, a subject does not have sole ownership or full control of the body and the body merely adopts gender as it encounters a dominant discourse at a given time (Butler, 1993). According to Whitehead, the male body can be understood as a "fluid and shifting materiality, invested through numerous truths and knowledges" (Whitehead, 2002. p 203). The male body may have had to change from the traditional labours whereby masculinity was expressed in the physicality of the body. But the male body has remained, in many instances, to be a reflection of strength and power.

3.3.3. The Powerful Man

The idea of hegemonic masculinity gained elaboration in the early 1980s partly against the backdrop of gay activism. It was contended that it was certain groups of men such as homosexuals who were oppressed because their situations "relate differentially to the logic of women's subordination to men" (Carrigan *et al,* 1985. p 586). Cheng notes that characteristics of hegemonic masculinity include: aggressiveness, competitiveness, athletic prowess, stoicism, control, and domination regarding those not in the dominant group. "Since hegemonic masculinity is thought to be superior, a characteristic of the in–group, the out–group is thought to be 'feminine' or some kind of non-conforming, or even failed masculinity" (Cheng, 1999. p 20). The most important feature of hegemonic masculinity is that it is heterosexual, being closely connected to the institution of marriage; and a key form of subordinated masculinity is homosexual. Hegemony is not stable and it is open to being contested either by women or indeed men who do not readily fit within its parameters.

3.3.4. The Nursing Man

Gender is a fundamental element of each person's identity. The individual's gender is one key aspect of identity that assigns relative status (Biklen and Pollard, 1993). Events in our childhood maintain traditional gender boundaries and children learn cultural meanings of gender through an active and agentive process of learning from the practices of the adult world thereby forming and informing our identity (Connell, 2003). It is this aspect of our identity formation that is carried into our work lives. In regard to nursing, Cummings postulates that success in today's healthcare environment is not about maleness and fe-maleness but about effective use of the necessary skills, knowledge and attitudes by whoever has these in a given situation. "Gender socialisation in nursing has been an evolving process and really reflects our collective history as individuals. Creating new images will be a difficult process. It is time to break out of old molds and meld characteristics of gender socialization in our culture as we move into the 21st Century" (Cummings, 1995. p 28).

In their efforts to maintain a positive masculine identity in a female-dominated profession, male nurses engage in different practices (Villeneuve, 1994). Such practices are an effort to maintain a hegemonic masculinity and include behaviours that both emphasise and minimise masculine identity. In a study by Evans and Frank (2003) an example of such behaviours include avoiding holding a door open for a female colleague so as not to draw attention to himself. Others engaged in behaviours that emphasised their masculinity, such as assisting with heavy work, dealing with violent patients and avoiding 'feminine' type work. By taking part in these 'manly' non-feminine practices, male nurses in a female-dominated workplace were able to portray the façade of a hegemonic masculinity (Evans and Frank, 2003). Men who choose to enter nursing "defy prevailing gender norms" (Evans and Frank, 2003. p 277).

3.3.5. Feminisation of Nursing

In the Republic of Ireland, women account for the majority of most grades in the healthcare service with almost 92% of nurses being female (CSO, 2011). The feminization of nursing brings with it low status and low pay. Cockburn (1991) notes that rather than a specific occupation being gender-neutral, the occupation is considered around the notion of whether it is suitable for women or men. From the overwhelming number of women in general nursing, it would be logical to consider that nursing is not seen as a suitable work arena for men. The suitability of an occupation for either gender is not static and there are examples throughout history where men were the numerically dominant force in what is now considered to be a feminized occupation. This is true of the history of men in nursing but with the advent of Florence Nightingale in the second half of the 19th century, nursing became firmly established as the domain of women.

Nightingale is charged with clearly and emphatically establishing nursing as a woman's occupation. To her, every woman who entered nursing was already a nurse and therefore it was only natural that it would be a female who entered nursing. They were "doing only what came naturally to them as women" (Evans, 2004b). Her reformed model of nursing allowed little or no room for the male nurse. His 'hard and horny hands' were not suitable to care for the body (Summers, 1988). Nightingale's philosophy of nursing embraced not only the abilities needed to be a good nurse but also the need to be ladylike and possessing certain personality traits. Therefore, nursing became a suitable occupation for young women of good character and standing (Miers, 2000. Evans, 2004b). These ladylike qualities coupled with the need for devotion to care resulted in nursing clearly becoming an occupation for women. Nursing was strongly embedded as an unskilled occupation and one of very low value in comparison to a man's work, especially a man who was a skilled and educated doctor (Palmer, 1983. Porter, 1992). Positioned within a patriarchal society, the devalued status of women and their work reflected in the female occupation of nursing where "stereotypical

feminine traits of nurturing, caring, dependence and submission exist in stark contrast to masculine characteristics such as strength, aggression, dominance, self-control and objectivity" (Evans, 1997. p 226).

The traditional Victorian doctor-nurse-patient relationship in the general hospital reflected the husband-wife-child relationship in the home. Doctors determined what should happen to the patients and nurses duly followed the instructions and cared for the patients, who had little knowledge and even less control over what was happening to them (Gamarnikow, 1978). Women's second-class status is in part "the result of assumptions founded upon a reductionist-socio-biological model of gender role differentiation" (Porter, 1992. p 512). Within this model, women, with their basic maternal instincts, have instinctual caring attributes but men are the rational and decisive ones. Political events also influenced the increasing dominance of the female within nursing. Two such events were the success of women's suffrage in 1919 coupled with the *Nurses Act, 1919*. This Act set up a separate supplementary Register for the small number of male nurses. Only female nurses were allowed full membership of the Nurses' Register. Because a very small number of hospitals agreed to train male nurses, the low number of males on the Register was maintained. The sex-segregation of the Register continued in the UK until 1947. Mackintosh contends that the negative attitude towards male nurses persisted. There continued to be the notion that nursing was naturally a woman's job. There was a strong belief that nursing was naturally the domain of women and that therefore for a man to be a nurse would lead to nursing being violated because men were not natural carers. Coupled with this was the belief that because men were not natural carers "male nurses could therefore not be 'real'" (Mackintosh, 1997.p 235). Legislative reforms following World War 11 attempted to actively attract men into nursing. Men who returned from war did not always have a job waiting for them. The Ministry of Health provided fast-track courses in nursing for ex-servicemen. The *Nurses Registration Act, 1949* amalgamated the different parts of the Register,

thus ending formal legislative discrimination against male nurses. Nightingale's image of the nurse as 'angel of mercy' reverberates in society to this day. Nightingale, coupled with the *Nurses Act 1919* that excluded male nurses from the self-governing processes of nursing, laid the foundation for the feminisation of general nursing.

3.4. SUMMARY

I have argued in this chapter that gender relations are the outcome of day-to-day interactions and practices but rooted in patriarchal structures and control. Because they are the product of a dynamic process, they can therefore be open to change and to challenge. It is not enough to consider the different dimorphic classification, that is, male versus female; heterosexual versus homosexual, feminine versus masculine. "Binary divisions along gender and sexual lives can be seen as an historical fiction which conceals a much more confused mixture of fears, anxieties and desires about what being a man means" (Weeks, 2005. p 53). Gender can be viewed as a performance, often an expected performance. Butler views this non-fixed view of gender as a sequence of performative actions that are put upon the physical body in order to comply with powerful discourses (Butler, 1990). From my own experience in the world of nursing and nursing-related jobs, men have been used and indeed abused for their muscle power. Culturally in the Republic of Ireland men have been traditionally viewed as fitting into muscular work such as farming or building. If men did enter nursing it was psychiatric nursing where caring for aggressive or confused patients sat well with the image of what was perceived to be masculine.

CHAPTER 4: RESEARCH DESIGN

4.1. INTRODUCTION

This chapter outlines the research design and gives more detail of the purpose of my research introduced in chapter 1. It gives an overview of how I decided to explore specific areas in the research. It reiterates the research questions. It shows why a qualitative approach fitted well with the topic of ascertaining and interpreting the experience of male general student nurses in the female world of nursing in the Republic of Ireland. There is an explanation of how quality enhancement was ascertained. There is further detail on the methodology used, that is, IPA. The data collection method of 10 one-to-one face-to-face interviews is detailed. The method of analysis of the interviews using IPA is explored. Details are given on the rationale used in the selection of the participants. As the participants are considered a vulnerable group, details are provided on the gaining of ethical approval, initially from the university where the EdD programme was provided and then by the two HEIs in the Republic of Ireland from whence the participants were drawn.

4.2. DECIDING ON THE AREAS TO EXPLORE

A number of factors informed the areas to explore for the thesis and were both subjective and objective. From a subjective perspective, (Refer 1.3) my own experience at all levels of nursing throughout many countries, had left me wondering why so few men went into general nursing and of the small percentage who did enter, why so many of them gravitated towards management or lecturing or the trauma or high-tech clinical areas. These thoughts informed the basis for my OWE assignment (1.4). The study participants in my OWE assignment were all male and included both

lecturers and student nurses. The findings further reinforced what I had experienced throughout my own career. The support for second-level school-boys to consider nursing as a career was sparse and when they did express an interest in nursing, they were often laughed at or equated with being gay. The nature of the work as perceived by their school friends was also considered to be gendered with the perception that the traditional Irish man must be manly and be seen to do manly things and this did not include being a nurse. Both groups interviewed in the OWE assignment, the registered general nurses and the general student nurses, stated that their gender had played a significant part in their work-lives, both as general student nurses and as registered general nurses. There was also a belief that salary and conditions were poor in nursing. The participants in the OWE assignment also considered that there were advantages and disadvantages in being a minority male among the majority females. The other area explored was career and promotion opportunities and the participants strongly believed that these were especially good for the male nurses.

The literature reviewed in chapter 2 reinforced the outcomes from my OWE assignment and indeed my own experiences. The literature showed that from the male nurses' perspective, nursing can bring with it challenges and more especially so for the male nurse, whose sexuality may be in question. The literature reinforced the notion that male nurses often use their physical power or their technical knowledge to their advantage. It has showed that there were both advantages and disadvantages in being a male in nursing. I wanted to explore more the overall concepts regarding gender bias that had begun to emerge as part of my OWE assignment and from the literature. Chapter 3 considered theorising gendered identities. It looked at how the male nurse engages in different practices that express or suppress their masculine identity in order to maintain the appearance of a hegemonic masculinity. The feminisation of nursing has resulted in nursing being perceived as including such traits as caring and nurturing, traditionally being viewed as that of the

female. The world of general nursing was certainly not perceived as the domain of the male. However, men continue to enter general nursing and could therefore be seen to be exerting their agency. My research was interested in looking at the outcomes or the reactions to exercising such agency and in exploring the concept of hegemony and the perception of male nurses as being homosexual. Part of my research was about finding out about the resources or the forms of masculinities that men draw on in a field that is feminized. It was concerned with the strategies, with a possible masculine performance or hegemonic masculinity, that they use as they inhabit the feminized world that is general nursing.

Based on my own life-journey and the findings of my OWE assignment, coupled with the literature review and the exploration of gendered identities, a number of broad areas began to emerge that would inform the basis of my research as follows:

1. Influences on the participants on their decision to do nursing
2. Reactions of others when they made that decision
3. Images of nursing that the participants consider to be prevalent in the Republic of Ireland
4. Roles and activities that the participants consider underpin general nursing
5. Masculinities and Identities considered by the participants on entry to the nursing programme and if any change occurred since starting nursing
6. Strategies used by the participants when working with a female-dominant group of registered general nurses
7. Career paths that the participants expect to follow.

4.3. AIMS AND RESEARCH QUESTIONS

4.3.1. Aims

My research aimed to find out what it was like for a man to inhabit a traditional female space. The participants shared distinct common features. They were all men and student nurses in their final year in general nursing in the Republic of Ireland. It can be assumed therefore that they identified with a masculine gender in a context that can be assumed to be one of femininity.

I was interested in finding out whether gender was significant when they first made the decision to enter general nursing. I wanted to find out how the image of general nursing in the Republic of Ireland is shaped or influenced by society's view of gender in nursing. Since starting general nursing almost four years ago, the male general student nurses would have had encountered reactions from others by virtue of them being male. Such reactions would have occurred in both their work and social lives and I was interested in learning about such reactions.

My research was concerned with exploring the male general student nurses' perceptions of themselves, both as men and as male student nurses. The interviews explored the impact of gender on the participants' sense of self/identity and their work. Men (and women) enter into the profession of nursing with an identity, with a masculinity or a femininity. I explored the participants' understanding of their masculine identity and if having spent almost four years in the feminized world of general nursing, this identity has changed.

The theories of gender were also considered when carrying out the interviews including the role of the biological, of the male muscle mass as a factor; the place of performativity; the place of hegemony; and the use of compensatory measures carried out by the male student nurses

including measures taken to assert their sexuality. I looked at ways by which the male student nurses considered they were either advantaged or disadvantages by virtue of being male.

My research was interested in finding out about the coping strategies used by the participants to assist with integration into this other-gender world. It considered the male student nurses' perceived career paths overall for men in general nursing coupled with their own ambitions in nursing.

4.3.2. Research Questions

Based on the above aims, the research questions were as follows.

1. In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

2. How do the male general student nurses understand their gendered identities?

3. In what ways do the male general student nurses feel that their masculinities have been reinforced and/or challenged by their professional identity?

4. What strategies do the male general student nurses use to integrate themselves into the nursing profession?

4.4. A QUALITATIVE APPROACH

In comparing a quantitative with a qualitative approach, there are a number of striking differences. The first relates to the focus of the data, with quantitative being mainly relating to figures and

statistics but qualitative relating to words. Cause and effect is the second contrast with quantitative analysis offering an explanation for some phenomenon whereas qualitative analysis strives to understand and interpret the experience. Objective versus subjective analysis provides the third contrast. Quantitative analysis is concerned with objective knowledge whereas qualitative research is interested in the participant's own words and subjective view. Subjectivity is also relevant to the researcher who must engage in a reflective process throughout the research process (Treacy and Hyde, 1999). As the overall aim of the research was to try to find out what it is like to be a man in a female-dominated environment, a qualitative approach was the appropriate one. Qualitative research involves a naturalistic and interpretive approach whereby the study takes place in the natural environment of the participants. Qualitative research endeavors to make sense of or interpret phenomena in relation to the meaning that participants bring. It uses a design that describes what is happening to the participants at a given time (Denzin and Lincoln, 1994).

From an ontological perspective, qualitative research has been influenced by the philosophy of phenomenology whereby through knowledge we may understand how we know something rather than objectively uncovering the nature of something. This ontological assumption clearly resonated with my research topic in that the research aimed to understand the subjective experiences of male general student nurses in the female world of nursing.

From an epistemological perspective, the researcher is concerned with knowledge of reality, about what we can know about that reality. My research was concerned with the experiences of the participants and therefore knowledge of reality would be knowledge of those experiences. But as researcher, I could not have full knowledge as it changes with time and is filtered by the participant and by the researcher. Therefore, the importance of using the participants' own words was relevant in attaining as close an approximation as possible to the experiences of the participants.

Methodology focuses on how we gain our knowledge, in other words, how I gained knowledge about the experiences of male general student nurses. The methodology focused on uncovering the reality from the worldview of those in that reality.

Interpretation by the researcher is a key component to the process. The researcher needs to understand and become immersed in the world of the participants. In keeping with IPA, I needed to interpret the participants' interpretation of their experiences and I needed to reflect on the process throughout.

Qualitative research has a number of characteristics (Creswell, 1998. p 16):

Natural setting (field-focused) as source of data

Researcher as key instrument of data collection

Data collected as words or pictures

Outcome as process rather than product

Analysis of data inductively, with attention to particulars

Focus on participants' perspectives, and their meaning

Use of expressive language

Persuasion by reason.

In applying these characteristics to my research, I noted the following. Although the interviews were not in the clinical setting, they were nonetheless in a natural setting for the participants, where they had studied for almost four years. As researcher I was the key instrument in the data collection, being the sole interviewer. When considering methods whereby evidence about the phenomenon is gathered, I was interested in affording the participants the opportunity to use their own words in describing what it is like to be a male student nurse among the predominant number of females.

Therefore, an appropriate data collection method was a semi-structured interview. The data was collected via recorded interview and the participants' own words were central to the analysis. The methodology needed to go towards uncovering the worldview of the male student nurses. It needed to allow for my interpretation of the participants' views. In order to allow the male general student nurses to 'tell it as it is' I needed to employ a methodology that best suited these requirements. Therefore, the methodology that I considered best suited was phenomenology and more specifically IPA.

4.5. INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA)

Underpinning IPA is phenomenology: the study of a phenomenon. Phenomenology emanates from different schools of philosophy. Husserl (1936–1970) believed that rather than sanitising an experience and tying it up in a neat package, he believed that we should try to focus on every component of the experience. Descriptive phenomenology emanates from the Husserlian tradition and focuses on identifying the very centre or essence of a phenomenon using bracketing whereby we put to one side the taken-for-granted world. In other words, we bracket it. In so doing we can then concentrate on our perception of that world. He considered that our personal experience is 'first-order.' We should step outside our everyday life and reflect on that life: "Adopting a phenomenological attitude involves and requires a reflexive move, as we turn our gaze from…objects in the world, and direct it inward, towards our perception of those objects" (Smith *et al*, 2009. p 12). As an influence on IPA, Husserl's notion of the importance of reflexivity is significant. In this approach "the analyst interrogates the description produced through a number of existential givens of the lifeworld e.g. selfhood, embodiment, temporality, spatiality" (Langdridge, 2007. p 55).

Another phenomenological philosopher was Heidegger (1889–1970) who was a student of Husserl. Whereas Husserl was interested in individual psychological processes such as awareness and perception, Heidegger was more interested with the nature of *Dasein*, of 'there-being' or existence itself. He believed that as human beings we are in the world, thrown into the world, a world of people, objects, relationships and language and that our being in the world is always relative to someone or something else. In this milieu we make sense of things, we begin to interpret. In the early 1960s, Merleau-Ponty contended "all my knowledge of the world…is gained from my own particular point of view, or from some experience of the world" (Smith *et al,* 2009. p 18) believing that our body is a means of communicating with the world and not merely an object in the world. Each of our experiences belongs individually to our own embodied experiences. Therefore, we can never fully engage with or share another's experience. Merleau-Ponty's influence on IPA is that whereas, I, as researcher, can never fully capture the lived experience of being a male general student nurse in the female world of nursing, such an experience cannot be discarded. Sartre (1905-1980) contended that we are always becoming, always developing the self, always continuing to uncover ourselves. Our perception of the world is, in his view, mostly shaped by others in that world or by the absence of certain other people or things in that world. IPA is about our encounters in the world, about our experiences and our reactions to those experiences in this world of others whether absent or present.

The main aim of phenomenology is a description of the "total structure of the lived experience, including the meaning that these lived experiences have for the individuals who participate in them" (Omery, 1983. p 50). Phenomenology aims to explore the shared meaning of a phenomenon: perceptions, thoughts and meanings. The 'shared experience' is important in phenomenology and I aimed to hear the experiences of a number of different people who shared a common experience, that is, they were all male general student nurses. They shared a point in time in that they all

commenced the general nursing programme in 2005 and 2006 and undertook the internship from January to September 2009 and January to September 2010. The interaction of me as the researcher with the participants was crucial and in terms of what I wanted to study, they cannot be isolated from each other. Interconnected with phenomenology, interpretation is key in IPA. Hermeneutics is the theoretical underpinning to interpretation. Heidegger believed that we cannot bracket ourselves from the world and that our way of being, of existing, needs to be not only described but also interpreted Gadamer (1900–2002) significantly influenced the concept of hermeneutics in phenomenology. Like Heidegger, Gadamer considered we are thrown into the world and in that world we create meaning. He believed that the world is "where all possibilities are already experienced interpretations" (Langdridge, 2007. p 43). This interpretation is gained through language but not simply a language that tells us what another feels or thinks but a language that brings our very self into the story. Therefore, our understanding derives from our own prejudice and history that needs to be understood. Ricoeur (1913–2005) like Gadamer, considered the importance of us speaking from somewhere, a somewhere that is influenced by culture and history in our understanding of being in the world.

IPA was developed by Jonathan Smith, a UK psychologist, in the 1990s and it is "probably the most widely known approach to phenomenological psychology among psychologists in the UK today" (Langdridge, 2007. p 107). It is an approach with greater emphasis on interpretation than is apparent in descriptive phenomenology. IPA has its focus on what a particular experience means to a person. The emphasis on what an experience means for a person is at the very core of what is a phenomenological study. The participant interprets the meaning of the experience on him. But the researcher, rather than merely affording a description, also engages in interpretation. Thus the term 'double hermeneutic' whereby the researcher interprets what the participants interpret from their lived-experience. IPA is a methodology that endeavors to understand how a person makes sense of

a life experience. Firstly, it is phenomenological in that it considers the experience in its own terms and facilitates the participant to tell it as it is. Intrinsic to telling the story about an experience is the process of reflection whereby the participant can start to reflect on the experience and its meaning. Therefore, interpretation occurs whereby the participant draws meaning from the experience. Such interpretation is informed by hermeneutics, which is the theory of interpretation. But when the participant tells the researcher his interpretation of the experience, the researcher then needs to interpret what is said in order to get close to understanding the experience. Thus the concept of a double-hermeneutic in IPA: "the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith *et al*, 2009. p 3). But the researcher can only have access to the experience second-hand through the participant's account of that experience.

IPA aims to understand and interpret other's lived-experience in the world. IPA involves both an understanding of a phenomenon and an interpretation of that phenomenon. I needed to try and understand the lived experience that is specific to the individual in the world. Through a process that needed to be dynamic and organic, I needed to obtain from the male general student nurses a subjective account of their experiences as they relate to the female-dominated world of nursing as opposed to an objective account. By the very nature of the research questions' I aimed to access the personal and professional world of the study participants. IPA embraces the concept that "access depends on and is complicated by the researcher's own conceptions…required in order to make sense of that other personal world through a process of interpretative activity" (Smith *et al*, 2009. pp 218-219). Central to IPA is affording the participant the space and time to think, to reflect, to speak and to be heard. There are many examples in the literature of where IPA has been used to understand feelings and emotions. In a study by Eatough, she explored "anger and anger-related aggression in the context of the lives of individual women" (Eatough *et al*, 2008. p 1767). Her research looked at women's subjective experience of anger with the women contextualized world

from which they make sense of what is going on. My own research was likewise about a homogenous group of people who were trying to make sense of their "subjective conscious experiences" (Eatough *et al*, 2008, p 1773) of being a man in a female world of nursing.

4.6. DATA COLLECTION METHODS

In trying to understand the experience of the male general student nurses, the whole interview process, as previously stated, needed to be dynamic and organic. Nonetheless, advance planning is prudent and essential in carrying out research and the following include an overview of the concepts involved in advance planning (Polit and Beck, 2010. p 260):

Determining the maximum amount of time available for the study

Identifying the types of equipment that could aid in the collection and analysis of data in the field

Identify any "gatekeepers" who can provide or deny access

In considering these guidelines as they applied to my research, I determined the following actions:

I carried out the research within the timeframe considered best in relation to the participants. The equipment that I needed includeda recorder and pen and paper while in the field.

The "gatekeepers" included the Directors of Nursing and Midwifery Studies in the HEIs who provided me with the information needed to identify and gain access to the participants. They also provided me with the details of the process involved in applying for ethical approval. Linked with the ethical approval was the concept of informed consent (Refer 4.8).

When considering an appropriate data collection method for an IPA study, a key factor is to use a method that "will invite participants to offer a rich, detailed, first-person account of their experiences…participants should have been granted an opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns at some length" (Smith *et al*, 2009. p 56). In reviewing the methods more commonly used, semi-structured one-to-one interviews have emerged as the most frequently used (Reid *et al*, 2005). In a review of data collection methods used, Brocki and Weardennote that "the vast majority followed a semi-structured format, employing some sort of interview format" (Brocki and Wearden, 2006. p 90). As the first aspect of IPA is to allow the participants to each tell their own story in their own words, a one-to-one format seemed best placed. The method of the semi-structured interview aimed to empower each participant to articulate his own story of what it was like to be a male general student nurse in the world of nursing that is mostly carried out by women. The second part of IPA, my interpretation as the researcher, was then supported with verbatim accounts of the participants' own words.

I considered that the one-to-one, face-to-face, semi-structured interview would "allow rapport to be developed; allowed participants to think, speak and be heard; and was well suited to in-depth and personal discussion" (Reid *et al*, 2005. p 22). I wanted to engage as much as possible with the participants. I considered that the distraction of taking notes would be a deterrent to such engagement. Therefore, I decided to tape-record each interview. Following each interview, I allowed a period of time to elapse during which I listened and re-listened to the interview. This careful listening, as well as allowing me to reflect on my contribution to the interview and how I conducted it, formed an essential component of the analysis. Although I had determined the research questions, by its nature, a semi-structured interview within the methodology of IPA, needed to be fluid. To a great extent, the participant dictated the flow of the interview and the questions could have been neither linear nor rigid. Therefore, to assist with the interview process, I drew up an

interview guide that would "identify a number of key issues…that will form the overarching structure to the interview" (Langdridge, 2007. p 67). In each aspect I included prompts. This interview guide formed part of the Information Sheet that I sent to potential participants. My initial questioning was the same for all the interviews whereby I asked each participant to tell his story of why he had chosen nursing (Refer Appendix G). Throughout the interviews I tried to ensure that the process was exploratory not explanatory and open and flexible in structure.

4.7. RESEARCH PARTICIPANTS

4.7.1. Overview

When considering the recruitment and selection of participants for an IPA study, they need to be selected on "the basis that they can grant us access to a particular perspective on the phenomenon under study…they 'represent' a perspective, rather than a population" (Smith *et al*, 2009. p 49). Sampling should be purposive and homogenous "participants are recruited who share the experience at the heart of the investigation…the aim is to recruit a sample of people such that the researcher can make claims about these people and their particular shared experience. Studies are therefore *idiographic*, and there will be little attempt to generalise beyond this particular sample" (Langdridge, 2007. p 58). An idiographic approach prioritises a focus on the particular rather than the general/universal. The main emphasis in an IPA study is with a "detailed account of individual experience. The issue of quality, not quantity, and given the complexity of most human phenomenon, IPA studies usually benefit from a concentrated focus on a small number of cases" (Smith *et al*, 2009. p 51). The importance of the traditional correlation between numbers and value is challenged in IPA. The focus is idiographic with 10 participants being at the upper end for sample size of most IPA studies (Reid *et al*, 2005. p 12). In considering the sample, I explored the areas described below.

4.7.2. Division of the Register

The first consideration was to decide on which of the five pre-registration disciplines I would use to carry out the research: general; psychiatric; intellectual disability; integrated general and children's; or midwifery. I decided to carry out the research with general student nurses. The reason for the discipline choice was that traditionally there have been more men in the disciplines of psychiatric and intellectual disability nursing than in general nursing. The statistics (Refer Appendix B) support this concept, with the percentage in general nursing being 5% on average but reaching double-digits in psychiatric nursing and in intellectual nursing. I chose neither the integrated children's and general nursing programme nor midwifery as the first group to commence internship would not have been until 2010.

4.7.3. Stage in Training

The second consideration was at what stage in the four-year programme would I carry out the research. There were 13 HEIs offering the pre-registration programme in the Republic of Ireland. This programme is a four-year honours degree programme and is at level 8 as per Quality and Qualification Ireland (QQI, 2012). For the first three years of the programme, the student nurses are in a supernumerary capacity in the clinical setting. The students have the usual college holidays. When in clinical placement, it is more in an observational capacity and they work under the supervision of a registered nurse. From January to September in the 4th year of the programme, they undertake a 36-week period of internship and although not yet registered, they form part of the workforce and are paid a salary. Having considered the programme design, I decided that the stage in the programme from which I would draw the participants would be where they had completed a minimum of two clinical placements during the internship. Each placement is typically six weeks in duration. Reasons for this decision included that the students would:

be at advanced stage in their training

have experienced what it was like to be a male student nurse at both supernumerary and internship levels

have settled into the role as an intern.

The starting time for conducting the interviews was therefore aimed at the end of March. The month of May is traditionally the month for examinations and I considered it best to avoid this month. I considered that the summer months of June to August were probably best avoided because of students' holidays coupled with the possibility of repeat examinations. Another significant factor was that some of the HEIs more-or-less close for the summer months and access might prove difficult. Picking the time of late spring early summer also allowed for a further cohort to be considered for the following year. Therefore, the ideal timeframe was March and April.

4.7.4. The Cohorts

The next consideration was which cohorts to consider. I decided to include two cohorts because of the methodology of preferably spreading out the interviews in order to carry out a preliminary analysis and to allow me time to reflect on the previous interview against the short window of opportunity to carry out the interviews. Coupled with this was the relatively low numbers from which to choose.

The first cohort that I studied was the student male general nurse intake of 2005 from one HEI who were due to complete the programme in the autumn of 2009 but I also sought ethical approval for the 2006 intake from another HEI in order to allow for sufficient participants from a small overall pool.

4.7.5. Number of HEIs

A linked consideration with the number of cohorts was how many HEIs I would include in the research. In order to better address this issue, I wrote to all 13 HEIs offering the four-year pre-registration honours degree programme in general nursing. The Candidate Register of *An Bord Altranais* (Refer Appendix B) showed that of the 1092 general student nurses who commenced in 2005, 56 were men. However, it could not be assumed that 56 would commence internship in January 2005 as a number of factors could alter that number, including students exiting the programme or deferral. In addition, other men from previous cohorts may have joined the 2005/2006 cohorts. Therefore, the first task was to determine a more realistic prediction of the number likely to commence internship in January 2009/2010. To this effect I wrote to the director of nursing and midwifery studies in the 13 HEIs offering the pre-registration general nursing programme (Refer Appendix C). All 13 HEIs responded (Refer Appendix D). I selected two of the HEIs with relatively high number of male student general nurses. Six students in the 2005 cohort from one HEI plus four students in the 2006 cohort from the second HEI indicated an interest in taking part in the research. Because of optimum time issues and the nature of IPA interviews, I decided on two different years when picking the cohorts, that is, the 2005 cohort due to complete the programme in 2009 and the 2006 cohort due to complete the programme in 2010.

4.7.6. Location of Interview

The fifth consideration was the location of the interviews. Although all the participants were going to be at least twenty-one years of age, they would still be categorised as a vulnerable group within the HEIs concerned. The ethics committees from both these two HEIs consider all students to be within the category of vulnerable. Therefore, the location had to be in their domain. I planned to interview them while they were undergoing internship in a general hospital. A number of general hospitals would have been involved. During this time, they are considered to be part of the workforce and

would be paid a large percentage of a first-year staff nurse salary. During their internship placement, the students have protected study time and frequently return to the HEIs during this time. By carrying out the interviews in the two HEIs, it caused no disruption to the clinical sites and I felt that the familiarity of the setting would help put the participants at ease.

4.7.7. Number of Participants

Six participants from one HEI for the 2005 cohort agreed to participate. Following discussion with my then supervisor, this number was expanded to ten interviews. Therefore, the four from the second HEI from the 2006 cohort made up the number to ten. As ten had agreed to participate, I decided to interview all ten of them, as all men spoken with initially on the telephone were very enthusiastic to participate in the research. The decision to interview all ten was expedient in that it fitted in with the suggested number of participants but it was also pragmatic in that it meant I could facilitate all those who showed an interest in taking part.

4.7.8. Summary of Participants

Based on the above, the considerations regarding participants for my research can be summarised as follows:

Male general student nurses from two cohorts, 2005 and 2006, who had completed a minimum of two clinical placements of their internship

The optimum timeframe was March and April in 2009 and 2010 but certainly no earlier than towards the end of March

The participants were from two HEIs

The interviews took place in each participant's own HEI

The number of participants was ten, that is, all who expressed an interest in taking part in the research.

Five of the ten participants had entered nursing directly following completion of secondary school, which is at on average eighteen years of age. The other half had pursued other careers before entering nursing, including teaching, manual work and senior executive in industry. The age of this latter five upon entering nursing ranged from twenty-three to early fifties. The participants were not asked about their sexual orientation but two of them stated that they were homosexual. Between the ten participants, they had worked in five major general hospitals and three major maternity hospitals plus smaller facilities during their nursing programme.

4.8. ETHICAL APPROVAL AND ACCESS

Throughout the preparation of my work, I kept in mind a number of broad considerations pertaining to ethical safeguards. In any research a number of goals must be achieved (Sliverman, 2005. p 323):

Making people's comments and behaviour confidential

Protecting people from harm

Ensuring mutual trust between researcher and people studied.

Gaining ethical approval and maintaining an ethical approach must underpin any research. My research method was semi-structured one-to-one face-to-face interviews. "Interviews are interventions. They affect people…The process of being taken through a directed, reflective process affects the persons being interviewed and leaves them knowing things about themselves that they didn't know-or at least were not fully aware of-before the interview" (Quinn Patton, 2002. p 405). My

research method plus the topic under consideration had the potential to involve reactivity on the part of some or all of the participants. In thinking about ethical matters regarding my research, I used a checklist (Refer Table 5) as follows:

Table 5**: Ethical Issues Checklist** (Quinn Patton, 2002. pp 408-409)
EXPLAINING PURPOSE How will you explain the purpose of the inquiry and methods to be used in ways that are accurate and understandable?
PROMISES and RECIPROCITY What's in it for the interviewee?
RISK ASSESSMENT In what ways, if any, will conducting the interview put people at risk?
CONFIDENTIALITY What are the reasonable promises of confidentiality that can be fully honoured?
INFORMED CONSENT What kind of informed consent is needed for mutual protection?
DATA ACCESS and OWNERSHIP Who will have access to the data and for what purpose?
DATA COLLECTION BOUNDARIES How hard will you push for data?
ETHICS VERSUS LEGAL What ethical framework and philosophy informs your work and ensures respect and sensitivity for those you study, beyond whatever may be required by law?

In preparation for applying for ethical approval, I considered a checklist on Table 5 as per the following.

Purpose

The first thing was to contextualise the research by explaining who I was and the programme that I was undertaking. The follow-on was the purpose of the research. Guiding the overall purpose was to explore how each participant socialized in both the work and the recreational settings coupled with each participant's identity and how it was or was not altered as a result of working in this arena. I developed a broad interview guide and included it as part as part of the Information Sheet (refer appendix G). In the interview guide I planned to keep the language simple and accessible. But as there was no technical specific language and as the participants were all adults having completed over three years on an honours degree programme in English speaking HEIs, I did not foresee any language issues. I considered the value of the work and decided that I would primarily attribute its value to the completion of my research. I decided to share all details of the research including why I was doing it and the full process to the point when it would form part of my overall thesis. I gave an overview of the purpose in the written communication but also expanded on it more fully as the introduction to the interview itself, thus affording an opportunity to clarify any issues.

Promise and Reciprocity

At the outset I decided not to make any promises regarding sending a copy of the recording or the transcript or the thesis. If requested I would advise that the interview was part of a full process that hopefully might result in the award of an EdD and that a copy would then be available in my work library. I had to consider why each participant should partake in the research. Again it was important to be honest. I gave an overview of why each participant was chosen together with a summary of what would happen if they chose to take part. In relation to the value of taking part I was very clear that whereas there would be no expected personal benefits for the participants, nonetheless the anticipation would be that it would help me in completing my thesis and in so doing would hopefully

contribute towards a greater understanding of the experience of being a male general student nurse.

Risk Assessment

The first thing that I needed to make clear was that there would be no repercussions if they decided not to participate. As a follow-on I needed to emphasise that they could withdraw at any point. This was an aspect that I especially emphasised at the start of the interview coupled with a full reassurance that there would be no repercussions whatsoever. I needed to build-in safeguards. One way I did this was to outline what they could do if they perceived that anything went wrong or that they felt aggrieved in any way. The option that was given to each participant was to initially approach me if there was any discomfort, risk or disadvantage. Obviously they could withdraw from the process at any point. Each participant was given the contact details of the Research Governance Officer, the Department Professor and my Supervisor at the university where I was undertaking the EdD programme should they wish to contact any or all of them. Regarding compensation, I considered it important to point out to each participant that there were no special compensation arrangements but that if a participant was injured or harmed due to someone's negligence, then there might be grounds for a legal action but that the participant would have to bear the costs.

Confidentiality

There were a number of considerations underpinning confidentiality that I needed to consider including:

Where the recordings and the transcripts would be stored

The use of a memory/safe stick and the necessary precautions

The involvement of the transcriber including the deletion of all data when the transcription is complete

When the thesis is written up all recordings would be deleted

Removal of any identifier from the transcript, for example, the mention of a location such as a specific ward or hospital

The coding of all data with each code known only to me.

As well as addressing confidentiality on the Information Sheet (Refer Appendix G) I reiterated its components prior to each interview. The voluntary aspect was critical. To allow for this, I placed the letter (Refer Appendix F) and Information Sheet (Refer Appendix G) in stamped opened envelopes and asked the Department secretary (with prior permission from the Department Head) to post to the male student nurses in the cohorts concerned. Each person could then decide whether or not to participate and could contact me directly. At no point did I share with anyone else who took part.

Informed Consent

According to Silverman (2005. p 258) informed consent is:

Giving information about the research that is relevant to subjects' decisions about whether to participate

Making sure that subjects understand that information (for example, by providing information sheets written in subjects' language)

Ensuring that participation is voluntary (e.g. requiring written consent).

Criteria considered important regarding informed consent include (Allmark, 2002. p 13):

The consent should be given by someone competent to do so

The person giving the consent should be adequately informed

The consent is given voluntarily.

Therefore, it was essential that I drew up a clear Information Sheet (Refer Appendix G) outlining all the necessary aspects pertaining to the research. I requested each participant to sign a consent form at the commencement of the interview but not before giving them another opportunity to re-read the Information Sheet (Refer Appendix G) coupled with the time to ask me any questions or clarify any matters.

Data Access and Ownership

Having already outlined the coding, anonymity and storage arrangements, the next consideration was who would have access to the interview data. I outlined that as well as forming a part of my thesis, it might also be used for other purposes such as to inform presentations or other research. In the Information Sheet (Refer Appendix G) I also mentioned the notion of collaborators who would read the scripts.

Data Collection Boundaries

My plan in relation to asking a question was to be sensitive and especially so if a participant seemed uneasy in answering a particular question. I needed to be at ease with the participants and to listen carefully and to give them my full attention.

Ethical versus Legal

To inform me I needed to fully familiarise myself with the ethical frameworks from the three institutions involved. The first institution to consider was the university where I was undertaking the EdD programme. My first submission required minor changes and ethical approval was given for me to proceed with the research.

The next stage was to identify the gatekeepers in the two HEIs in the Republic of Ireland who would guide me in gaining ethical approval and therefore access to the students. I identifying the gatekeepers and getting access to potential participants can have different problems. There are nine points identified by Wolff (2004) as potentially problematic (Refer Table 6).

Table 6: **Points Identified as Problematic when Identifying Gatekeepers and Gaining Access** (Wolff, 2004. pp 195-202)
Research is always an intervention in a social system
Research is a disruptive factor for the system for which it reacts defensively
A mutual opacity exists between the research project and the social system to be researched
To exchange a whole mass of information on entering the research field does not reduce the opacity. Rather, it leads to increasing complexity in the process of agreement and may lead to increased "immune reactions." On both sides, myths are produced, which are fed by increased exchange of information
Instead of mutual understanding at the moment of entry, one should strive for an agreement as a process
Data protection is necessary, but may contribute to increased complexity in the process of agreement
The field discovers itself when the research project enters the scene (for example, the limits of a social system are perceived)
The research process cannot offer anything to the social system. At most, it can be functional. The researcher should take care not to make promises about the usefulness of the research for the social system
The social system has no real reason for rejecting the research.

From the nine potential problems as outlined in Table 6, I was aware that the two HEIs were unlikely to benefit, certainly in the short term, from my work. Instead I was going to intrude on their space and time. My study caused a disruption to and a commitment from the two HEIs, including:

My initial contact with the Heads of the two Departments necessitated the use of their time

The consideration by the ethics committee necessitated the members taking the time to consider my submission

Following ethical approval, there was a time involvement with the secretaries of the two Departments, after the Head of each Department had briefed them

The interviews themselves required the organising of a suitable space by the secretaries of the two Departments.

At the outset the information I provided in introducing the potential research to the two HEIs (Refer Appendix E) had to be sufficient to address the research but not so cumbersome as to cause more confusion. The feedback received from the HEI where I was undertaking the EdD programme helped to produce more clarity in the documentation. Careful completion of the application forms for ethical approval in the two HEIs where I proposed to carry out the interviews also helped.

Based on my previous work regarding regulation and inspections, I knew the heads of the department of nursing and midwifery in the two HEIs and had had interaction with them on other projects. Their knowledge of me as a person and of my work made gaining access relatively easily. I made an appointment to meet with each head of department and they outlined the process for gaining ethical approval and access and their support undoubtedly contributed to the success in gaining access unhindered. I then wrote to the appropriate person in the two HEIs. I completed the necessary application forms and included the following documentation:

A letter from the Professor in the Department in the University where I was undertaking the EdD Programme

The three documents for potential participants

Stamped Addressed Envelope

Letter of Invitation to Participate in the Research (Refer Appendix F)

Information Sheet including the interview guide (Refer Appendix G)

Consent Form (Refer Appendix H).

4.9. ANALYSIS

My research was about trying to understand and to interpret the lived experiences of what it was like to be a male general student nurse in the female world of nursing. As researcher, I needed to develop an initial insider's perspective and an outsider's perspective. My 'emic' position was a phenomenological position and was one of being an insider. In this position I heard the story of each of the male general student nurses and I prioritised their view of themselves and their interpretation of their experience in the world of nursing. My 'etic' position was an interpretative position and was one of being an outsider. In this position I tried to make sense of the participants' views.

In IPA, the analysis of the phenomenon and the double-hermeneutic necessitates a detailed process of coding, organizing, integrating, and interpreting the narrative from each interview, initially on an interview-by-interview basis and then collectively. IPA analysis needs to be carried out in a methodical manner and the following six broad steps provide a framework for such analysis (Refer Table 7).

Table 7: **Steps in Analysis** (Smith *et al*, 2009. pp 79-107)	
Step	Action
1.	Reading and re-reading
2.	Initial noting
3.	Developing emergent themes
4.	Searching for connections across emergent themes
5.	Moving to the next case
6.	Looking for patterns across cases

Step 1: Re-reading

At this stage, the researcher is concerned with starting to make some sense of each participant is saying and therefore "spends a considerable amount of time working through the transcript (and listening to the tape) in order to identify major themes" (Langdridge, 2007. p 110). I carried out ten interviews and the first four steps needed to be carried out on each case before moving on to the next case. Of key importance in this first step was that I immersed myself in the transcript. Each interview script needed to be read and re-read with the first reading being done whilst also listening to the recording. Listening to the recording helped me to remember or imagine the voice of the participant during the ensuing re-reads. The re-reading helped to understand any emerging patterns such as returning to certain ideas. It also helped to illuminate any contractions. But of importance it ensured that I really tried to hear what the participant said and not just what I thought was said. It helped me to re-enter the participant's world.

Step 2: Initial Noting

In this step, the transcript is examined for "semantic content and language use on a very exploratory level" (Langdridge, 2007. p 83). My initial noting at this stage was preliminary and exploratory. It looked at semantic content and language and noted anything of interest within the transcript. It set the scene for trying to identify the specific ways each male general student nurse talked about, thought about, and understood his experience of working in the female domain of nursing. Each transcript was explored line-by-line and the process of exploratory coding put in place. As a guide, I found three headings to be useful: description and content; language use; and conceptual and interrogative coding.

Description and content: Here the focus was taking at face value what the participant said, while highlighting key concepts such as events, experiences, words. It was about asking what he was talking about when he said what he said.

Language use: This involved examining the ways by which description and content were presented. It was about looking for the use of words in a particular way and about non-speech patterns such as hesitancy or laughter.

Conceptual and interrogative coding: This allowed for the opening up of possible interpretations. This was where my voice as that of the researcher was to the foreground. The analysis now began to shift from the descriptive to the opening up of possible interpretations. At this point I used my own experiences as a sounding board against which to think about each participant's experience. I considered the language, the construction of particular phrases and what might underpin them. The way in which meaning and concepts fitted together was explored.

Step 3: Developing emergent themes

In this step, themes begin to emerge within the transcript/s with an emphasis on convergence and divergence, commonality and nuance (Eatough and Smith, 2008). By fully considering the initial noting, themes began to emerge within my research. The process of initial noting obviously greatly increased the volume of the data set. The large volume needed to be managed. The focus was now on the initial notes rather than on the transcript itself. But as a comprehensive exploration was carried out via the conceptual and interrogative coding, I felt that it closely aligned to the transcript and I therefore considered that the voice of the participant remained. The data was re-organised based on the set of initial notes. The interview at this point was broken-up and fragmented. Here I as the researcher was central with an apparent distancing from the participant but throughout the participant remained close, with the desired outcome being a merging of both the interviewer and the participant, both the I and the P. The emergent themes needed to reflect both the participant's original words and thoughts plus my interpretation. The themes were a reflection of both the transcript and the associated exploratory codes. They represented the two players in the process: me in the form of 'I' and the participant in the form of 'P'. The emergent themes reflected an understanding and not just description. They were more fixed than were the more loose exploratory codes. The themes were then ordered chronologically in the order in which they came up.

Step 4: Searching for connections across emergent themes

In step 4, "Themes are appropriately named and each theme linked to the originating text through reference to specific quotes" (Langdridge, 2007. p 111). At this point I began a process of clustering. Patterns across the identified emergent themes were considered. Similar themes were clustered together and a matching to the seven identified areas. In considering the emergent themes, I needed to note if there were opposites whereby one emergent theme from a transcript might be the opposite to another theme from the same transcript, some experience that was

negative may also have had a positive result. In the clustering process I also needed to consider the context, for example, if the secondary school gender was a factor for the male student nurses or if the point at which they declared they were going to a nurse was significant. Another aspect that I needed to consider in the clustering was the frequency with which a theme was repeated. Searching for patterns and connections across emergent themes represented the development of a map of how both the 'I' and the 'P' was thinking.

Step 5: Moving to the next case

I completed the first four steps for each interview individually before I moved onto the next interview. When each of the ten interviews was fully considered based on the first four steps, I moved onto the next stage.

Step 6: Looking for patterns across cases

When all transcripts were individually analysed, the next stage was looking for patterns across cases commences. Smith *et al* (2009. p 101) propose questions as a guide:

> What connections are there across cases?
>
> How does a theme in one case help illuminate a different case?
>
> Which themes are the most potent/strongest?

Typically, there is no reference to the literature in the analysis, with the analysis being kept to the participants' verbatim accounts. According to Eatough, the analysis should depict a structure that illustrates the relationship between themes. The material needs to be organized in a way that allows for coded data to be traced right through the analysis-from initial codes in the transcript, through initial clustering and thematic development, into the final structure of themes (Eatough, 2012).

Synopsis of my analysis

There was rich data from which to carry out my initial noting. Having read and re-read each transcript I picked out lines that seemed to be relevant to the topic in question and then began to interpret the narrative. The rich data allowed for the development of emergent themes. I was careful to keep the voice of the participant plus my own voice to the forefront. Connections between the emergent themes became apparent. Having repeated the process for each of the ten interviews, the patterns between the interviews became clear and were matched to the seven identified areas:

1 Influencing Factors

2 Reactions

3 Images of Nursing

4 Roles and Activities

5 Masculinities and Identities

6 Strategies

7 Career Paths.

A summary table indicates where I got the examples from each interview. The number in front of each example in the summary table shows step 3 of my analysis namely developing emergent themes. The interview number is given in brackets at the end of each reference together with the line number/s pertaining to the interview.

4.10. QUALITY ENHANCEMENT

As the researcher, I was unlikely to enter the process blank. I brought with me my own narratives and life experiences. As researcher, I was an integral part of the research process. As a

phenomenological researcher, I had a strong interest in what I was studying. Acknowledging the fact that I was never a male student nurse, my own memory and history were important to the research. For many years I worked closely with male student nurses as I traversed the ranks: in the clinical settings as a staff nurse and ward sister; in the management arena as deputy director of nursing; in the world of education as a nurse tutor/lecturer; and in the arena of policy-making, accreditation and regulation. I, the researcher, was a mature female who held a senior position on a national level and who had been involved in some aspect of nursing since I was 18 years old and in truth probably felt somewhat precious or defensive about it and all this, along with, no doubt, biases and presumptions that I had gathered along life's journey

Reflective Practice: Whereas I needed to embrace my knowledge and memories, I needed to engage in reflection (Refer 4.11). The reflexive nature of any social research is of significant importance. I used a reflexive approach throughout the research. Reflexivity is defined as: 'critical self-reflection about one's own biases, preferences, and preconceptions' (Polit and Beck, 2010. p 566). I needed to reflective at different levels. I needed to consider my own values and commitments. I needed from the outset to reflect on how my own biography might affect my research (Treacy and Hyde, 1999. pp 28-29).

Minimizing Distance: I also needed to find a way of minimizing the distance between the participants and myself. By using IPA as the methodology underpinning the research I minimized this distance by affording an open space that the participants could fill when recalling their experiences of being male general student nurses in the female world of nursing IPA has "its origins in those fields of inquiry, such as phenomenology and symbolic interactionism, which hold that human beings are not passive perceivers of an objective reality, but rather they come to interpret and understand their world by formulating their own biographical stories into a form that makes sense to them" (Brocki

and Wearden, 2006. pp 87-88). In the analysis, the interpretation needed to be clearly supported by verbatim accounts by the participants.

One aspect that required attention was bias. According to Polit and Beck (2008. p 36) bias can result from a number of factors, addressed as follows:

Study participants' candor: Sometimes people distort their behavior or their self-disclosures (consciously or unconsciously) in an effort to present themselves in the best possible light:
I hoped that by using a number of participants that this would lessen. I emphasized to the participants that what each one said would not be repeated back to the authorities but that it would be used (anonymously) as part of my thesis. Therefore, I asked each person to be as honest as possible. Also, as the participants did not know what I would have like them to say, then this should have promoted more candor.

Subjectivity of the researcher: Investigators may distort information in the direction of their preconceptions, or in line with their own experiences:
As stated above, I knew that there was a danger that my then role and my experience could have pushed the research in a particular way. Therefore, reflexivity was of paramount importance.

Sample characteristics: The sample itself may be biased:
I selected two HEIs and interviewed ten participants and considered that this might lessen the bias.

Faulty methods of data design: An inadequate method of capturing key concepts can lead to biases:
I reflected on this as the research progressed. The outcome was that the semi-structured style interviews well suited the needs of the participants and of the research.

Faulty study design: A researcher may not have structured the study in such a way that an unbiased answer to the research question can be achieved:

I felt that that the dynamic process throughout each interview did afford the opportunity for probing questions to grow and develop.

I approached triangulation from two perspectives, namely time triangulation and space triangulation. Triangulation attempts to "overcome the intrinsic bias that comes from single-method, single-observer, and single-theory studies" (Denzin, 1989. p 313). Time triangulation relates to gathering data on the same phenomenon at different points in time. Space triangulation relates to collecting the data in multiple sites (Polit and Beck, 2014. p 326). Concerning time and space triangulation, the participants in my research were from two HEIs but had worked in multiple clinical sites throughout the programme. The data collection took place over a period of time, and involved two cohorts of students who had commenced the programme a year apart, thereby determining the congruence of the phenomenon across time.

As part of my work, I used my collaborators or community of practice (Rossman and Rallis, 2003) to act as a sounding board and to offer a constructive critique of my work. I also asked two work colleagues to read the transcript of two interviews and I discussed their findings with each of them individually. I had included the notion of collaborators in the Information Sheet (refer appendix G) that formed part of my application for ethical approval. In keeping with ethical procedures, the transcripts were anonymized and the collaborators had no way of knowing where the participants were undertaking their programme. Both of these collaborators are nurses: one female and one male. One of them had completed her PhD in education and another colleague was embarking on a Doctorate programme. Each colleague gave a feedback as to what themes were emerging from the two interviews and both were in line with my own analysis.

Elliott *et al* (1999) developed a set of evolving guidelines when undertaking a qualitative approach to research. There are three main functions of these guidelines:

They support qualitative research as being methodological rigorous

They can lead to a more valid review of qualitative research

They can help the qualitative researcher to be more reflective at different points in the research.

The guidelines are:

Owning one's perspective

Situating the sample

Grounding in examples

Providing credibility checks

Coherence

Accomplishing general vs. specific research tasks

Resonating with readers.

In 'owning one's perspective', I have detailed my own context and how my experiences have brought me to being interested in the topic of men in a female dominated world (Refer 1.3). I have outlined my personal and professional experience in relation to the research. I have chosen a methodological approach that is relevant to the research, that is, IPA. Finally, the theoretical approach based on gender fits in with the research topic.

In 'situating the sample', I have clearly contextualised the participants with specificity to their stage in training (Refer 4.7.3) and with gender being a central aspect.

In ‘grounding in examples’ the central tenet of IPA is verbatim examples of the narrative from the interviews and this was adhered to in the analysis.

In ‘providing credibility checks’ I engaged with my community of practice in reading two of the interview transcripts.

In ‘coherence’ my method of analysis building up to emergent themes with narrative accounts from the interviews provided examples of good practice.

In ‘accomplishing general vs. specific research tasks’ I explored the participants’ feelings and experiences from the point at which each made the decision to enter the world of nursing right up to the point where they were at the interview stage, that is, over half-way way through their final year.

In ‘resonating with readers’ by using the words of the participants, I hoped to clearly represent the phenomenon and by retrospectively relating to the literature to increase the understanding of the experiences of male nurses in a predominantly female milieu.

4.11. REFLEXIVITY

Before each interview I took some time to myself to remember what my role was in these one-to-one face-to-face interviews. I carefully read and re-read my reflexive journal of the previous interview/s. In using reflexivity, I was able to determine if I was affecting the process in any way. I needed to keep an awareness that I, the researcher, “as an individual brings to the inquiry a unique background, set of values, and a social and professional identity that can affect the research process.” (Polit and Beck, 2014. p 326). I needed to remind myself that I was there to enable each

participant to tell his story. Because of my then role and experience I needed to be mindful not to be interrogative. Aware that this is a trait I can fall into, I focused on the overall tenet of IPA, before and at times throughout the interviews. As I gained more experience I found that I became much more facilitative. I was also aware that I brought my own preconceptions based on years of experience and I consciously parked these outside the door of the interview room. But of course there were times when I was making a running commentary (in my head) of what was being said. But I had written a few words on a sheet of paper beside me including 'listen; 'stay in the moment;' 'don't judge.' I was acutely aware that my own biography could well affect my research but I felt very comfortable that if I stuck to the spirit of IPA then I could allow the participants the time and space to speak.

IPA allowed me to give space to the participants to open up about their experiences of what it was like for them to be male general student nurses in the female world of nursing. I tried to be careful to allow each man the time and space to express their feelings and perceptions. At times I found myself anticipating the next question that I had in mind rather than staying in the moment and fully listening to what the participant was saying. But I think that this was more evident in the first two interviews and as I relaxed into the process I became better able to allow the participants go on their own journey of telling their story at their own pace.

At times it might seem as if part of a participant's journey was long in terms of volume. Had this been in another context of my life I think I would have interjected and asked them to 'get to the point.' But my note of 'don't judge' would stop me and I allowed the participant's journey to happen and I did not interrupt. As I read over the voluminous interviews I was pleased with this approach as I consider it yielded some rich data.

In most of the interviews the data was voluminous and at times I found it somewhat challenging to deal with it, especially with ten interviews.

Because of the short window of time in which the interviews could be carried out I found it good to have two cohorts, with twelve months in between the interviews for each of the two cohorts. However, the short window did not always allow sufficient time for me to carry out the steps inherent in IPA before starting the next interview.

In my OWE (Refer 1.4) I had used both one-to-one face-to-face interviews plus focus groups. For my thesis I used only the one-to-one face-to-face interviews. I found that this method very well suited the aims of the research and afforded me the time to allow the participants to speak.

The Interview Guide (Refer Appendix G) was especially useful for me and I kept it to one side. However, I did not need to refer to it very often, as the interviews seemed to flow very well.

The fact that, because of my work, I was well known to the HEIs, made access very easy. As I reflected on the process of gaining access and ethical approval, the systems in all three institutions were transparent and facilitative while maintaining the integrity and centrality of the participants.

On reflection I believe that IPA very well suited what my research set out to achieve. By and large I think I let the men have their say and I listened attentively. Some of the men offered their own reflections on the whole process and the following extracts from the interview indicate what they thought.

Yeah great. I mean I was very happy with how it went. It was a sort of reflection for me and kind of interesting to put the various thoughts and feelings together. The time flew and it went fine for me (1: 288-289).

Certain things, certain connections I've made now – definitely in the general roles and the pre and post experiences in nursing. There have been some things I've been very interested to find links between and I'm suddenly very appreciative of my family, despite how much they drive me nuts and yes, I find it very illuminating, and I thank God I did it (3: 774-777).

Interesting. I never-it made me think about ideas that I had in my head…I never really thought about – I never weighed up the pros and cons of being a male student nurse before. I never really thought about the pros. I only ever thought about the cons. I realise now that I have gotten away with things that my colleagues wouldn't have gotten away with (4: 567-571).

It was great. I mean I know there was no financial reward or anything for doing the interview, but I'm still glad of the opportunity, because it's made me look at things and think about things that I wouldn't have done otherwise and thanks for the opportunity (7: 708-710).

Yes. When I read over the stuff, I didn't know what way it was going to head, but I enjoyed it. Actually it was a great de-briefing session to be honest with you. It was a really good de-briefing session, 'cos when I talk to the other nurses about the kind of things I'm talking to you about, it's very unstructured and in a jovial, kind of joking manner rather than seriously: this is what I experienced. You told me to be very honest and I said what was in my heart at the time rather than nothing was pre-rehearsed (9: 603-609).

I've enjoyed it. Thank you and it's great to see that research is being done on the male in nursing (10: 214-215).

4.12. SUMMARY

Chapter 4 dealt with Research Design. How I decided on the areas to be explored in the interviews was considered. The purpose of the research was expanded upon to that outlined in chapter one and the research questions were reiterated. The rationale for using a qualitative approach was outlined together with the theoretical underpinnings to a qualitative study. Guidelines for undertaking a qualitative approach were applied to my research. The methodology of IPA was outlined together with its appropriateness to the research topic. The method of data collection was explored. Aspects surrounding participant selection were considered in detail. I expanded upon ethical approval plus access for the research. I explored the underpinnings to an IPA analysis. The measures undertaken to achieve quality enhancement for the research were considered. Finally, I reflected on the whole research process and offered my own thoughts plus those of the participants.

CHAPTER 5: ANALYSIS: FROM OUTSIDE TO INSIDE

5.1. INTRODUCTION

In this chapter I start with when the participants decided to do nursing to their image of nursing now, after almost four years in the profession. It looks at the influences on them making the decision to enter nursing and the reactions of others to that decision. The images of nursing are dealt with including the images of others and of the participants. The three areas dealt with are:

Influences on the participants on their deciding to do nursing

Reactions of others when they made that decision

Images of nursing that the participants consider to be prevalent in the Republic of Ireland.

For each of the three areas, I have developed sub-headings as a means of making the data more accessible for the reader. I have considered the relevant emergent themes from each interview and re-grouped them under the sub-headings. To support each of the three main areas dealt with in this chapter, I have included a comprehensive list of emergent themes from each interview in a table format. This is presented at the start of each area explored. The number at the start of each of the emergent themes indicates the chronological order in which it appears in the transcript of each interview. In line with IPA methodology, there are verbatim accounts from a sample of the interviews and the extracts are in italics. At the end of each extract is the interview number from which it was taken followed by the lines from the interview. Prior to each extract/s, I offer my interpretation, thereby completing the double hermeneutic, typical of IPA. In keeping with IPA analysis, there is no reference to the literature at this stage. My interpretation will continue in the 'Discussion' chapter

(Refer chapter 7) where there will be reference to the literature. In chapter 7, I link the analysis of each of the three main areas to the relevant research question/s.

5.2. INFLUENCING FACTORS

The influencing factors included having a friend or a family member who was a nurse; a general interest in health and paramedics; nursing as a route to another profession; work experience; natural nursing abilities; job security; and nursing as a practical based programme (Refer Table 8).

Table 8: INFLUENCES

The number and my naming of the emergent theme for each interview

Interview	Emergent Theme
1	1. Influence
2	2. Alternative reason for entering nursing
3	1. Backdoor entry to another profession; 10. The nun aunt
4	1. Mother asked him; 2. Influence: secure job and travel opportunities
5	1. It found me; 2.Aunt a midwife; 3. Everyone said
6	1. Male friend who was a nurse; 2. A backup to the army; 3. Male friend more of an influence than mother
7	1. Change of course; 10. A female friend
8	1. They said I'd be good; 2. Job as care assistant; 3. Route to being a social worker; 4. There'll always be a job; 5. Good with people
9.	1. No way: it's a woman's job
10	1. It wasn't the culture; 2. No initial influence but partner influence

Friend or Family Member

A member of the family who was a nurse or having a friend or a family friend who was a nurse had some influence on some of the participants deciding to train as a nurse. An example was participant number 1 whose family was friendly with a neighbour who was a nurse. This nurse seems to have been a key influence on the participant in making his choice to do nursing. The friendship between this male nurse and the participant's family already indicates an acceptance by the parents of the concept of a male general nurse. The participant's fond memory of him has from an early age embedded in the participant the centrality of caring. Knowledge was also seen as an important attribute.

Known to my family was a male nurse, a neighbour of ours, and he impressed me considerably. Growing up my parents would always call him if any of us were sick. He was a font of knowledge...A local font of information, and my mother and father and him were close friends...I was impressed by him, his kindness, his care, the way he took care of people (1: 6-12)

Similar to participant 1 was the experience of participant 6 who was influenced by a friend. Although his mother had been a nurse, this does not seem to have had an impact on him. It would appear as if the selling point from his friendwas that career advancements were better for men in nursing. Even before he entered nursing the seed was sown that men do better that females in nursing.

My mother, maybe not so much...My friend, yes, very much so. He would have told me about the career advancements for male nurses were better than for female nurses. You tended to move up the ladder quicker (6: 38-41)

Participant 4 had a number of family members who are/were nurses including his mother plus ten aunts. Although he had never actually considered nursing, it was when his mother discussed it with him that he had an enlightened moment.

Basically…I hadn't a clue what I wanted to do…And Mam said to me "God, did you ever think of doing nursing?" and once she said it to me, something just flicked a switch in my head and I was like, nursing-it literally never, ever, ever came across my mind, even though I'm surrounded by so many people who were nurses (4: 27-35)

Another participant was influenced by his aunt, who although she was not a nurse, had always encouraged the participant to pursue nursing.

I have an aunt that I'm very close to… We always talk about the nursing. She's really interested in it …she'd be somebody very close in my life, a big influence and a big positive influence and I think her opinion would have made a big impression on me (3:148-156)

General Interest in Health and Paramedics

A general interest in health and paramedics was cited by three participants as a key influencing factor in deciding to become a nurse. However, participant 2, very early on in the interview, clearly establishes that his motivation for having entered nursing was to use it as a stepping stone to paramedics.

I was involved in the first aid and always had an interest in paramedics, so I saw it as a way of my entry into the paramedics (2: 6-7)

Two participants had returned as mature students after having spent two and three decades respectively in other professions. Both participants had suppressed a burning desire to become a general nurse for social reasons as it was only considered acceptable for men to enter the profession as psychiatric nurses at that time. The guidance counsellor at the time when one participant was in secondary school vehemently discouraged him from pursuing nursing. The image and reputation of the entire all-boys' school was in danger if a boy from that school was to undertake general nursing: in effect this seems to have approached a form of bullying. The participant was upset at the time but so strong was the guidance teacher that the participant thought maybe he was right and it was no place for a male. But his desire for nursing never really went away and 20 years after finishing school he started nursing. That was over twenty years ago but I believe that this idea of general nursing not being a place for men persists.

I was teaching for a number of years; for about 17 years actually...I went to an all boys' school and the career guidance teacher... discouraged me. He told me there was no way that a young lad from their school was going to go into a woman's job and it wouldn't be good for the school's image…He said that I'm wasting my life. I thought well, maybe he's right …but then it kept coming back to me and then I worked voluntarily in a hospital…So I applied when I was 39 (9: 13-29)

Another participant worked in industry for over thirty years. But he had always wanted to be a nurse but this was not the 'done thing' for a lad in the 70s. He was very successful in industry. Again in line participant 9, there was a distinction between psychiatric and general nursing whereby it is acceptable for a man to do psychiatric nursing.

I worked for a company for 30 years…always wanted to be a nurse from when I left school, but back then, in the 70s it wasn't the done thing for a lad to be a nurse from my school. It wasn't the culture

at the time … Certainly psychiatric nursing was no problem…but not general nursing…it wasn't the political thing for men, lads, to do general nursing (10: 6-12)

Nursing as a Route into Another Profession

Another influencing factor for some of the men to enter nursing was to use it as a route to another profession. Participant 1 clearly establishes that his motivation for having entered nursing was to use it as a stepping-stone to another profession, that is, paramedics, and it would appear as if that is still the case. In contrast, participant 3 initially wanted to be a social worker but decided to do nursing as an alternative entry route because of location of social work courses and lack of money led him to nursing. But the four years has changed his mind and he no longer wants to pursue social work as he loves nursing. His use of the word 'love' in relation to nursing is strong. Participant 6 wanted the army and so used nursing in order to get a degree and better his chances of getting into the army. There is a stark contrast here between the traditionally masculine army and the traditionally female nursing.

I always had an interest in the health side of things, and was involved in the first aid and always had an interest in paramedics, so I saw it as a way of my entry into the paramedics (2: 6-7)

I think I originally wanted to work in social work actually…I didn't have the money to move down to the country so I thought nursing would be kind of the back door in, but now I just love nursing and I don't think I want to go for the social work at all. I think I just want to carry on (3: 34-53)

When I left school... the original plan was to go into the army as a cadet to train to be an officer and ...that year the army were looking for people with a degree, so I said I'd do my degree and try again then after the four years (6: 31-34)

Work Experience

Work experience had an influence on some of the participants. Participant 5 strongly associates a certain type of personality with nursing and along the way people reinforced him by saying that he had the personality for it. Participant 6 gained work experience in a general hospital and he loved the experience. Participant 8 initially thought about social work. He worked in operating theatre and liked the logic of it: logic a trait associated with the masculine. He clearly separates the bodily care of the awake patient with the logical care of the unconscious patient in theatre. He mentions equipment, again more associated with masculine and their tools of the trade. He saw operating theatre as being representative of what nursing is all about.

I was…30 years of age when I made the first step into nursing...and I worked in nursing homes then as experience and I just ended up loving it. It wasn't actually –it just kind of built up in me more than me deciding to do nursing, it kind of found me in a certain way (5: 27-36)

My mother was a nurse but she gave up when I was born. I'm the oldest child and then I had a friend who's older than me but he was a nurse as well, so he helped me get some work experience in the general hospital at home and when I went up there I liked that because it was very different (6: 28-31)

I originally thought about social work ... I also got work…as a care assistant in theatre and...I saw that particular aspect of nursing, as in the operating theatre and I kind of liked it...it was kind of logical that you follow that kind of progression rather than doing – I wasn't giving bed baths and you know, washing and dressing patients and all that kind of stuff. It was much more, you know, moving people around, looking after the equipment and that kind of stuff so I thought 'This is not bad. I can do this as a nurse' (8:26-37)

Natural Nursing Abilities

Two participants felt that they had what they or others considered to be natural nursing abilities. Participant 5 references that he has the personality for nursing and an influence was that everyone said he would make a great nurse during his time as a barman in US. There is a clear equation of banter with bedside manner. He acknowledges skills are needed to be a nurse but personality seems pivotal**.** Participant 8 had tried a lot of jobs. As a bartender he found it easy to talk to people. He could listen to people and make them laugh. He could make people feel better. A regular in the pub said he thought that the participant would make a great nurse. Already the link between listening and making people feel better about themselves is established as being important in nursing. The big influence was that he was good with people. There is a masculine connotation with the construction industry in his use of the term "cemented it over time."

Everyone said I would have a good bedside manner that I would make a great nurse but personality is just a little bit of nursing, you have to get the skills as well, but I think the personality helped me (5: 55-57)

I was able to sort of chat to people and I was able to read people quite well, so if somebody came into the bar and they weren't happy…I think I just had the natural ability to make people laugh and to forget what they were worried about...one of the regulars sort of recommended that he thought that I would make a very good nurse...the more and more I thought about it the more I thought that maybe it would be something that I would be good at (8: 8-19)

Primarily it was that fact that I knew that I was good with people - I think that was the main thing that pulled me towards it rather than doing anything else. And then all the other factors sort of cemented it over time (8: 54-55)

Job Security

Two participants specifically mentioned job security as having had an influence on them in deciding to embark on nursing as a career. Participant 4 noted that there would always be a job was a persuading factor. When participant 8 had made his decision to enter nursing, the economic climate was very different and again he thought that there would always be a job for a nurse.

In the back of my mind I always said there was going to be a job there so that was an advantage and I could work anywhere. The global travel thing didn't appeal to me but I could get to work anywhere in Ireland, in a small town or a big city – that appealed to me (4: 35-37)

Then there's the fact that hopefully you could always get a job because there's always jobs in nursing, and then all of a sudden things changed there recently (8: 50-52)

Practical-Based Course

Of note to one participant was the practice-based element of nursing. Participant 7 had started a teaching course but did not like it and took time out. The hands-on aspect of nursing appealed to him and he did not want a desk job. It would be interesting to see how his preferred career path in nursing when he qualifies will fit in with the hands-on non-desk job, which were influencers in changing from teaching to nursing. Meeting different people is also important to him.

The course appealed to me because it was half practical and half theory, because the English and History was all theory and I wanted to do something a bit more hands-on...I didn't want to be sitting at a desk. I like to be on the go the whole time and every day is different and you get to meet different people (7: 15-19)

In summary, there were a number of factors that influenced the participants in their decision to enter the nursing programme, despite it not being the norm for men to do general nursing. In chapter 9 'Discussion' I link the analysis of the influences into the research question number one pertaining to gender: In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

5.3. REACTIONS

The analysis now considers the reactions experienced by participants once they announced their intentions to join the nursing profession. The reactions primarily focussed on the participants' families and on the community generally including old and new friends (Refer Table 9).

Table 9: REACTIONS The number and my naming of the emergent theme for each interview	
Interview	**Emergent Theme**
1	2. Reaction: Family; 4. Reaction: the gay male nurse; 5. Reaction: lucky to be among women; 12. Reaction from doctors
2	3. Reaction: family; 4. Reaction: from friends; 5. Reaction from doctors. 12. Male nurse = gay
3	3. Reaction: mother; 4. Reaction: father; 5. Changing views of father; 6. Father pleased; 7. Brother's view important; 9. People's views important; 12. Reaction from friends
4	3. Reaction: opposition from the ten aunts; 4. Reaction: opposing sides; 5. Reaction: father; 6. Reaction: mother v the aunts; 7. Reaction: aunts' reactions for his own good; 8. Reaction: aunts ashamed; 13. Reaction: all boys' Catholic boarding school; 14. Reaction: male farming neighbours; 15. Reaction: from other students at parties; 29. Reaction from other males who are not nurses; 31. Reaction: male school friends: image of the dress
5	5. Reaction: mother; 7. Reaction: pretty much everyone; 8. Reaction: father; 9. Father's philosophy; 10. Father has come round to it. 13. Reaction: the lads
6	4. Reaction: mother; 5. Reaction: male friends; 6. Reaction: mother-4 years on; 8.Reaction: father; 10. Reaction: new male encounters; 11.Reactions: new female encounters; 12.Reaction: old male mates; 16.Reaction: aunts, uncles, grandparents
7	2. Reaction: mother; 3. Reaction: father; 4. Reaction: friends; 5. Changing reactions: father; 6.Father proud; 11. Reaction: new female encounters
8	6. Mother; 7. Father; 8. Friends of the family
9	1. No way: it's a woman's job; 2. Reaction: mother; 3: Reaction: mother; 7. Reaction: new encounters
10	1.Not the done thing; 3. You must be mad

Family as support

Participant 1 describes how he received the full support of his family, particularly his parents, in his choice of career. His family placed a value on nursing as being secure and steady. Possibly partly

because of the positive influence of the neighbour who was a close family friend and a male general nurse, the parents were very supportive to the participant. Both parents were equal in their support. He has a younger brother who is now showing an interest in becoming a nurse, so the participant is perpetuating the support and influence.

I guess they would consider nursing, like many other public service roles, to be a secure job, a steady income, a reasonably middle type profession...They supported me in my decision...I have 3 brothers and one sister. They are all younger than me, but it's interesting the next one to me is also showing an interest in nursing (1:16-24)

Likewise, participant 2 was met with a very positive response. His parents considered that nursing was considered a secure job and. He had a very positive and equal reaction from both his mother and his father. His mother is in the healthcare profession and viewed nursing as a secure job.

She (mother) *was happy that I was going into a healthcare profession. She would be interested in healthcare as well and she saw it as a secure job as well**...***he* (father) *was delighted that I would take an interest in caring for people* (2: 11-16)

Some parents were ambivalent to the choice of nursing but were happy that their son was doing something that he would be happy at. Participant 4 emphasised how is father is laid back and would be more concerned with his son's happiness that the particular career choice.

My father is a very, very, very, very quiet man and he wouldn't react to anything…he just always said, "As long as you're happy" and I've gotten good feedback; the Nursing Home that I went to work in – my mother worked there as well and a lot of her colleagues gave her good feedback about

how well I was doing. He was happy to hear that and as long as I was happy, he was happy, so he didn't care (4: 62-67)

Participant 3 spoke about his father's reaction who he considers being very masculine and describes him in terms such as tough and dominant in all areas. He describes his dad as old school male who is as set in his ways. But over the course of the nursing programme, the participant has been finding out more about his father and his father is not afraid of veering from the traditional masculine image and opening up with his feelings, telling him that he is proud that he is doing nursing.

My Dad. It was strange actually, he's an odd creature. He's a tough old kind of guy…He's very much a dominant figure in my life…I think he was first of all surprised that I went into it ... he's just been very supportive and pleased that I've kept on with it and haven't had any problems or anything. So, yeah, it's been interesting and also I figured he's kind of a tough guy – not in a bad way, but he's kind of that old school…and I thought he would be more conservative and stuff. But I'm finding out more about him. He's not as I thought; he's very proud of me, he tells me. He's got a son doing nursing (3: 88-103)

Participant 5 was met with mixed reactions. His mother was delighted but his father was unsure as to his choice of nursing as a career. His father's reaction may have been because he was traditional working on building sites, doing what a man should be doing. However, he also notes that people laughed when he said he was going to be a nurse and his language indicates a sexualisation of nursing with reference to people saying to him that he would be wearing a dress. This is an example of viewing the male in nursing as not being the norm.

My Mom was absolutely delighted. I don't think my Dad was so sure. He wanted me to work with him on the building sites doing what a man should be doing…pretty much everyone at the time laughed and said would I be wearing a dress and all this type of stuff but as time goes on everyone that's known me says I picked the right path and I certainly know I have (5: 69-77)

Participant 9 was met with a negative reaction from his guidance teacher in secondary school when he indicated he might like to do general nursing. But he discussed it with his mother who was a nurse and she told him to go for it and not to mind the reaction of the guidance teacher. But his voice was louder than that of his mother's in the participant's head at that time and it was to take decades before the participant would enter nursing because of the profound affect the guidance teacher had on him.

I just said it to him first and after saying it to him and his reaction, I didn't say it to any of the boys in my class… I then said it to my mother...and she told me to go for it – never mind what your man said but his voice was sounding much louder than hers (9: 41-47)

Non-Supportive Family

Some participants were met with strong negative reactions from family members. Participant 5 had a mother and ten aunts who were nurses. The reaction from his ten aunts, who according to the participant were burnt-out nurses, was completely against it, thinking it was crazy…the repeating of 'No No No' emphasizes how much they were against it. The aunts pressured his mother to stop him doing nursing. They as nurses considered it not to be a man's job especially coming from a traditional family. As nurses, the aunts asked if he is not intelligent enough to do medicine and therefore viewed nursing as second rate. And these are nurses currently working who have such a dim view of men in nursing and indeed it would seem of nursing itself.

All of my other aunts went out of their way to make me not do it – nursing. They thought I was crazy to do it; there was no money, you know, blah, blah…'No, no, no' to the stage where they would ring up my Mam and tell her to make me not do nursing. A lot of that as well could have been the fact that I was a man and my family would be very traditional, especially my father's side where nursing isn't a man's job – like – is he not intelligent enough to do medicine (4: 39-46)

Some of his aunts were ashamed because nursing is not what a man does and anyway why couldn't he be like the cousins who did medicine or pharmacy-obviously more acceptable professions for a man to pursue. Again this is a frightening expression of female nurses about the male nurse.

'I can't tell people that he's going to become a nurse'. 'he's a man and that's just not what you do' (4: 85-86)

Participant 5 describes his father as old-fashioned whereby men should be on building sites. There is a strong alignment with the traditional masculinity of the building sites.

I think my Dad is just old fashioned and like he went to work on the building sites. He's working with fellows all his life. He's working on the building sites – joking – and all that goes with working on building sites, where building sites just aren't for me. I worked on them and it was just to get a wage... my Dad, he grew up with all his brothers, they worked on building sites and he thinks that that's what fellows should be doing. I feel he's very old fashioned (5: 93-100)

Participant 7 switched careers...his father was concerned because nursing is a female profession and his son understands this concern. The participant then goes on to say that nursing is under-

rated and the link with this under-ratedness and the female aspect of it is interesting. Another link with the female is the word "doodah" which has a forgotten or not worthy of a name connotation. It's as if the father (or at least the son thinks that his father) is saying nursing is a woman's job and not one for his son.

He obviously wanted what was best for me like, no matter what. Any big decisions, I would always ask his opinion because I always valued it…I suppose just the general doodah. It is a female profession, which is understandable, I suppose. I don't know, just his view and maybe the general view, I think, is that it's under rated (7: 42-469)

Non-Supportive Family: Changing Views

Some family members, notably the fathers, had misgivings about their son entering nursing but have become more positive about the idea. Participant 5 for example has made every effort to reassure his father referencing potential embarrassment for the father and other men if dealt with by female nurses and the father now accepts it and even pats him on the back and has no doubts any more.

But he has come round to it and he really agrees now and thinks it's great, what I'm doing. He pats me on the back and is very proud of me now, but at the start, no… he kind of had his doubts, his opinion and his doubts (5: 109-113)

Likewise, for participant 7 there has been a change of heart by his father who now acknowledges that his son made the right choice. The father speaking to the son through the mother regarding a "feelings" issue such as being proud of his son is a reflection of a certain generation of men in the Republic of Ireland, whereby they are not the best at the 'touchy-feely stuff."

Four years – the fact that I'm nearly qualified – he's seen that it's the right decision, but he was always saying the whole way through... 'Is it the right thing for you to be doing?' but at the same time he wouldn't' tell me himself but my mother tells me that he is very proud about it and his attitude has changed, yes (7: 49-53)

Reactions of Community

Reactions from community members varied but some were very negative. This was especially so for participant 4 whose father's friends ridiculed the father and seemed to blame him for how the son turned out: gay; sings in a choir; and doing nursing and wonder what he is going to do about it. Again, like the aunts, they asked the father what he's going to do about it. Again the participant emphasizes words such as 'really' and in this instance it is the equating of farming with the masculine: one of the strongest traditional roles for sons in the Republic of Ireland.

Neighbours…they're all farmers. They'd meet up every Saturday night in the local pub and one night in particular – I used to sing in the choir as well and I think his friends knew that I was gay or that I was different and when they found out that I was doing nursing .., they kind of started saying 'What kind of man are you to have a son like that? He sings in the choir, he's doing nursing. What are you going to do about this – like are you OK with this?'... They are really, really old set men, really, really old set men. Their sons become farmers. That's what they do (4: 161-175)

Initially participant 5 got a lot of stick about his choice. He was the butt of jokes. Again there is reference to wearing a dress; to wearing make-up; to changing in the female dressing-rooms the sexualisation of the image of nursing. As a counterbalance he establishes that he goes for pints with the lads and watches sports: he does manly/blokey things.

Oh, I got a lot of stick...I was expecting it but I was the butt of all the jokes for a while Well, things like 'What's it like to be wearing a dress?' and 'Do you get changed in the girls dressing rooms?' 'Do they have men's dressing rooms?' Things like that and 'Do you have to wear make-up?' All stuff like this, especially when they're all together, they can rhyme them off one after the other (5: 142-153)

There were sexual tones in the reactions from some friends. Participant 4 was met with a negative connotation with the 40s pin-up plus the idea that the men must wear dresses. For participant 6 opposition or at least non-positive reactions came from his friends who thought it was funny and a joke. His attendance at an all-male school gave him a sense of isolation. His male friends saw that his entering nursing was positive in that it was a way of being introduced to a load of girls. Despite his sense of isolation from being in an all-male school his two choices: army and nursing: have an equal potential for isolation. Participant 6 has gained kudos with his old male school mates because of being surrounded by so many females. Here the participant is seeing the merit of being in the minority male among so many females, while participant 1 experienced the reaction of him being lucky to be among women and that he could have his pick of the females.

Well my male friends I went to school with, they would have been always like 'Oh do you wear the skirts? Do you wear those dresses? Is everyone in your class really hot?" Like they don't know – it could be all men in my class. They just presume I'm in the minority, and then they just – the straight lads my age, when you say nursing, they think that pin-up 40s pinafore dress look of nursing (4: 347-351)

My friends, then – a lot of them thought it was a joke when I was starting, when I said I was doing nursing and thought I was just being funny…Where I was in school, it was an all boys' school so I

was kind of isolated. I had many male friends, so yes it was males…They thought it was great, that I'd be introducing them to a load of girls. That was their main objective for it (6: 46-67)

I suppose they'd meet up with me or they'd see me out and I'd be with a lot of my female friends from the class and they're shocked. They think I'm a great player with all these girls coming up to say hi to me (6: 143-145)

You're in with a group of woman, lucky you, and you're blessed among women. It would be a little bit mixed, some people see that there I am, a young man, in with a cohort of young women, 3 guys, therefore we have the pick of the crop and all that kind of rubbish (1: 63-66)

For some participants the reaction of new acquaintances has been either the assumption that they are gay or too stupid to do medicine. The link between being gay and being a nurse was introduced by participant 1. He noted that if one is a male general nurse, there is an implication that the person is gay. He uses the phrase 'and all that thing' as if he assumes I know what he means and he doesn't need to elaborate. When I asked him to expand on what he meant again he uses the phrase 'and all that kind of thing.' He seems to be distancing himself strongly from the association with being gay. He clearly links gay with effeminate-with an other-that is not him as the masculine. But it doesn't seem to matter how you look, once you're a male general nurse there is an assumption that you're gay.

I guess some of the innuendo that I would have encountered, particularly in relation to general nursing, it doesn't apply to psychiatric nursing, there's this notion that there is a higher percentage of gay men in general nursing…The perception is that there is more likelihood of a man being gay in general nursing…it would be very often situations where you would be discussing what you're

*doing, raised eyebrows...there would be kind of a nod and a wink and all that, effeminate phrases or references to TV programmes that had gay icons. It is marginal...limp wrists and all that kind of thing. Whereas others have the notion that if you're a general nurse, you must be effeminate, a homosexual. But it doesn't always go by the look; it's linked to the fact that I am a male general nurse (*1: 42-69)

Likewise, participant 2 mentions the definite link in the mind of society that all male nurses are gay.

I suppose traditionally again there may have been an attitude that male nurses are all gay maybe. There are gay male nurses certainly, but not all male nurses are gay. That's I suppose what society think in general (2: 108-110)

For participant 4 there is a questioning by others as to his sexuality and his intelligence. Just like his aunts, other college students equate that he doing nursing as meaning he must be too stupid to do medicine. He says as he's not overtly gay, people question his sexuality when he tells them he's doing nursing. Again there is the strong linking of the man in nursing as meaning he must be gay. He gets scrutinized for signs of being gay like a limp wrist.

Myself and my friends would have been at a lot of parties with predominantly business students and law students and when you tell them you are a student nurse you basically get 'Oh, are you too stupid to do medicine?' ...Personally I find that if I'm talking to girls, or guys really, actually at parties... they start to question your sexuality and they'd give you the look up and down and 'has he got a limp wrist?' and 'what way does he do this or what way does he do that?' (4: 187-197)

For participant 6, he continues to be met with disbelief that he is doing nursing, which echoes the reactions when he first indicated that he was interested in nursing. An added reaction is one of shock. He explains such reactions by his own image of what a nurse looks like and it's not a big fellow like him. He is distancing himself from being associated with a traditional image of what a nurse should look like: petite female.

I suppose shock. I'm a big fellow. I don't really look like a typical nurse that people have in their minds. Some of them think it's a joke still, especially if you're out, on a night out, and you met somebody, you're introduced to somebody and they ask you what you did, they think it's very funny (6: 124-127)

In summary, the participants encountered a considerable amount of opposition by virtue of their gender when they told people that they were going to enter nursing but there was also support. In chapter 7 'Discussion' I link the analysis of the reactions to the research question number one pertaining to gender: In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

5.4. IMAGES OF NURSING

This section on the image of nursing considers the participants' view of how they perceive the society in the Republic of Ireland views nursing plus it also looks at the participants' self-view of nursing (Refer Table 10).

Table 10: IMAGES

The number and my naming of the emergent theme for each interview

Interview	Emergent Theme
1	3. Acceptance of men being in psychiatric nursing; 6. Self-image; 9. Image: society
2	10. Men are better; 11. Image: society; 13. Male as leader; 15.Nursing not as well regarded in the university; 17. Money matters
3	8. An uncomfortable reaction; 38. Image of nursing; 39. His prior image of nursing; 40. Extremes of femininity as image; 41. Society's image of the male nurse
4	9. And he's gay; 10. Nursing = gay; 28. Image of nursing in society; 30. Image of nursing in society; 32. Image: society: foreign males v Irish males
5	4. Self-image; 12. Self-image;29.Why are you doing that;30. Don't expect to see an Irish male;31.Foreign not gender;40.It's their vocation; 41.Servants; 42.Maternal;52.Assumption that it's psychiatric
6	7. Self-image of nursing; 9.Boring; 13.Image: society; 14.Image: a rough fellow; 15. Image: woman's work; 22.Are you sure; 23.Oh a psychiatric nurse
7	7. Image: father; 8.Soap star; 9.A hard job; 22. Image: a calling for women; 35.Image: self-image
8	9. Fair play to you; 10. Well done; 11.A vocation; 12. Males: out of the norm; 16. Males: out of the norm
9	6. Hard job: taxi-men; 12. Public image
10	6. Nurse = female; 7. Image change: foreign nurses; 11. Image: society; 12. Society and gender in nursing

The Outsider View

Female Profession

There were strong references to nursing being a vocation and strongly linked to caring and above all with the female. For participant 1, the image of nursing being a caring profession is important to the participant but there is a perpetuation of the image of the nurse as being the doctor's handmaiden. The image of nursing may be in a state of transition and perhaps veering towards a professional image, but again the participant places strong emphasis on maintaining care at the very centre, the very heart, of nursing. Nursing and women are overtly linked but the male in general nursing is a hidden male and does not register with society. The participant also relates this sex-dominated image with the police and although he acknowledges that of course there are female police, he nonetheless associates the force with men.

*A lot of society would still consider nursing to be a vocation, a group of very caring people who are highly skilled, there is a move away from that, towards a professional agenda...I think society is caught between its perception and having some people see nurses as handmaidens to the doctor…I probably think that society, by and large, sees nursing as being a female profession…I think that the image of nursing is probably seen as being a female dominated profession. Saying that, I'm not sure that if, for example our impression of say the Gardai is that it's a male profession. I know that there are a lot of female guards. So, if you present an image of a guard to me, even verbally, I'd probably think of a man first, and perhaps society does the very same for nursing, in reverse (*1: 87-107)

Participant 3 considered that even identifiers are female images: on-call badges and bells and pic-art. But he reiterates of course nursing is all women with a somewhat resigned acceptance. It could be suggested that updating such symbols and imagery of nursing to portray it as a profession that is

inclusive of both genders could have a subtle but positive impact on perceptions of nursing as a career option that is as acceptable for men to choose as it is for women.

But it's still very much female orientated…I wish I had it to show you – my nurse on call identity badge - the very symbol of the nurse on call is a woman, you know… Every time you see it – even the nurse bell is the…The little symbol on the bell is a nurse in that almost triangular dress and the hat – the nurse's cap – it just looks like the stereotypical nurse on the little bell and that's everybody's image. If you go on to Pic Art – you know, Microsoft Word, and you type in nurse – it's all women – of course it's all women. There's not a single picture of a man, a male nurse or anything like that. Of course it's still very female centered but I think that's kind of how society looks at it and that's certainly how I would have thought about it before going into it (3: 556-566)

Participant 5 makes reference to the subservient who is well mannered and carries themselves well and speaks well: all of which would have been traditional female attributes.

I think servants. That you're there to serve them and you're there to be, at the drop of a hat, what they want and like well-mannered and stand with your hands beside your – at your waist – and carry yourself in a well-spoken manner…The majority of people, yes, associate like, more caring, maternal instinct with the female more than with the male (5: 502-508)

Participant 6 projects his image of what society sees as a typical nurse and this echoes his previous reference to someone smaller in contrast to himself as he describes as a big fellow. He also considers timid to be an image and this is an image that is not associated with the masculine. Another image is timid in voice and although he may be a little quieter than presumably you'd

expect for a man, he counterbalances his quiet voice by asserting his masculinity with a shaved head.

I suppose someone smaller, very gentle, I suppose, very timid in voice. I suppose I would be a little quieter you know, but usually the hair is all shaved off (6: 152-153)

Participant 6 continues to show a clear position between caring and a woman's work, clearly stating that caring is not in a man's mentality. The basic work of a nurse is not for the man, with such work including emotions, feelings, washing and keeping things clean. He has clearly put the basic body care and the emotions into the realm of the feminine and not one associated with masculinities.

I suppose, first of all, the caring, you know. It's not really a man's mentality, you know. I suppose they see it as emotions and feelings. Then the washing and things like that, you know. It's keeping things clean – that's seen as women's work as well (6: 166-168)

Participant 7 believes that the average person in the Republic of Ireland firmly link general nursing with being female. He acknowledges that his image of nursing has changed and he believes that the average person in the Republic of Ireland considers nursing to be a calling. Because of its nature of being a 'calling' the nurse therefore does not necessarily deserve nor need praise. However, in contrast others will say admiringly that they don't know how he does nursing. He believes that the average person would reduce nursing to simple tasks rather than to it as a profession.

From the average person…still thinks of it as a calling hence why you don't deserve to get praise… They just see the, you know, being at the bedside maybe, talking to patients and then doing the

cleaning, you know, and stuff like that but they don't see you as a professional, as we now are, I don't think that has changed in the public's eye, yet…they definitely do think of nursing as a woman's profession, definitely (7: 389-402)

Participant 8 considers that although in the domestic scene there may be evidence of role reversal, a man in nursing is still considered out of the norm in the Republic of Ireland.

I think we're quite accepted, especially now, more so than we were before about role reversal and that kind of thing. I don't know whether – I think it's still out of the norm. I think people still see male nurses as being out of the norm (8: 169-172)

Participant 9 thinks that the image of nursing in the Republic of Ireland is still one of white dress and little hat. But things are changing and he believes that the change in the uniform image is helping change the public's image of nursing. The more unisex uniform is now commonplace, partly brought about by the presence of a 'few more men' on the wards. But a huge element of society still considers nursing to be a woman's job.

Well, I think it's still a little bit of the white dress and the little hat, but it is changing...uniforms definitely from the white dress, navy cardigan and cap to a kind of unisex uniform for both men and women and that there are more men, a few more men on the wards and in the first line places like A&E…There are a lot of male nurses going into that area and they wear shirts and ties and trouser (9: 180-192)

Participant 10 has moved from hating being referred to as male nurse to saying it is traditional and you have to forget about it. He establishes that nursing is still seen as a female domain and while that continues the male will be referred to as male nurse and not simply nurse.

Ah, it's traditional. You just have to forget it – get on with it. Nursing continues to be seen as female. And I suppose while that continues, we will always be referred to as male nurses (10: 50-51)

Linked with vocation are attributes such as nurturing, which is clearly linked to the feminine and again linked to the maternal is that nurses would do everything for the patient. Participant 10 sees that society views nurses as being there to help the doctors and as being servants. It is interesting that he connects servant with body excretions, in other words he is considers that society reduces nursing to the body excrement. Whereas he sees nursing as more than just servant, he does acknowledge that this may at times be the case and that nurses are there to act as a buffer for the patient regarding other professions.

Well, I think they have this concept of nurses being nurturing…They expect nurses to do everything for them... Sometimes they see us being there as a help to the doctors…Sometimes we're seen as servants, running off to get the vomit bowl…You're nearly a gate-keeper for everybody. You're the entry point for other professions to the patient (10: 83-94)

The Angel Nurse

Society still has a traditional view of nurses as handmaidens to the doctors. They see nursing as a vocation, as an administering angel providing care, as a caregiver. It's your lot in life so put up with it. There is no awareness of the extending and expanding role of nurses and they are still viewed as caregivers who wash patients and dress beds.

Caregivers, certainly. Attitudes from patients would be the angel kind of thing, it's a calling…maybe it's felt by nurses that the system maybe looks at them more as hand maidens …I don't think there's a huge awareness of the changes nursing has gone through. Everyone still sees them as caregivers, whereas there are so many different expanded roles now of nurses, different jobs, different expanded roles. There isn't awareness out there. I think the perception mainly is that nurses are out there to wash patients and dress the beds (2: 92-103)

Participant 4 was the man who had such strong opposition from his aunts when he declared he wanted to do nursing. He dislikes what he sees as society's link between nursing and vocation and sees this link to vocation as belittling. He sees it as a job and he went to college like everyone else. He emphasizes that he is doing a science degree. Perhaps the views of others like his aunts have rubbed off on him and in a sense he is qualifying that he is doing nursing by declaring that he is doing a science degree.

You'd get that pre-recorded jargon that you get from absolutely everybody that you tell you're doing nursing – 'Oh, it's so fantastic. You're so good. I wouldn't be able to do it myself but you're so good." and it drives me mental. I think it's so patronising. You get the whole – 'It's not a job, it's a vocation.' Like, it is a job. I went to college the same way everyone else went to college. I'll have a degree; it's a degree in nursing and it's a science degree in nursing. Like, don't belittle it. Do you know what I mean? (4: 334-349)

For participant 8 there is an altruistic notion surrounding nursing and he considers that society in the Republic of Ireland associates nursing with cleaning up after people and not minding about dealing with blood and they greatly admire those who can do nursing.

I think some people admire it a little bit, rather than being - because they realise what you're doing, especially people who have a social conscience I think – a lot of my friends would do - they look at it and go 'Well at least you're doing something that I couldn't do because you have the ability to do it. You don't care about blood; you don't care about cleaning up after people - that kind of thing. If you're fit to do it, that's great. Well done' (8: 132-137)

Male Nurses Are Gay

There was a link between male general nurses and being gay expressed by some of the participants. Participant 1 defended his position-reinforcing he's not gay. He is distancing himself from being gay.

But when they look at me, I don't necessarily come across as effeminate; I certainly don't behave like one who is effeminate (1:67-68)

Participant 4 declares that he is gay and that this is probably at the crux of the issue felt by the aunts. The aunts now seem to be equating gay and nurse together, as being interlinked. This is the opinion of his aunts who are still nurses.

And I'm gay as well which probably added a lot to it. It's kind of like 'OK, first he's gay and now he's going to become a nurse'…They were aware of me being gay at that point yes. That had a massive part to play in it as well (4: 93-97)

The Male Component

Participants linked image and gender, for example, participant 6 reinforces his own image with other men's image of him being that of a traditional man and one of being a rough fellow. Again he is

reinforcing his own masculinity with the use of the word rough, which fits easily with previous words such as big fellow and shaved head.

Last night I actually met guys and they were asking me what I do and I said I'm a nurse and they said 'I wouldn't like to see you coming with an injection or anything'. It's happened with patients, one patient in particular. I went into him; it was the first time I met him. He was a male and I thought he'd be delighted to have another male to give him a hand with a wash and he sent for a female 'cos he thought I'd be a rough fellow…He didn't say it to me that he thought I'd be rough but I got the vibe from him and I told him I'd be gentle (6: 155-163)

In relation to participant 7, his male friends link the participant with a Soap male general nurse. But the participant firmly establishes that he is a male general nurse and that it's firmly a part of who he is now: "It's just who I am." He accepts that lads poke fun at each other but the female friends are different and this is in part due to the fact that a lot of his female friends are themselves nurses.

The lads would still drop a comment here or there from time to time like – I don't know if you know Coronation Street, but Martin Platt – you'd often hear that. He's probably the most famous male nurse there is. But it's all in good fun like, and not as much, they know that that's part of what I am now, that's my job. I'm a nurse, the same way as one of them is a plumber and that's his job and you'd still talk about the job like, were you busy in work or what are you up to at the moment? It's just who I am and being the lads, you expect to have the fun taken out a bit, the same way I take fun out of them (7: 80-86)

For participant 10, gender is an issue in nursing, initially anyway. But after a while the gender seems to become invisible. However, then he gives an example of where gender continued to be a

problem saying it was understandable but then asking was it understandable. It would seem as if he is not entirely sure where he stands in relation to gender. This distancing from and uncertainty about gender echoes his previous considerations.

When they get to know you, they soon realise that it's not just being male or female. Certainly the guys I looked after…by and large, gender wasn't an issue. Yeah, maybe there've been occasions where they would have preferred…to have a male nurse. I suppose one example I came across was of a young patient who needed his catheter removing. I mean obviously he would prefer a male nurse to do that than a female nurse, but I mean that's understandable, isn't it? (10: 96-102)

It is OK to be a psychiatric male nurse

Most participants felt that society considered it perfectly acceptable for men to be psychiatric nurses but not general nurses. Participant 1 grew up in a community close to a large psychiatric hospital and the concept of men in psychiatric nursing was firmly established from the start. Not only was it established in the community but it was the norm among the fathers of a number of his school mates in primary school. However, although he knew or at least was aware of many male psychiatric nurses, he knew only one general male nurse and it was this person who was the key influence.

I went to an all boys' school. I grew up in an area close to a psychiatric hospital; a lot of the nurses in psychiatry are male nurses…The neighbour I talked about earlier, he was qualified in general and psychiatry, and there would be a number of the psychiatric nurses that would also be general nurses, but the practice for most of them would be psychiatry, so I didn't have a strong sense of men in general nursing (1: 26-39)

Participant 5 believed that the traditional view of it being OK for men to do psychiatric nursing is common and when he tells people that he is doing nursing then it is automatically assumed that it is psychiatric and not general nursing.

More males going into psychiatric nursing than actually general nursing and that is something that when I'm asked 'What do you do?' and I say a student nurse, the first thing they say is 'Oh, psychiatric?' and you say 'No, I'm doing general' and they say 'Oh, you're a male nurse?' ...They expect you, as a male nurse to be a psychiatric nurse and I think I get that a lot from some of the nurses as well...it was only last week that one of the girls said to me that you don't get too many fellows. They're more interested in psychiatric and it's great to see fellows coming into general...they think straightaway it's psychiatric (5: 636-645)

Participant 6 considers that it is acceptable for the man to be in psychiatric nursing but not in general nursing.

Generally female and especially for general nursing you get, a lot of the times I'd say 'I'm a nurse' and they'd say 'Oh, psychiatric, is it?' They're surprised that it's general (6: 310-311)

It is OK to be a foreign male nurse

Just as society in the Republic of Ireland consider that is normal for men to work as psychiatric nurses but not general nurses, participants also felt that society considers it OK for foreign men to be general nurses. Participant 4 saw a strong link between nursing and female and describes nursing/nurses as caring, hard work, and dedicated. It's not unusual to see male Filipino and Indian nurses but Irish male nurses are in the minority, an interesting cultural observation.

It's caring, hard work, dedicated – yeah…Well, when they think of nursing, straightaway they would think of a female nurse...the influx of foreign nurses and overseas– because there's an awful lot of Filipino male nurses, and an awful lot of Indian male nurses and ...it's not as strange to see male nurses any more. Irish male nurses would be very much in the minority. There would be far more male overseas nurses than male Irish nurses (4: 355-364)

Likewise, participant 4 believes that there is the perception that it's OK for foreign men to be nurses but not Irish men.

Like the majority of people don't expect to walk on the ward and see a male nurse. But they expect to see Filipino male nurses but Irish nurses – the majority of people don't expect to see us (5: 364-366)

Participant 5 felt that when society looks at foreign male nurses they register foreign as opposed to gender but when looking at 'their own' that is the Irish nurses, society sees gender. This is an example of discrimination by race and by gender.

We've got so many Indian nurses and Filipino nurses...so for them to see a male Filipino nurse isn't much of shock to them because deep inside I think they look at male and female as being foreign. They don't actually look at the sex, they think they're just foreign people, whereas when they're looking at their own they are seeing male and female...looking at us as you see male nurse, so you're a man nurse or a woman nurse, like you're a male nurse whereas the Filipinos - they look them just as nurses. They don't look at the actual sex; they look at – they're foreign people (5: 373-380)

The Insider View

Positive images

The next aspect to consider was what the participants themselves viewed as the image of nursing. Participant 1 considered that men are better. Although he laughed when he said it, the participant did state that men are better. Up to this point in the interview he had been serious. Therefore, some part of him probably believes this.

Because we're better (2: 87)

It is noteworthy that despite all the opposition experienced by participant 4, he has a pride in how he feels about nursing.

I think it's well respected (4: 325)

Participant 5 has a self-image that he has the personality for nursing and he now qualifies that calm is an important part of his personality coupled with laughter.

I think I've got a very calm personality. I think I'm calm and reassuring. I have a great way of reassuring people in a calm way and my motto is that a day without a laugh is a day wasted. That's Charlie Chaplin (5: 59-61)

Participant 7 believes that in order to do nursing, one needs to be a certain type of person with certain type of qualities and that it is more in the natural order of things for women to have these qualities. There is a reiteration of a potential link between nursing and a calling: a term associated with the priesthood or with primary school teaching whereby the term was 'called to teaching.'

It's just I think nursing; you do have to be – I won't say it's a calling – but you do have to be a certain type of person. Maybe the qualities of that certain type of person – maybe women have those qualities easier and hence – but then again - more and more men are starting to take up the profession and as that happens perceptions change and then more and more men will take it up. I think it will always be female dominated, I just think that's just the way it is but I can definitely see the balance decreasing, definitely in the future (7: 614-620)

Negative Images

Poor pay and recognition were negative views held by participant 2.

I suppose only maybe in the way that, maybe some of my friends who may or may not have done college courses seem to be gaining more awards, especially financially. Their jobs, especially those ones who haven't gone to college and got trades, pay more…Yes and I suppose recognition (2: 160-164)

Participant 2 was also concerned that there is a dis-connect between the hospital campus and the university campus and the participant feels the nursing is not as well regarded as other traditional university courses.

Well in the university itself, certainly my class would feel that we are maybe not as a high ranked as some of the courses, say med students or engineering students or traditional university courses...we do feel a big divide there between the university and the hospital (2: 120-126)

Participant 6 came close to admitting that the potential for boredom is there but high tech areas like intensive care or the pacing of emergency are more to his liking. Already he appears to be distancing himself from the wards with their routine and boredom potential.

There can be slow days there when there wouldn't be much happening. I'd be fed up, thinking – you know I like some of the specialist placements; A&E and ICU where it was busy and constant (6: 118-120)

In summary, the images of general nursing in the Republic of Ireland are firmly embedded as a being a woman's job and one where the position of a male nurse is scrutinised. In chapter 7 'Discussion' I link the analysis of the images of nursing to the research question number one pertaining to gender: In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

CHAPTER 6: ANALYSIS: ON THE INSIDE

6.1. INTRODUCTION

In this chapter I look at the participants since they started nursing almost four years ago. I use the same format of presentation as I used in the previous chapter (Refer 5.1). I explore the four areas as these apply to the participants in their experiences as general student nurses.

The four areas dealt with are:

Roles and activities that the participants consider underpin general nursing

Masculinities and Identities considered by the participants on entry to the nursing programme and if any change occurred since starting nursing

Strategies used by the participants when working with a female-dominant group of registered general nurses

Career paths that the participants expect to follow.

6.2. ROLES AND ACIVITIES

By virtue of their gender, participants discussed both positive and negative discrimination in regard to roles and activities of nursing. They commented on gender bias from both male and female patients and from relatives. They articulated what they perceived to be the centrality of nursing (Refer Table 11).

Table 11: ROLES and ACTIVITIES **The number and my naming of the emergent theme for each interview**	
Interview	**Emergent Theme**
1	7. Muscle power; 8. Gender matters; 10. Positive discrimination from female seniors; 11. Reaction from female peers because of positive discrimination; 14. Centrality of care
2	6. Positive discrimination from female seniors; 7. Muscle power; 8. Gender matters; 9. Gender matters; 14. Caregiver and link
3	14. Grunt work; 15. Called away; 17. Reaction of female patients; 18. Maternity; 19. Disgusting body fluids; 20. Feelings of disgust and emotions; 31. Opening up of emotions; 33. Touch or not
4	16. Men get away with more in nursing, thinks female colleagues; 17. Men blag their way through; 18. patients: man = doctor; 19. Reaction: male patients; 20. Chaperones: a pet hate; 21.Reaction: maternity: stay on post-natal; 22. maternity: no one suitable for you; 23. maternity: the last minute delivery; 24. Reactions: maternity: is it OK?; 25. maternity: what's suitable?; 26. maternity: anti-man; 27. maternity: post-natal and babies; 28. maternity: a man is the last thing needed; 33. Nursing: what's needed; 39. Body muscle but missed opportunities
5	6. Tools of the trade; 15. Just given a free ride; 16. Heavy burden; 17. They don't push as much; 18. Gentle approach; 19. Maternity: laughing at me behind my back; 20. Maternity: Feeling of isolation; 21.Maternity: Marched into these rooms; 22. Maternity: Bordering on bullying; 23. Maternity: Too much; 25.It's great to have fellows; 26. Reaction from female patients; 27. Fantastic feedback from the men; 32. Servant; 33.Educator as well as caregiver; 34.Carry out the doctors' orders; 43.Bringing something as a man

Table 11: ROLES and ACTIVITIES(continued) **The number and my naming of the emergent theme for each interview**	
Interview	**Emergent Theme**
6	17. Reactions from patients; 18.Maternity: not comfortable; 19.Maternity: not called because a man; 20.Maternity: flooded locker; 21.Being male as a hindrance to experience; 24.Assist patient; 25. Appropriate or inappropriate; 26. Discrimination: positive and negative
7	12.Reaction from relatives; 13.Reaction from female patients; 14.Need for a chaperone; 15.Maternity: shouldn't be there; 16.Don't drop the baby; 17.An outsider man; 18.Man = better treatment; 19. The favoured man; 20. He's a man: he should know; 23. Caring = female; 36. Qualities are not all gender neutral
8	13. Maternity: male or student; 14. Reaction: older women; 15. Reaction: younger women; 17. Type of care as an influence; 18. Reaction: male patients; 19. Maternity: personal discomfort; 20.Maternity: male = an issue; 22. Jack of all trades; 23. Proficient in a skill set
9	8. Reactions: female patients; 9. Maternity: midwives had issue; 10. Reaction: male patients;13. Perceived qualities; 14. Not a job for a female; 15.Nurses harder on females; 16. Nurses easier on the males; 17. Women can't let it rest; 18. Not nice to each other; 19. Different treatment; 23. Novelty strong man; 26. Female nurses treat men in authority differently; 28. Men may not offer as much help; 31. Women not nice to each other; 36. Oh women are horrible to women
10	4. Reaction: male patients; 8. Reaction: older nurses; 9. Maternity: nothing but positivity; 10. Nurse = woman = vocation; 13. Patient = customer; 14. Stay cool; 25. Different treatment

Maternity: Negative Experiences

Gender emerged as a negative matter when participant 1 worked in maternity. Here he felt an intruder as if he should not have been there. Both in his language and in his presentation, up to this point the participant was extremely positive and engaging. Therefore, the use of the words 'intruder' and 'intruding' were stark and dramatic and he clearly aligns this to his gender.

In my obstetrics experience … I've had an experience of being an intruder, of intruding on the dignity of patients who are my opposite gender (1: 74-85)

Likewise, for participant 2 maternity was a negative experience. Here the patients were given the choice as to whether or not the male student nurse could observe and inevitably permission was refused. Consequently, at this advanced stage in his training he has not yet seen a birth. The concept of choice was in marked contrast when it came to male student doctors. In such instances the choice was not afforded the patient but it was simply stated that the male student doctor would be present.

The patients were given the choice that there was a male student nurse and asked if they would mind if I came in, and every time except maybe one exception, the patient chose that I wouldn't attend... And certainly the choice wasn't given when there was male student doctors. The patients were just told that the student doctors were there to observe and that was it. There is no difference made between the male student doctor and the female student doctor, whereas there is that distinction made between the female nurse and the male nurse (2: 68-76)

Participant 4 was told he would be spending most of his rotation on post-natal because he was a male. Already the CPC who is meant to ensure equity in experience was complicit with the attitude

of the staff; a worrying situation as the CPC is meant to be the student's advocate. He had to persevere in order to see a delivery and wait for over eight hours in the coffee room and keep going up and down checking if there was an available delivery despite the fact that there were several deliveries that day. This adversity is a strong reflection of that image by the aunts of nursing being no place for men plus the aunts had also been midwives. It is sad to deduce that not much seems to have changed.

Our Clinical Placement Co-ordinator…she said to me that basically a lot of the managers in the hospital are very old fashioned, very old set. They are hard to deal with and she just said I am going to put you on the post-natal ward every single day...because you're male and they don't like male student nurses…We had two weeks there and I spent eight days in post-natal and half a day on the delivery ward and three hours on an ante natal ward…I literally sat in the coffee room from 12 o'clock until 8.30 that night, going up two or three times and she was like, 'No there's still no-one suitable' (4: 259-268)

The ordeal for participant 4 continued when he handled the babies. There was still a strong negative reaction to him when he picked up a baby and this is in stark contrast to his female colleagues who were much less capable but nothing was said to them. The strong anti-male nurse attitude prevails into other areas in maternity.

I found on the post-natal ward if I decided to pick up a baby or if a baby needed to have a wash, I was lucky enough to - I used to baby-sit so I was used to being around babies whereas I was on the ward with two other girls who had never held a baby in their lives, but it was alright for them to pick up a baby and wash it but when I picked it up, it was 'Oh gosh, the male student nurse has the baby. Let's go over and make sure he's doing it right'. I could wash a baby with my eyes closed but

the two girls they hadn't a clue – they had never held a baby in their lives. It's just because you're a man, it's just presumed that you don't know how to do it (4: 301-307)

Participant 5 really expresses his annoyance of how he was treated during the maternity placement: a treatment that seems like bullying with people laughing at him. His exasperation was evident in his emphatic 'no more.' He refers to the maternity placement as the worst part of his training with strong language in his use of feeling isolated. Here the participant himself is clearly linking his gender to the way in which he was treated in maternity. He uses bullying-like term 'marched.' This was an extremely negative and potentially undermining position for him.

I didn't like it at all...My very first day, first five minutes, I was taken in for a delivery and on our placement we had to see two deliveries and I was in for three on the first day, taken out from one, getting late breaks and I could see that everybody was having a good laugh behind my back, but after the third one I told them 'That's it. No more.' It was too much for me I felt – it was the first time I felt that I actually was the only man in the hospital. I kind of felt very isolated…I just didn't like it and I hope I never have to go back to it...I wouldn't like to go through that again…it was all women and I was being marched through different rooms. I was very embarrassed, to be quite honest with you, and I showed my embarrassment and I just ended up getting moved to another area…I felt that they knew I was embarrassed and, I don't know, I felt that it was bordering on bullying (5: 213-243)

Maternity was a clear stumbling block for participant 6 and he describes the experience as pretty bad. In his view there was clear discrimination whereby all his female colleagues got to see a section but he was by-passed on all occasions He links his poor experience in maternity with being a man.

Maternity was pretty bad...I put my name down every day to see a section and they'd call up the wards to bring people down when they were doing one and all the girls I was on placement with they got called down but I never got called down unfortunately. I think it was because I'm a man (6: 207-227)

It is very concerning that maternity caused participant 7 to consider that he shouldn't be a nurse. It is also of concern that his experience in maternity firmly links the female with this profession and an example that reinforced why he should not be in maternity was when he was asked to measure the vaginal output of a patient. He does not seem to have been given any guidelines as to how a vaginal output should be measured and his feeling out of place was reiterated further by the staff midwife's reaction. And one has to consider that at this point he was only a 2nd year general student nurse on a short secondment to maternity. He reiterates that maternity is clearly a female profession and his identity was well and truly in question whereby for the first time he felt he was treated because of his gender and not his profession. He now believes that maternity is a woman's profession and that he should not be here.

That was probably the only time I felt like I shouldn't be a nurse, I shouldn't be in this profession...it's a woman's thing...It's just something I couldn't get to grips with because it's – you know there was one case where I was asked by a staff nurse to measure the vaginal output of bleed on a woman and I was sent in to ask the patient and I asked the patient and the patient said 'Oh yes, it was a good amount' and I went back and said it to my staff nurse like and she was like 'Sure here, I'll ask her myself ' like 'cos I didn't know how to put that and I felt very uncomfortable asking those kind of questions, but then again I was only in 2nd year…I just felt uncomfortable like in that this is a woman's place and that I am a male nurse – it was the first time I was seen as a man and not as a

nurse, as I felt. ...it was the only time I felt this is a woman's profession and I shouldn't be here (7: 201-215)

Participant 9 found women patients to be more welcoming than male patients. In relation to his time in maternity it was not the patients who had an issue but it was the midwives who created the barriers. He comments that whereas he can stand up for himself in overcoming the barriers, the younger males in his cohort are not as confident and stay outside the labour ward. This can lead to a feeling of not being wanted and can result in a very negative experience. Again when it came to catheterizing female patients, it was the nurse and not the patients who had problems with it.

The only issues I have had around that was when I was in maternity placement and where patients or clients didn't have an issue, but the midwife had an issue. There were more barriers from the nurses rather than the patients…some of the younger guys, the midwives would say 'I don't think she wants you in there.' In the general sense I have never had a problem with women patients, even with catheterising them and everything, apart from a female nurse saying she might not want you to do that. That was the only obstacle I ever had (9: 127-146)

Maternity: Positive Experiences

Two participants experienced a very positive time during their maternity placement. For participant 9, his experience in maternity was not the norm throughout these interviews and perhaps the fact that there were three men allocated at the same time may have been an influence. Again there were three male students together and this was a novelty but also seems to have been a protection. He was one of a group and not a lone man. He describes the whole experience in maternity as nothing but positivity.

Yeah, there were three of us – three men – all from the same year. And we had a ball. It was a novelty for them to see three male students. None of us had any problems, getting to see births or in the ante natal or postnatal wards…Everyone treated the same and everyone shown everything. No, nothing but positivity (10: 68-74)

Participant 2 considers that he was lucky to witness the lovely birth of a lovely girl. His words such as lovely and lucky are emotive ones and ones more frequently associated with the feminine.

That was great…I was very lucky in that there was one couple that were lovely and they didn't mind me being present for the birth of their daughter - it was lovely (3: 253-258)

The Male Body: Discriminated Against

There were several incidences reported by the participants where they were used because of their male body. Male nurses were associated with grunt work such as heavy lifting or violent patients.

Generally, if there was physical work to be done, such as lifting the patients, the male would always be the one called upon (2: 64-65)

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They often get me to do the 'grunt' work. If there are violent patients or a lot of heavy lifting or something, I often get asked to do that and that's OK, I don't mind…Oh, grunt work, sorry, yes. I suppose some of the heavier work (3: 204-209)

Participant 4 considered that while he is being manly or the handyman, he is missing out on learning opportunities. Because of his gender he has been paired with a carer instead of with a qualified nurse and this gives rise to serious issues around getting adequate experience and around

supervision and preceptorship. Females are given opportunities such as dealing with a cardiac arrest while he was lifting and washing. These are examples of negative discrimination because he is male.

You're missing out on opportunities over the female students…I was not paired with a nurse, I was paired with a carer, given a male carer and told 'Hey, you've to go over and do those washes' and while I was doing those washes, two other girls that are in my class on the ward – they would have been brought to look at a dressing or they would have been allowed give an IM injection (4: 444-451)

Participant 9 felt that men are called upon to do the manly jobs such as lifting heavier patients with the assumption that men are stronger. Even though he is smaller than some of his female colleagues, there is the assumption that he must be stronger because he's male. Even though all students are trained in correct manual handling and lifting techniques, the staff nurses pass by his female colleagues to get him to help with the lifting.

They think you're stronger and will lift the heavier patients and it's not always the case. They assume that you're much stronger. Like, I'd be a lot smaller in stature and build than some of the girls I work with, but you know it didn't really matter that much like you were called everywhere (9: 358-361)

Another example of a negative discrimination was that considered by participant 4. He is bothered by the chaperone concept whereby the female patient is asked permission to have a male nurse present but the opposite is not the case. Again his repeating of words such as 'massive' emphasizes his feelings.

It's a massive, massive, pet hate that I have in nursing and it's the whole idea of chaperones and how nobody bats an eyelid when an 18-year-old female student nurse and a 21-year-old qualified staff nurse, female as well, go in and wash or go in and do a dressing on a very sensitive area of a young man but if I go in with a female staff nurse to do a female dressing in a sensitive area – well that's 'Oh, let me ask the patient first if it's OK'. Nobody ever asks the male patient if that's OK …That's my big pet hate (4: 246-254)

The Male Advantage

There were several examples where the participants considered themselves to have the advantage simply because they were male. For participant 1, female senior nurses show positive discrimination to the male general student nurse in both actions and words. There is strong phrasing repeated in the words 'get away with.' This 'getting away' with things is upsetting to his female peers.

I've got to say this drives my female colleagues mad. The reality is, as boys, as men working with females, it's what I can get away with. Their conversations with me are far more personable and sociable, even in practice… So I think as a male student within a female setting, I think I am protected a little bit more. Certainly treated a little bit differently (1: 111-118)

Participant 4 notes that female colleagues think that male nurses get away with more because they are male. Men can charm their way out of situations and especially with Indian female nurses because of how their culture hold their men in high esteem. This introduces the notion of certain cultures holding a greater regard for men, regardless of what they do.

I think they think we get away with a lot more because we're able to charm our way out of situations and like a lot of nurses would be Indian nurses-not that men are superior over there but you know

that kind of thing where they're submissive to their husbands. I think a lot of female colleagues would think that because you're a male student, she's not going to give out to you as much (4: 210-219)

Participant 5 gives examples of getting away with things and how the female and male students are treated very differently for the same issue.

Certain things like maybe if you make a little mistake, that, maybe, leaving the ward with, maybe, a commode but not the lid on, things like that and you're taken aside, where you should see the younger students, especially the girls, would get a right tonguing for it (5: 208-210)

Participant 6 considers that his female colleagues think that male nurses get away with murder and have less work to do. Interestingly it seems to be the female senior nurses who are coming in from other rooms and doing the female bodywork on the patients that he as a nurse should be dealing with. By contrast the male nurses get called on to do the heavy lifting of patients who are not in their care. There is a perpetuation by the senior female nurses of the perception of what a male nurse should and should not do.

I suppose they think we don't have to do as much work and maybe if you're in a room with patients that the nurse next door might come in and say to us 'Oh, I'll do that for you' so that we don't have to. I suppose especially being with female patients, you know, 'I'll wash such and such a patient because she's female'. I don't see it as getting away with murder because a lot of the times I think the men get called for the heavy lifts and it balances out really (6: 358-362)

Gender Bias from Patients and Relatives

Female Patients

The older females ('old dears') love to see the male nurse on duty but the male patients do not seem to mind if it is a male or a female nurse.

I suppose the best example is the old dears, who love to see a male around, and maybe a lot of them might still think that I was a doctor. But generally the old dears love to see young male nurses. You might expect that they (male patients) *would prefer a man dealing with the more intimate things like personal hygiene, but this wasn't the case* (2: 83-90)

Participant 8 felt that the older women patients regarded him as a 'grandson' and he feels that older female patients are not as conscious of their bodies.

I found that a lot of older women tended to look at you as kind of like a grandson or a son and…they were perfectly happy and I think they were less conscious of their image in relation to how you would see them (8: 197-200)

However, when it came to intimate care of the younger female patients, some participants considered that there was an issue because they were male. Participant 3 notes that whereas the younger females may have an issue, there is not a problem with older female patients. He considers that the system results in the older patients losing their inhibitions.

Sometimes they'll call the bell and I'll arrive and they'll be on the bedpan or stuff like that and they might ask for a female nurse. You know, funny enough, it's the younger women that I look after that are less comfortable with guys. Older women, I'm not sure if it's because often that elderly people

are in the system, and it's an awful way to put it, they almost begin to lose their inhibitions (3: 238-245)

The more intimate the care is, the age of the person you're providing the care for dictates very much whether it's acceptable or not to provide the care, or whether it's considered to be normal. The more intimate, the more likely that there could be a problem (8: 216-221)

Participant 6 shows a clear distinction between how men and women differ in relation to their care. For the female patients, they either did not want him looking after them or they were delighted to see him because of his size and therefore being able to lift them up the bed. By contrast, with one exception who thought he might be a rough fellow, men just get on with it and unlike the females do not seem to have an issue whether it's a male or female nurse. Although they do like discussing manly things like sport with the male nurse.

From a lot of the older female patients, sometimes they wouldn't want me going in to give them a hand with toileting or washing, you know. ...I suppose, with my size- some of them, when they see me – 'Oh great, someone that can lift me up in the bed' and they're only too delighted. That was really the only, kind of, I suppose, negative comment – for a man to think I was going to be too rough. I think the other men – I suppose because I'm a man – and I'm Irish they like to talk about hurling and football, you know, if I saw a match or something like that, so that they'd be happy enough. I think men tend just mainly to get on with it and they don't mind either way (6: 195-204)

Male Patients

Some participants considered that there were advantages in being a nurse when working with male patients. Participant 3 considered that male patients are more comfortable with male nurses especially when it comes to sensitive issues.

Some of the sensitive issues - maybe sexual issues – maybe genito-urinary issues, catheterisation and things like that and dressings. Sometimes people feel more comfortable if it's a man or even going for a shower. ...that person might feel more comfortable with a man and that's fine (3: 209-214)

Participant 5 emphasizes his tools when working with the male patients and being able to converse about blokey things. This is a reiteration of his earlier reference to tools. Again, there is a masculine connotation with the use of the word 'tools' - like the tools of the trade or of the building site.

I'm a fellow and I'm up to date with all the stuff that the fellows are into so I think they really appreciate it and I get great feedback. I get fantastic feedback from the males and a lot of the time I'm put into the male rooms. I lift their spirits and have a bit of craic and I get some enjoyment out of it as well (5: 319-323)

There was a sexual connotation from participant 9 of male patients wanting female nurses to change their incontinent pads and this being condoned by the qualified staff. But other male patients would consider this to be a woman's job and not suitable for a man to do and therefore if a male nurse is willing to do this then he must be gay.

Some men were wearing incontinence pads or something like that and say they would prefer a girl to change them...When I bring that to the attention of the female staff...they know the patients very well and the men would have different agendas than having a problem with me changing them. Some men would consider it to be a woman's job and some men have vocalised 'Does that mean you're gay?' Some men said that out straight and would ask you that question directly (9: 146-154)

Relatives

The assumption regarding the sexuality of male nurses continues on with relatives. Participant 7 acknowledges that there have been times when a male patient/and his visitors reacted differently because he was a male student nurse. He references that he sensed a reaction such as a 'raised eyebrow' a gesture that often has connotations with questioning or assuming that a person is gay.

When you could have a lot of family around the place, and at the bed space and you just got that feeling that when you walked in and you're a male nurse, that when you walked out that there might have been a raised eyebrow or something like that (7: 165-169)

Another assumption experienced by the participants is that because they are male they must be doctors. Participant 4 notes that patients assume the male nurse is a doctor even though they are in nurses' uniforms. He equates tall with being a doctor. In a sense he seems to be aligning himself with being a doctor: a reiteration of the views of his aunts and non-nursing college students.

I think relatives of patients treat you differently and I think elderly patients think - even though we're wearing the same uniform-there have been many situations where patients thought I was a doctor and it would be completely nothing to do with my competency or my skills as a nurse, but it would literally be that I walk into a room, they see a man – I'm tall –so they think he must be a doctor, 'cos he's in a uniform he has to be a doctor (4: 233-237)

Centrality of Nursing

When discussing the roles and activities surrounding nursing, care featured as important and for participant 1, the patient must be at the forefront at all times. Participant 2 views the nurse as a care giver and as pivotal to the MDT and that all members of the MDT depend on the nurse.

It's about providing good quality patient care and it is about providing care within the team, about doing the best for the patient. But it is about the patients; it's about centring what I do on the needs of the person…it is about professional care. We as a profession are providing care on a continuous day in day out basis. So provision of care falls continuously within our remit (1: 171-177)

A caregiver and I suppose an awful lot is to do with being a patient advocate as well. Kind of tie all the bits together...Nurses are the key link between the services. Each member of the team depends on the nurse as the link between them all. Looking after their needs, whatever that might be, with their activities of living (2: 114-118)

Participant 7 considers care as central to nursing but attributes such as caring, empathy, and sympathy are perceived to be female characteristics and associated as being central to nursing. Therefore, nurse equals female and the average person in society in the Republic of Ireland sees nursing as firmly linked to the female.

A woman's job is the feminine thing. It's the caring thing. It's being able to, you know, have empathy and be allowed to show that empathy. Yes, it's just the caring thing, that's just the way it always is, the woman being associated with that (7: 408-410)

Participant 9 considers the public's image of the qualities needed for nursing are caring, being neat and tidy and this reverberates with his previous references to the uniform and he laments that the public do not see nursing as the science it is now. The public still has an image of the nurse as a very patient doctor's handmaiden.

They don't really see it as the science that it is now. Like you're no longer a doctor's handmaid now. You're a professional in your own right. Patience – they like you to have patience. They think you have a lot of patience (9: 197-200)

Participant 6 considers that the average person's image of the caring nurse is one who is the doctor's handmaiden and with the patients, especially the older ones, checking if the doctor said it was OK to do something. The perception is that the nurse cannot work in an autonomous way.

I suppose it's a caring profession, looking after people. I think a lot of it as well is doing what the doctors tell you rather than having your own initiative. Especially with, kind of, the older people – 'Did the doctor say that was OK?' You get a lot of that (6: 305-307)

Caring as linked to the female continues as a concept with participant 10**.** The image of nurses is being awfully good. It is something that others could not do. It is linked with women who are caring and he links nursing with a vocation.

I would think people see nurses as being caring, probably as being women. You'll always meet people who will say 'Yeah, yeah, you're very good to do nursing. 'They have this concept of nurses being 'awfully good'. They wouldn't do it themselves and I think they see nursing as being a vocation (10: 77-80)

For participant 7, caring and empathy are of significant importance and he considers these to be female qualities. But then he acknowledges that he always had the ability to care even though it is a female attribute. Showing empathy is difficult for the male and to show empathy can make you

seem less of a man and open to ridicule. There is a link between showing empathy and weakness, which has been strongly aligned to the female and away from the strong masculine.

Caring and empathy are probably the most important qualities, which are female qualities, as I see them anyway…For a lad that can be so hard. When you're showing empathy...you can't do it without getting in a little dig or something, 'cos maybe that is showing weakness, that empathy, and you don't want to show weakness to the other lads and that's why you toughen up (7: 623-643)

In summary, the experience in maternity was talked about at length. Participants reported being discriminated against in other clinical areas simply because of their male body. But juxtaposed to this was the numerous situations where they had the advantage again simply because of being male. Participants talked about the gender bias they experienced from patients and relatives. They also spoke about what they considered nursing to be. In chapter 7 'Discussion' I link the analysis of the roles and activities to the research question number one pertaining to gender: In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

6.3. MASCULINITIES and IDENTITIES

This section looks at how the participants viewed their masculinities and identities and if having spent almost four years in the world have nursing these had changed (Refer Table 12).

Table 12: MASCULINITIES and IDENTITIES **The number and my naming of the emergent theme for each interview**	
Interview	**Emergent Theme**
1	13. Men make an impact; 15. Emotional work; 16. Talk about if needed; 17. Men don't discuss deeper issues; 18. Internal v external masculinity; 19. Sports and the masculine; 20. Expected behaviour
2	1. Sports; 16. Macho masculine rubbed down
3	2. Intimidated and scared; 11. Him as source of knowledge; 13. Icebreaker; 16. Expected to be more in control; 21. Blokey language = not gay; 22. Becoming effeminate: entering a mode; 23. Masculinity: that's a big question; 24. Masculinity: the shaping by the father; 25.Self-image of masculinity; 26. Masculinity and sports; 27. Masculinity and music; 28. Masculinity and ease into nursing; 29. All-boys school as inhibitor; 30. The daunting but exciting world of women; 36. The influence of women as communicators; 47. If you can't stand the bitching; 48.The bitching mode
4	11. Sort out his gayness; 12. The nursing role in boarding school; 34. Masculinity: No drama No politics No bitching; 35. Masculinity: defined; 36. Emotional: neither masculine nor feminine; 37.Has become more masculine; 38. From helped to helper; 40. Taking control
5	11. Establishes his sexuality; 14. I'm a lad who is a lad; 24. Feel proud with the Filipino male nurses; 28. Fellows bond; 35.Females put up with more; 36. Male not a weak target; 37.Gay or straight; 38.Is he gay; 39.Not the sort to do nursing; 44.Saying no to the lads; 45.Changed me immensely; 51.Fellows say it straight; 53.The difference in a name

Table 12: MASCULINITIES and IDENTITIES (continued) **The number and my naming of the emergent theme for each interview**	
Interview	**Emergent Theme**
6	27. A lad with calluses; 28. A lad without calluses; 29. You've turned into a right woman
7	21. Cultural thing: how to talk to a man; 24.Don't show it to the lads; 25. Soak it up like a man; 26. A changed masculinity without a doubt; 27.Nurse = woman = weak = not masculine; 28. Woman the weaker sex; 29. Bottle it up; 37.We think differently
8	21. A male provides more confidence; 24.Not as worried as female colleagues; 25.Requirements are not strong masculine ones; 26.Masculine = heterosexual; 27. A career should not define the individual
9	4. Prove macho; 5. Denial; 11. Qualifying sexuality; 21. He thinks like a woman now; 22. Student or male; 29. A questioned masculinity; 30. Walking like John Wayne 32. I'm a man: are you OK with that; 35.Difficult being with women all the time
10	5. Don't call me male; 15.Influence on identity; 19. Emotions on pitch v ward; 20.Masculinity: em an interesting question; 21. Feminine = woolly; 22. No change

Traditional Models of Masculinity

There were several examples given by the participants whereby they had a traditional view of masculinity. An example was that given by participant 3 who clearly equates masculinity with being in control and forceful and therefore because of these traits it seems as if male nurses can handle difficult situations such as patients who are aggressive, confused, or heavy, better than can the female nurse.

*Special patients, patients that would be very aggressive, that would fly off the handle, very confused, patients that would be very heavy and would involve a lot of work, they might ask for a male carer... I'm expected to be a bit more manly, a bit more, you know, forceful and in control, I guess (*3: 216-222).

Participant 1 considers that we behave in a way that we are expected to behave. We are conditioned into expected behaviour. If one does not behave to the expected norms, then we let ourselves down. Even in sport there is a clear distinction in expected behavioural outcomes. The participant references two very physical, fast and contact sports. But whereas it is OK for girls to cry when they lose a match, it is certainly not OK for a man to do so. Previously the participant said that the sports he plays afford no hiding place. However, on the other hand he would certainly not show any vulnerable emotion, reflective again of the exterior and interior masculinity.

I think, by and large, you behave the way you think you are expected to. If you are hurt you are hurt, but it's part of the experience you are not meant to show it. You have to employ some kind of strategy not to let yourself down. I have girlfriends who cry when they come off the pitch after being beaten in a hockey match. But I guarantee you if I cried after coming off losing rugby match, I wouldn't survive (1: 255-259).

Participant 5 links men and building sites and with laddish things like drinking beer and playing cards and football matches. Men are not the sort of person to do nursing. Again he reiterates his own laddish likings such as love of sport and beer.

Males...they do all the work on building sites or in bars, they're into football, they drink their beer, they play cards, they play pool and they do all these things that fellows are supposed to be into...I

am one of these fellows that loves going to football matches and watching football and does all that, likes a beer and that (5: 484-492)

Participant 9 has always, since he was a boy, wanted to fit in with the view of expected masculinity such as playing sport and getting into trouble and this image is engrained in you from childhood and you bring it with you throughout life.

I would want to fit in to what the world sees as being masculine…Which is, you know, playing football, but not playing with girls; playing with boys and throwing stones. I'm talking about the early years now…Getting up to devilment and getting into trouble. You were much better if you got into trouble. You're much more of a boy if you did. I guess in some way that's engrained into you and you bring it with you through life unless you confront it and say 'What am I doing'? (9: 443-453)

Participant 9 is comfortable with who is he and is not bothered when others question his sexuality and therefore he is able to respond in a courteous manner. There is a perception that they feel the need to qualify their sexuality before it's even questioned. There is a need for male nurses to reference their fiancé and to qualify their sexuality by saying for example 'I'm a nurse and I'm not gay.' Again he references how some male nurses feel forced to join traditionally macho clubs for example rowing or judo when they really want to do set-dancing. He believes that a lot of the male nurses are concerned that the public think they are doing a woman's job.

Well, I'm very comfortable with who I am…I remember a guy in A&E, a lovely chap, and we were talking away one day and he kept talking about his girl who was going to be his fiancée. He talked about her a bit too much, like when "the lady doth protest too much" …then qualified everything by saying 'I'm a nurse, but I'm not gay'...Some are very uncomfortable with the clubs and I feel sorry

for them because they are going training and they've never played football in their lives. They're in rowing clubs or judo and all those kind of things when really they want to do the set-dancing club and I know they do. They've said it. I think not a lot of the male nurses know themselves and they perceive that the public think that because they are a nurse they are doing a woman's job (9: 158-176)

Participant 10 believes that there is a clear gender distinction in how emotions are expressed with the female being more open at work but whereby the male's openness is confined to the football pitch.

Yeah, females seem to be more open at times. I think men are better at expressing their emotions on a football pitch for example but you can't behave the same on a ward (10: 162-163)

Another participant sees men in a patriarchal society such as Ireland as being like Gary Cooper: strong, silent, confident, in control, distant, not showing emotion and this reflects back to how he viewed his dad. He sees masculine traits are not warm.

I suppose traditionally if you're talking about when Ireland was a more patriarchal kind of society and that, and I suppose the health system is still-the follow-on from…I would say that men were seen to be, particularly in a professional capacity, you must be the very strong silent type, maybe the Gary Cooper kind of thing … in control, confident, wouldn't really ever show emotion, never – always be a little bit distant, particularly with patients (3: 309 – 315)

Participant 4 equates physical strength with masculinity. A clear masculine trait is not to show emotions.

Being physically strong would be something that you'd think of being masculine…I think in the stereotype of men - of masculinity, you don't wear your emotions on your sleeve, you're quite reserved with your emotions (4: 406-412)

Participant 6 talks about his persona prior to entering nursing whereby he was a lad's lad, an outdoor lad, who was going to enter the man's world of the army. The calluses that he had on his hand were a clear reflection of the male patient who considered him to be a rough fellow. But this image only reinforces that he equates it with being 100% pure masculinity.

I suppose I was a typical lad's lad, you know. I had calluses on my hands like from doing manual work and really I suppose I looked like a fellow that was outdoors a lot, you know and then I suppose going into the army anyhow, that's considered a man's world compared to this…definitely, pure 100% like (6: 371-375)

Identity: No Change

When participant 10 is asked if his masculinity has changed since he entered nursing he says that he does not think it has suffered. Nursing's subjects are 'wooly' and feminine but the sciences are strong and masculine. He wants to align himself to the strong sciences. Therefore, feminine equals woolly and masculine equals strong.

I don't think my masculinity has suffered. I don't think it has changed. But sometimes nursing's subjects are seen as woolly subjects and they are seen to be more as female, like for example the psychology of nursing or the sociology of nursing – they are seen as woolly, as feminine. But the sciences, they're seen as stronger, as masculine (10: 179-183)

Participant 5 re-emphasises that he is one of the lads who does laddish things. He talks about the perception of the incongruence between being a laddish lad and being a nurse and therefore, it must be a joke.

You see I'm one of the lads that is a lad. I love football and sports…and I do all fishing and camping and all types of stuff, and when people ask me...what do I do and I say 'I'm a student nurse and I qualify this year', people kind of wonder am I serious or am I joking and they're waiting on me to say 'I'm only joking.' There always is a reaction…I think they can't put two and two together... I'm a typical lad (5: 160-173)

Participant 7 considers that he was a man's man when he started nursing and in front of the lads he is still a man's man. Whereas he might converse about feelings with his female friends: their feelings and not his, he certainly would not do that in front of the lads. He is still a man's man with the lads.

I played Gaelic football and I went out with the lads but I still have friends who are girls and I still – I could chat to them about, you know, about relationships and stuff like that, but I definitely won't show that in front of the lads or talk about feelings or that with the lads. I'd still be the same way with the lads, like (7: 426-429)

Participant 8 considers that his masculinity is the same now as when he entered nursing four years ago and that it is tied in with his sexual orientation. He considers it a perception issue. On the spectrum of masculine towards feminine, the more boorish aggressive types are considered to be on the masculine end. He considers himself to be more contemplative rather than aggressive and does not really worry about how others perceive him.

I think masculinity is very much tied in with your gender orientation, so it you're perceived to be masculine, then you're considered, I think, to be heterosexual. If you're considered to be more feminine then that's equated more to be homosexual...I would be definitely more maybe contemplative as sort of, not sheepish, but more just reserved I would say, rather than being boorish or aggressive or whatever. So wherever I fit in that particular scale is what I am (8: 511-527)

Identity: Change

When participant 7 started nursing he would never discuss his feelings and if he was worried then he would act as a man should do. But nursing has changed him and he is now a bit better at talking about his feelings.

The differences I can see...back then...any problems I had, I wouldn't talk to my friends about it – I'd just - like, being a man, I'd just soak it up and deal with it yourself like, sort the problems out yourself which can be difficult at times, but I think now I'd be – I can see the good in talking – and I'd be a bit more open, a bit more easier to talk about my own feelings and a bit more comfortable about it so I have changed in that way (7 443-451)

Participant 6 says that he no longer looks like the typical man and seems to lament the loss of his calluses. He also laments missing sports events. Just in case anyone might accuse him of being feminine he pushes to do more manly things rather than hanging out with the girls or going shopping. It would seem as if his previous 100% pure masculinity is in danger of being reduced.

I suppose I wouldn't look like the typical man's man. I don't have the calluses anymore and wouldn't be working outdoors as much...Nobody has ever said that I turned more feminine or anything like that to me, so I try, I suppose, to really push for the more manly things to be doing in my spare time rather than hanging out with the girls or going shopping or things like that (6: 379-387)

External versus Internal Man

For participant 1 there is a sense of a 'double-centre' with the outer harder shell and the softer interior. What you see is not necessarily the real or at least the full picture. The participant establishes that the outer shell of the male is harder than the outer shell of the female. There is a firm establishment that whereas girls cry, big boys certainly do not cry. The girls show emotions on the outside but it would be shocking for the male to do this. There is a revealed and a hidden masculinity and as a man one must conform to a stereotypical image and respond to emotional issues in a different way to females.

*I think I have an external masculinity and an internal masculinity. In my opinion my external masculinity is probably harder than my internal masculinity…I think as a man you are expected to be strong. You're expected to be harder than your female colleagues. You're expected to behave in a different way in the same setting...if you see somebody in distress, the girls in my class cry. But I can't do that, but inside I feel it. But the girls are different, they show it on the outside as well. But if I was to do that, I'm not so sure how people would react. I think they'd be shocked. I think I would be shocked as well. Therefore, I think that there is a masculinity that we show to others, and there is a masculinity that we don't show. Even a simple thing like watching a movie, I can get teary eyed, but I very quickly change if anyone comes in. As a nurse you are affected by things, but in my opinion, you are expected because you are a man, to demonstrate, to respond in a different way. You're meant to respond like a stereotype, I guess (*1: 223-242).

Participant 2 considers that he has always been the more understanding and caring type. He sees understanding and caring as being opposite to masculinity. He links such traits as caring, understanding, listening as being effeminate. He seems to turn the question on its head and considers how femininity has crept up on him and shaped his masculinity. He seems to equate

traditional thought with femininity. He seems to see that hanging around with so many females have rubbed off on him and shaped his masculinity and whereas he does not see his masculinity has been affected by nursing, he does see that it has been rubbed down and dampened. He sees that he has the best combination of the masculine and feminine traits.

I suppose, before I made the decision to become a nurse, and maybe I may have always been more understanding, more caring type, not traditionally the male macho type, as some of my friends may have been. And I suppose that developed as well mmmmmmm perhaps the question might even be how femininity or traditional thought of femininity have crept into it and shaped the masculinity of me... things are going to rub off on you. I suppose again in some ways, rubbing down the macho masculinity, damping that down and taking on again the more effeminate traits, of caring, understanding, listening and that kind of stuff. I suppose that I may have the best traits of masculinity and femininity and the better mix of the two of them (2: 136-152)

Participant 9 notes that some of the younger males deny doing nursing and say instead that they are doing a science degree, which is correct but the intention is not to admit to doing general nursing.

I've heard them say 'I'm doing a Science degree'. They don't say nursing when they're being asked what they do (9: 82-84)

In summary, this chapter looked at the participants' responses to masculinities and identities including their consideration of traditional roles of masculinities; how they perceive that their identity has or has not changed since starting general nursing; and their exterior versus interior persona. In chapter 7 'Discussion' I link the analysis of the masculinities and identities to research questions

numbers two and three: How do the male general student nurses understand their gendered identities? In what ways do the male general student nurses feel that their masculinities have been reinforced and/or challenged by their professional identity?

6.4. STRATEGIES AND CAREER PATHS

6.4.1. STRATEGIES

This section deals with the strategy employed by the men in coping with working with a majority female workforce (Refer Table 13).

Table 13: STRATEGIES

The number and my naming of the emergent theme for each interview

Interview	Emergent Theme
2	18. Coping
3	32. Entering a different mode: changing the uniform; 34.The effeminate uniform; 35. The influence of male nurses 37.The uniform as protection from the real selves of women; 42. One of the girls
4	41. Coping strategy: step back; 42. Coping strategy: playing the gay card
5	46. Leave it all behind; 47.Helpful
6	30.Work hard
7	30. Be myself and have fun with the girls; 31.Point to prove; 38. Switch-off
8	29.Bite your tongue; 30.Stand back; 31.Do not question
9	33. Befriend the popular girls; 34. Over-helpful
10	23. Just do it; 24. Pander to the women

Uniform

The strategies employed by the participants included the importance the importance of the uniform; engaging in gender-based behaviours; and becoming removed. The uniform as a significant factor in employing a strategy of coping was referenced by participant 3 who noted that he goes into a different mode when he goes on to the wards. The uniform seems to be a catalyst for this different mode. This mode makes him a different kind of person and he becomes confident. It is like a superman metamorphosis.

I go into a different mode like, it's so strange. I put on the uniform and I go on to the ward and I start my day or whatever... I just become, you know, a kind of different person and I try to remain confident and smiley or whatever but I don't have the slightest problem with – when somebody goes to talk I immediately go to their eye level and I just sit on the bed and sit down (3: 412-417)

He goes on to say that as soon as he dons the uniform he becomes more effeminate and loses all his masculinity as manifested by his language. Again this is in marked contrast to his use of language with the medical interns. He sees the lingo that he uses as being associated with the female nurse and he thinks he must have picked it up from them. He frequently uses the word 'love.' The uniform causes such a change that he says he loses all his masculinity.

I just become slightly more effeminate... I just totally lose all the masculinity stuff and I'd say words like, you know, 'Will I get you something for the pain, love' or 'Roll over to me now love'. It's so funny when I say words like 'love' and stuff, 'cos I never would have done it before. I just picked up the lingo from nursing and I suppose it's very much – that's a very kind of female thing as well, I didn't think I'd really say that at all (3: 434-441)

Participant 3 notes that patients react differently to him. They see him as one of the girls. Again he references effeminate but this time to say that he is not effeminate but neither is he overtly masculine. He seems to equate making the patient comfortable with being asexual-as one of the faces-and they stop seeing him as male. It seems as if being in uniform makes him lose his identity.

After you get to know them there's no difference, really and they begin to see me almost like one of the girls. Like I said, I'm not effeminate as such but I'm not overtly masculine either. I make a point of making them feel more comfortable around me 'cos they're not – almost like an asexual presence, almost a non-threatening, just kind of one of the faces, you know, and they begin – I think they stop seeing me as male after a while, particularly after a day or two of working with the patients (3: 630-635)

Gender-Based Behaviours

Participant 4 distinguishes between the heterosexual and the homosexual man. He believes that gay men are treated an awful lot easier and that female nurses are more comfortable around gay men that around heterosexual men. The first thing that the female nurse does is to determine if the male nurse is gay or not and then is easier on the male nurse when she finds out he is gay; he is almost treated like one of the girls. He plays the gay sisterhood card as one of his coping mechanisms

I also think that with Irish nurses, once they find out that I'm gay, they do act an awful lot easier around me. They're more friendly, chatty. They'll tell me to take a longer break. They're less uneasy around you once they know that you're…And I just generally find that once a staff nurse finds out if you're gay she's far more easy with you. The friends thing comes out – like she'll ask you 'Where

are you going out tonight?' or 'We should meet up' or 'All the girls are going out tonight and you should come along'. Whereas if I wasn't gay they would never say that to me (4: 506-518)

A way of coping for participant 5 is that he sees himself as the helper for the girls and he uses it as a strategy for winning them over.

On the ward I try my best to help out as much as I can. I think that the girls do have their hands full. They have a lot of work and if I have a spare moment I will tell them if there's anything they need me to do and they like to hear that – not everybody does that, but I do, because I feel that's my way of winning them over (5: 565-568)

For participant 7, a strategy that he used was to work hard: a concern of his father and of others was that nursing was a hard job. He feels that because he was a male nurse he had a point to prove and this is another emphasis on the difference of being male in a female dominated situation.

I just worked really hard and was really caring with patients. Maybe I had a point to prove because I was a male nurse, so maybe that made me a bit more – maybe like I felt I had to – I had a point to prove – maybe I had to try that bit harder because I was a male nurse (7: 543-546)

A coping strategy that participant 10 used was to pander to the women and for emphasis he repeats the word 'pander' in one sentence after another. But he recognizes that when he was using women to his own means, they too were using him because he was a man. But he does not like that he was used and even lied about his back in order to get out of lifting.

I recognised early on that the women knew more than I did and I learned to pander to them. I used the fact that I was a guy to pander to the women to get what I wanted. But, on the other hand, often the women were happy to see me on the ward. I mean, I was a guy and I could help with the lifting. I used to find this annoying. I mean, I have a good back and I wanted to keep it good. Once I refused 'cos I was fed up and I was worried about my back (10: 193-198)

Become removed

For some participants, the best strategy was to become removed from the situation. Participant 4 refers twice to how he uses the coping mechanism of stepping back. He does not become involved in the bitching.

Being able to step back and not try and get involved in anything that's not nursing orientated so it's kind of idle chit chat or talking about such and such a patient, or such and such a patient is such a bitch or she's-I would always step back from that because I find a lot of people make the mistake of jumping in and trying to join – trying to fit in and it ends up backfiring on you, so I always-because it just doesn't interest me, I just would always step back (4: 501-506)

Out of a sense of duty, participant 5 shows his face at social events but does not stay too long. He does not share issues with his group. His coping is to leave problems behind him before he gets home. These are further examples of the participant distancing himself and setting himself apart.

I try to socialise as much as I can – but only a small-like maybe an hour, if they were going out, I'd show my face for an hour. I think that's my way of showing that I respect them as a group…but coping – if I have a bad day I like to be away on my own. I don't bring it to the group or anything. Once I walk out the door, I leave work behind me as in, I don't talk about it, but I do bring it with me

as I do think about it. I think, because I have a bit of travelling - I have that time to think about it from the hospital…till I walk in the door. So for me, coping, I have my little stops on the way home. I might go for a coffee or I might go in somewhere quiet or I might even go for a pint, I don't know. But from I leave till I get home, that's where I do my thinking (5: 551-561)

Participant 6 keeps his head down and just gets on with the work as a way of coping in a world where he considers himself to be an outsider.

Mainly I just try to keep my head down and do the work and get it done and the last few wards I've been on have been very busy so the kind of social aspect– they knew each other and we were outsiders (6: 424-426)

Participant 7 emphasises that he keeps his mind on the job and that when he leaves work he can truly leave it behind: unlike his female colleagues.

Like, women would be more touchy-feely with the physical contact and stuff like that but I think, as a man...one thing I could do is switch off…I do care for my patients, no one could say otherwise, but when I do go home I am able to leave it behind which is a good thing and women find that harder to do (7: 692-699)

Participant 8 bites his tongue and he repeats this phrase four times in four lines. In order to cope he has learnt to ask questions in a different way. This participant learned early on to step back, both in the professional and personal settings.

You do bite your tongue I think. You're asked why didn't you do this but you know why you didn't do it and you have to bite your tongue...You have to bite your tongue until you get through. I don't want to get on the wrong side of someone who has power. It's very much like you bite your tongue and do as you're told. You ask questions and you approach people in a certain way. I changed the way I would communicate and I ask questions completely differently than I did before. I ask them in a different way…I learned very early on that I needed to stand back, take a background stance, keep to myself and I'm not going to get too close to anybody. I stand back. I try to keep professional. On a social level I keep to myself (8: 569-579)

In summary, the participants were articulate in the strategies that they used to cope with working in the female world of general nursing. In chapter 7 'Discussion' I link the analysis of the strategies used to research question number four: What strategies do the male general student nurses use to integrate themselves into the nursing profession?

6.4.2. CAREER PATHS

This section deals with the self-expected career paths of the participants (Refer Table 14).

Table 14: STRATEGIES The number and my naming of the emergent theme for each interview	
Interview	**Emergent Theme**
1	Men at the top; 22. Career path; 21.
2	19. Career Path; 20. Men at the top
3	43. Career path; 44. Away from the general; 45. Men are more ambitious; 46. Where men end up
4	43. Career path; 44. Men: managers v clinical
5	48. Fast flowing action; 49.Fast non-stop; 50. Lack of other males
6	31.Pace and knowledge
7	32. Specialise: away from the general; 33. Men move up faster; 34. More men higher up
8	32. Career possibility: theatre; 33.Grey more than white matter
9	20. Men move up quicker; 24. Women in nursing and men in authority; 25. Career options; 27. Men should tell the women what to do
10	16. The intervener; 17. Career path; 18.Foreign men on wards

Away from the general

Participant 1 expressed a keenness to get away from the general wards. His masculine alignment with the 'buzz' and the fast pace of A&E is clear. Other areas of interest are infection control and education, both of which, like A&E, are removed from the general wards and are areas that afford greater autonomy and control.

Education. I'm very impressed with the teachers in the university, about how these people teach. But I want to have a number of years' clinical experience, I don't believe I could teach without that. I

would like to work in A&E or infection control. I get a buzz about A&E but I like the idea of infection control and how we can prevent infection. But education is where I want to end up (1: 282-285).

Participant 2 had entered nursing as a way into paramedics. He is still keen on the paramedic course but he also aligns himself with A&E that would provide a more autonomous setting with a distinct veering away from the general wards.

I think there are better opportunities than before, nurse practitioner, nurse specialists, emergency nurse practitioner…I really enjoyed my placement in A&E so hopefully I would see myself there, again with the view of hopefully doing the paramedic course (2: 180-186)

Participant 3 considers that males want to move out of the wards and upwards but he wants to move out but in different directions: definitely not a general ward and definitely not a desk but specialist work would be fantastic (again more excitement). He sees working on the general wards as having paid his dues but when they are paid he will move to something interesting and different.

When I think of a career path for nurses I think of moving on from the wards eventually... people are always saying males are very ambitious and want to move up...I wouldn't want to be on a general medical or surgical ward for the whole of my career, definitely not, but I certainly don't want to end up in behind a desk at the end of it either, earning lots of money, 'cos that's never really appealed to me. Doing a specialist thing would be fantastic…once I feel I've got everything I can out of general, surgical and I guess paid my dues to the general career path that's going to be expected of me, then I'd do something more interesting, do something else, something different (3: 682-697)

Participant 5 believes that the fastness and non-stop high pace of emergency excites the masculine. Regarding the operating theatre, he again makes reference to the masculine concept of 'tools.'

I think the A&E because it's fast, you know, it's non-stop. You're facing new challenges every hour, even on a minute basis rather than an hourly basis. I think that excites the male, that they're thrown in and it's fast pace, you don't know what's around the corner. You don't know what to expect and the whole challenge of working in such a high paced environment, I think the male likes that. Theatre then – I think – because actually it's scrub nurse, I think it's because the hands on, and passing tools and looking at the anatomy where I think that's another thing that the male finds interesting (5: 611-617)

Participant 6 clearly distinguishes what the male and female like and how that is linked with their respective reactions. The men like the areas such as emergency and intensive care, areas that are fast paced and require knowledge. The patients are moved out from these areas as quickly as possible and therefore there is no space to become attached. This suits the male psyche as opposed to the female psyche, which is too emotional for these areas. The men like action at work and on the sports field.

I think in the more or less specialised areas in theatre or ICU or A&E… They enjoyed the pace there. I think the knowledge as well. Anybody who works there has a vast amount of knowledge and I think for me as well, ICU and A&E – it's the pace, you know, people aren't there for a long time and they're acutely sick and then they're moved on. You don't get attached to your patients as much there…I think girls are more emotional - the patient dies - I don't know if that's a male thing – I suppose the pace of it. The guys just like action you know like playing sports (6: 443-455)

Participant 8 has observed that over his four years in nursing he has noticed that the technical jobs of A&E and ICU and Operating Theatre are the areas to which men gravitate. These jobs requiring grey matter are more suited to the male nurse and there is more money in them. By contrast, the tactile-type jobs that do not require grey matter are better suited to the women.

Theatre, A&E, Intensive care. There are very specific career paths, very technical jobs. Well, using the grey matter more than the white matter. Yes, those kind of jobs are better for men. The tactile is better for the woman. There's always more money in those particular career paths as well (8: 606-609)

Men at the top

Participant 1 observes that there are more men in senior positions in nursing than there are women to a considerable disproportionate extent. It may be that the journey is made easier for men or it may be that men have other responsibilities. This sense of men having other responsibilities as opposed to women is a very traditional male viewpoint. It is analogous to the 'public man' and the 'private' female-the marketplace versus the home.

In terms of the ratio of men to woman and even in the universities, in the nursing school, there is still a higher percentage of men in authority, even in the academics. There is a perception that men seem to have an easier journey than woman and I'm not sure why that is. Is it purely because they are men or is it because they have other responsibilities, I'm not sure really (1: 277-280)

Participant 2 places a strong emphasis on male nurses having more promotional opportunities but he sees that this is the case in other professions and not just nursing. He sees maternity leave as a

stumbling block for the female nurses who stay longer as staff nurses. The use of the word traditional permeates the interview and in this instance refers to the view of male as leader.

I think there are more opportunities for promotion... it's definitely the way in nursing... It does seem that a lot of male nurses rise to management positions, and positions like that where females have to stay as staff nurses for longer. I think one of the main reasons, the same in every job, maternity leave. If females take 6 to 9 months out, that's 6 to 9 months more experience the male has when applying for a job. And I suppose the traditional view of male leadership may be a factor in it (2: 188-194)

Participant 4 has his career ladder mapped out and would like to get into management. He would also like to train in midwifery or public health. Despite his bad experience in midwifery he would still like to train as a midwife but not in Ireland.

My hope is to become – to get into management first. My long term goal is Public Health Nursing and to do midwifery as well.... I would love to do midwifery, but not now, because my experience completely put me off it. I might go to England, work as a midwife for a while and hopefully get into Public Health Nursing (4: 547-551)

Participant 7 notes that men move faster on the career path. But he does not think it should be that way and that the best person should get the job and not because of preconceived ideas about gender. He clearly notices that whereas nursing is a predominantly female profession, it is the male nurses who occupy the relatively few positions at the top of the profession.

I've been told that it's meant to be that men get moved up the line quicker and faster and the reasons you're told is because of women taking maternity leave which affects career prospects, so if a man and woman go for a job, they'll hire the man because the woman gets maternity leave...Given the fact that it is largely, predominantly female nurses, you do notice that there are male nurses taking up those fewer positions higher up. Yes, that is noticeable (7: 581-593)

For participant 9 the two-sided coin is that whereas men seem to move up the ranks quicker, there can be negative somewhat sarcastic comments from the female nurses and this is because some female nurses can feel threatened even by male student nurses.

I think they feel a bit threatened because you're a man. 'Do you think that as soon as you're qualified you're going to be a CNM?' and this kind of stuff being thrown at you. Men move up the ranks quicker and – they say this to me…they just assume that you do and in feeling threatened like that, they do try to bring you down (9: 293-298)

In looking at where male nurse work most, participant considers 9 that men end up in management or A&E or surgical but not on the "plod-along" medical wards. Traditionally nurses are seen as women and men are those in authority managing women.

Men usually end up in management positions or in A&E, or in surgical placements. There are few on the medical wards who are happy to plod along with that and some are really happy 'cos that's what they feel and that's what they love. I don't actually know what it is but traditionally like nurses were seen as women and men were seen as somebody in authority or somebody who could well be developed. It worked really well in the nursing milieu because of - they're managing 30 women kind of thing and I think it's a really hard role to take on (9: 375-380)

Staying with the psyche of the female nurses, they clearly see the males as being the managers who give the orders and not doing menial tasks like direct care.

That's still in the nurses' psyche, when they still see the male as managers on the ward, 'That's what he should be doing. He shouldn't be changing pads and making beds and changing dressings. He should be making all the rosters and rotas and telling us what to do and what not to do (9: 425-428)

In summary, the participants linked gender to their future career choice in general nursing. In chapter 7 'Discussion' I link the analysis of the career paths to research question number one: In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

CHAPTER 7 DISCUSSION

7.1. INTRODUCTION

Attaining a place on a nursing/midwifery programme in the Republic of Ireland is, for the vast majority, based on points attained in the Leaving Certificate examination (at completion of second-level education) and therefore gender is not a matter in the selection criteria. All student nurses, whether male or female, must undergo the exact same training in their clinical rotations. When nurses and midwives, whether male or female, qualify, they must be registered with the NMBI and are, at least in theory, eligible to work in the same areas. Yet despite all these gender-neutral frameworks, on average only 5% of the general student nurse population in the Republic of Ireland is male (Refer Table 2) and only 5% of the general division of the Register maintained by the NMBI are men (Refer Table 3). From the verbatim accounts of the participants, there is little doubt the general nursing in the Republic of Ireland "remains strongly coded as feminine thus presenting difficulties for the creation of male nurse identities" (O'Connor, 2013).

The methodology used in my research was IPA and typically there is no reference to the literature in the analysis (Refer 4.9) with the analysis being kept to the participants' verbatim accounts. In the previous two chapters (Refer chapters 5-6) the analysis of the ten interviews is provided under the following areas (Refer 4.2):

1. Influences on the male general student nurses on deciding to enter nurse training
2. Reactions from family, friends, community when the participants made the decision to enter nurse training
3. The participants' view on the image of general nursing and how it is perceived in the Republic of Ireland
4. The participants' perception of the roles and activities of general nurses
5. The participants' view of masculinities and if they consider that their identity has changed since starting general nursing
6. The coping strategies used by the male participants while working in the female world of general nursing
7. The expected career paths of the participants.

The participants were all male general student nurses and the research set out to explore what it was like for a man to inhabit a traditional and current female space. I wanted to find out if gender was significant when they decided to become a nurse and how the image of general nursing is influenced by society's view of gender in nursing. By virtue of being male, I wanted to explore if they had encountered any reactions because of being male in the nursing world. Therefore, in applying the analysis from the previous two chapters, gender emerged as a topic for discussion.

The research was concerned with exploring the participants' perceptions of themselves and the impact of gender on their sense of self/identity and specifically with their masculine identity and if that had changed in the four years of having worked mostly with women. With this consideration of identity, the notion of whether they had been advantaged or disadvantaged by virtue of being male was looked at coupled with the use of compensatory measures carried out by the participants,

including measures taken to assert their sexuality Therefore, in applying the analysis from the previous two chapters, identities and masculinities emerged as a topic for discussion.

My research was interested in finding out about the coping strategies used by the participants to assist with integration into this other-gender world.

In summary, applying the analysis from the previous two chapters to the research questions of this thesis (Refer 4.3.2) this chapter will discuss the analysis under three broad headings:

Gender

Identities and Masculinities

Strategies

Gender addresses the research question:

In what ways do male general student nurses perceive their gender to be an influence on their professional and social experiences?

Masculinities and Identities address the research questions:

How do the male general student nurses understand their gendered identities?

In what ways do the male general student nurses feel that their masculinities have been reinforced and/or challenged by their professional identity?

Strategies address the research question:

What strategies do the male general student nurses use to integrate themselves into the nursing profession?

Applying the analysis findings to the three broad aspects, the following are considered:

Gender considers the analysis of influences (Refer 5.2); reactions (Refer 5.3); images (Refer 5.4); roles and activities (Refer 6.2); and career paths (Refer 6.4.2)

Masculinities and Identities considers the analysis of masculinities and identities (Refer 6.3)

Strategies considers the analysis of strategies (Refer 6.4.1).

7.2. GENDER

7.2.1. Influences

Chapter 5 (Refer 5.2) analysed the influences on the participants in deciding to train to be a nurse. The low numbers entering general nursing may be influenced by the poor career advice offered in second-level education to male students. A study by Whittock and Leonard (2003) considered the motivations of sixty male students regarding their motivations in entering nursing. It was reported that for those who had a family member as a nurse, it made no difference. In my own research, it was likewise reported that that having a nurse in the family was cited as a secondary influencing factor that was more likely to be superseded by an interest in the profession or a perceived competency in health and paramedics. In my own research, three participants cited a general, but nonetheless emotionally-led desire, to become a nurse based on their interest in health and paramedics.

There are examples in the literature where prior experience as a carer was an influencing factor (Whittock and Leonard, 2003. O'Connor, 2013). In my own research, three participants were influenced by work experience that brought them into a nursing environment and they discovered

they liked this type of work. My analysis also showed that knowing another nurse was considered an influencing factor in the decision to become a nurse.

Men, like women, may well enter nursing for the same reasons of wanting to help people and to care for the sick (Whittock and Leonard, 2003). In a survey of 308 male nurses as to why men choose nursing by Rheaume *et al*, the participants indicated that "their primary reasons for entering nursing were the desire to care for people in need, the opportunity to help people, an interest in science or in medicine, the opportunity to work with a variety of people and good employment opportunities" (Rheaume *et al*, 2003. p 27). In my research, two participants cited an innate aptitude for nursing as key influencer in their decision to enter the profession. Two participants considered job security to be an influencing factor. One participant cited the practical elements of the course as the key driver in his decision to join the profession. By merging the influencers into emotional and practical, it is possible to see the extent to which participants were influenced by their heads or hearts when deciding to enter the profession.

Whereas two participants in my study cited a lifelong burning ambition to become a nurse, other influencing factors that informed participants' decisions to enter the nursing profession were rooted in more pragmatic factors. Three participants cited nursing as a route into other professions as an influencing factor in their decision to become a nurse. In a study by Zysberg and Berry (2005) regarding gender and students' choices in choosing nursing as a career, the gender differences in influencing factors was that men "put greater emphasis on aspects such as salary, job security" (p 197) both of which were referenced by the participants in my study.

For my participants, the key influencing factors in entering the profession were emotionally-led factors underpinned by a strong desire to fulfil a need rather than more traditional and less

vocationally-led deciding factors such a monetary reward, career advancement or job security. On the face of it, gender did not seem to be a factor in the influence on the participants although the reaction to their decision was certainly based on them being male. However, they did enter a feminised profession where nursing's image is still embedded in that of the female (Poliafico, 1998). Therefore, although gender may not have been an obvious factor when they made the decision to become a nurse, it became so after that point, starting with the reactions of others.

7.2.2. Reactions

O'Connor (2013) noted that there were mixed reactions when the men in his study decided to enter nursing including a lack of encouragement coupled with innuendo and suspicion. The participants were very aware of the different levels of support that they had received. In my own research (Refer 5.3) there were similarly different forms of support from family and friends and where it had been negative it seemed to still simmer beneath the surface of the participants. The reactions of family were supportive with all ten participants citing good levels of support generally. Despite high rates of positivity, where opposition did occur it was often gender-related with traditional notions of masculinity and what a 'real man' should or should not do. The opposition was embedded in the notion that general nursing was women's work. The fathers of a number of participants expressed concern about their son entering nursing and the participants seemed to be in no doubt that such concern was linked to gender-based roles with general nursing being viewed as a female job. One participant in particular was met with vehement opposition from ten aunts, all of whom themselves were nurses 'back then, they knew I was gay but no-one else knew I was gay but if he does nursing he might as well have a big neon sign on his head saying he's homosexual' (4: 109-111). Most participants were aware of these concerns at the time of entering the profession but it did not deter them from pursuing nursing as a career even though "paid employment provides an important arena through which the discursive subject can achieve a sense of identity...men's sense of masculine self may be constantly reaffirmed at work" (Whitehead, 2002. pp 124- 125).

Likewise, as far as friends and community were concerned there were mixed reactions. Whereas male friends and other male members of participants' communities were supportive, they qualified that support with endless jokes. The gender-based jokes suggest perhaps a degree of discomfiture with the idea of a male taking up general nursing, discomfiture that could best be disguised or glossed over with banter and jokes. This phenomenon was reported by half of the participants. The issue of this sort of male approach to male participation in a predominantly female working environment recurs under a number of other areas including images of nursing, roles and activities, masculinities and identities, and strategies. When some participants met new friends since starting nursing there was often the assumption that they were gay and indeed this was perpetuated in the clinical settings where the participants perceived that the qualified nurses were looking for signs such as 'limp wrist.' Therefore, there was an inherent risk that the men who decided to enter the feminised arena of general nursing were in danger of being put in the margins and the subordination in the hegemonic order of masculinities. "The concept of hegemony…refers to the cultural dynamic by which a group claims and sustains a leading position in social life" (Connell, 2005. p 77).

"Boys and young men develop and explore masculine identities in particular contexts (their schools, communities and societies) and in relation both to other males and females" (Mac an Ghaill *et al,* 2003. p 140). Therefore, if there is a lack of career advice in secondary schools for males, it has a potentially negative influence coupled with images of nursing being firmly viewed as female (Whittock and Leonard, 2003). In my own research the opposition from the guidance counsellors in secondary school was so strong for two participants that they did not pursue a career in nursing for a number of years. One guidance counsellor seemed to think that if the participant entered nursing it would bring shame to the school. It was to be over thirty years before that participant changed careers to pursue nursing. O'Connor (2013) in his study noted that career guidance counselling in schools was mentioned by six participants as being negative. This is indicative of the strong

influence of schooling in the formation of certain types of masculinities as detailed by Mac An Ghaill (1994).

7.2.3. Images

The participants considered that the images of general nursing in the Republic of Ireland are embedded within a gender construct. Participants believed that the overall image of nursing/nurses is that it is a woman's job. This was reiterated in a study by Norman that explored Year 11 pupils' perceptions of nursing: A response from the participants in her study was the coupling of the characteristics of nursing to those of motherhood, encompassing caring and love. When Norman asked the students to describe a nurse "all responses described female form and used gender specific language when describing nursing roles and characteristics" (Norman, 2013. p 134) thereby continuing to reinforce the stereotypical image of the general nurse.

In my own research, while indeed, in terms of numbers, there are much more females than males in the profession, some participants highlighted the importance of symbols and imagery, such as a nurse's cap as the symbol on the call bell, in perpetuating the notion that the nursing profession 'belongs' to women or is inherently a female profession. The 'angel nurse' was cited as an image frequently encountered from outside the profession. In this view, a nursing career seems analogous to the status of a vocation to which would-be-nurses are called, similar to the traditional perception of a 'calling' to enter a religious order.

In discussing their career choice with others, seven out of ten participants in my research experienced homophobic-like responses. Some comments were overt while others were more covert in nature. This concept was also noted over twenty years ago by Mangan "The public image of...male nurses as homosexual...well known and persistent" (Mangan, 1994. p 60).

Patients' perceptions of the male were reported in my research as being at times an image of a rough fellow who does manly things and not womanly things such as caring for the hygiene of the body or giving an injection. Participants considered that society can accept the image of a male nurse as being a psychiatric one but not a general nurse. Irish society also seems to find it acceptable that foreign-non-national men are general nurses. "Nursing's image perpetuates cultural understandings and societal attitudes about occupations appropriate for men and women. As such, nursing remains stereotyped as a female occupation" (Meadus, 2000. p 6).

7.2.4. Roles and Activities

In chapter 6 (Refer 6.2) the roles and activities are detailed as considered by the 10 participants in my research. Participants reported being favoured by qualified nurses but they also experienced negative discrimination. The negative discrimination was nowhere more evident than in maternity. There was a significant pattern in the data in this regard. There was strong evidence of workplace behaviours that would be unacceptable in any other domain. Participants were articulate and clear that they understood the primacy of patient dignity and did not complain about respecting patient's privacy. However, it was clear from their experiences at the hands of colleagues that many of the discriminatory behaviours were gender-based rather than out of concern for the dignity of the patient. Various forms of discrimination and bias dominated the participants' discourse on roles and activities. In contrast to the very negative experiences of eight of the ten participants, two found maternity to be a positive experience. There was voluminous data in this section from all 10 participants in my research. Maternity is a defined clinical site where male nurses feel different, feel isolated, feel disempowered. Keogh and O'Lynn researched the experiences of gender bias felt by male general student nurses in Ireland (diploma programme) and in the USA and the findings in relation to midwifery showed that the staff were "cold and hostile...and many male students were made to feel uncomfortable" with one participant from Ireland saying that "on postnatal care, I was

told to sit in a cupboard and learn about mastitis and then write an essay" (Keogh and O'Lynn, 2007. p 257). The very idea of 'sitting in a cupboard' is like putting the naughty child on the 'bold step' of a previous style of parenting. In a study by Mac Williams (2013) the male nurses noted that they often felt isolated and lonely (like the nurse in the cupboard or the child on the step). In a work by Cude, it was noted that "The experiences of men in nursing show that the male nurse or nursing student often feels that he is viewed differently by his female counterparts regardless of the quality and sincerity of his work" (Cude, 2007. p 256). In a study by O'Lynn and Tranbarger, gender-based barriers are noted including different treatment for male students during clinical placements encompassing limitations in their experience in maternity and children's clinical placements "This construction creates a second-class status for men" (O'Lynn and Tranbarger. 2007. p 176).

A study by O'Connor (2013) found that the male nurses' bodies carried a currency at both ends of the spectrum, from being rejected as in the maternity scenario to being valued for their ability to do heavy lifting and deal with aggressive patients. In my own research, nine of ten participants cited a bias imposed by colleagues for physical work and as a result some felt that it often limited their scope of experience. Participants were frequently called upon to assist with the lifting of patients who were not within their care team. Some participants reported being called upon to handle aggressive patients on the basis of gender alone. Whereas one participant protested, he found it very difficult to voice his frustration and this was particularly true for participants when they were in 1st and 2nd years.

The expectation that males would handle situations such as an aggressive outburst was not always viewed negatively as one participant described his presence as adding value to the team through their perception that having a male on the ward made them feel more confident in handling any difficult patients that may be in their care. In a study by Fisher, the male nurses engaged in gender

performances and one participant noted that he behaved like a “chameleon...change colour (metaphor for performance) that ensured that they were identified as heterosexual” (Fisher, 2009. p 2672). But taking on the extra workload of, for example, a disproportionate amount of heavy lifting, can bring about role-strain for male nurses and Mac Williams notes that “although such stereotypical roles affirm masculinity, they may generate extra work for the man and compromise relationships in the workplace” (Mac Williams, 2013. p 41).

Chur-Hansen (2002) carried out a survey with patients, both male and female, to determine their preferences for male or female nurses. In the general routine nursing care there were no appreciable differences. However, when it came to more intimate care intervention, both male and female patients preferred a nurse of the same sex. This preference was higher among female patients. In my research, nine out of 10 participants experienced gender-based bias or preferences from female patients during their placements over four years. However, this bias was not universal and participants told stories that were contradictory as their experiences were very different in various placements and the broader context of the nature of the placement was an influencing factor. Five participants also cited circumstances where there was no experience of bias or that bias was positive in favour of the male nurse. Issues of patient dignity were areas where participants showed sensitivity and understanding and they contextualised these issues beyond gender-based attitudes and beliefs.

Participants also reported gender bias or preferences from male patients in a similar fashion to those experienced from female patients. Eight participants told stories of experiencing bias or preference in certain wards while seven reported having the opposite experience in different circumstances. Participants contextualised and were philosophical about bias or preference from male patients and it did not deter them in any way from their nursing practice. Participants

considered that nursing is about providing good patient care and that nurses are pivotal within the multidisciplinary team.

Participants reported that often relatives assumed that the male nurse was a doctor. One participant noted that when relatives discovered he was a nurse that there was a raised eyebrow, a gesture that often has connotations with questioning or assuming that a person is gay. Participants considered that the view of nursing in the Republic of Ireland is closely linked to the female and to traditional feminine traits and that the male nurse is often met with a gestural innuendo such as a wink of an eye.

Apart from maternity, the phenomenon of senior female nurses favouring participants was pervasive in the data and widely recognised. Nine out of ten participants reported the phenomenon of female seniors being more forgiving and this was a source of advantage but also of annoyance, not least because it often alienated participants from their colleagues. There was a consensus that most of these behaviours could be explained by normal sexual chemistry combined with a novelty factor because males were still relatively rare in the profession. Participants did not believe their work was fundamentally different from their female colleagues; rather the social dimension of their work, which naturally included discipline, was where they commonly cited preferential treatment. There were some examples offered of being used more frequently for demonstrating procedures because males stood out more on the ward. Another factor influencing this phenomenon was a cultural dimension where female seniors who came originally from India or The Philippines were more likely to show undue deference when speaking to a male as opposed to a female. Participants were quite happy to take advantage of this preferential treatment whilst recognising that it was unfair to their female colleagues.

This preferential treatment affords to male nurses by female nurses continue after completion of the nursing programme. Positive career opportunities often happen for the 'token' male who is in the minority. In a study by Simpson, many of the male participants believed that being in the minority gave them a considerable career advantage including being fast-tracked into higher positions more quickly than females. Another perceived advantage felt by male nurses was that the older registered nurses tended to 'mind' them or 'mother' them and afforded considerations not given to their female counterparts (Simpson, 2004).

7.2.5. Career Paths

The insider view looked at the positive images and negative images as considered by the participants themselves. It was felt that male nurses are given more opportunities that their female counterparts, thereby preparing the career path for the male nurses to be become managers and leaders. Nursing was considered at times to be boring especially when working outside the trauma areas such as A&E Department or the Intensive Care Unit.

All ten participants referenced a difference between the male and female nurses. The participants expressed a desire to move away from the general wards and into the high-tech areas. Participants commented on their desire to work in the 'buzz', fast pace, high tech areas such as A&E and ICU and Operating Theatre. There was a clear desire to move away from the general 'plod-along' wards and into areas of specialism or management. There was a reference to 'having paid one's dues' and now it was time to leave the wards behind. Oxtoby quotes a female nurse as having said "Men are glory seekers. They enjoy rushing off to cardiac arrests and would rather avoid the nitty-gritty of nursing care. Men practise selective nursing and are always happier fiddling with machines and equipment" (Oxtoby, 2003. p 20).

Participants in my research commented on the lack of Irish male nurses at clinical ward level coupled with the high number in management positions. Participants considered that whereas nursing is a predominantly female profession, it is the male nurses who occupy the relatively few positions at the top of the profession. Evans believes that "patriarchal gender relations play a significant role in situating a small number of men in positions of status and power" (Evans, 1997. p 997). It may be that the journey is made easier for men or it may be that men have other responsibilities. This sense of men having other responsibilities as opposed to women is a very traditional male viewpoint. It is analogous to the 'public man' and the 'private' female–the marketplace versus the home. Traditionally nurses are seen as women, and men are those in authority managing women. Evans comments that "Within nursing, the division of labour based on gender, has resulted in men being channelled into areas of specialization that are considered more congruent with masculinity. These areas reflect the superior value of men and everything masculine in patriarchal culture" (Evans, 2004b. p 327).

However, as my analysis found, men are also disadvantaged, with certain clinical placements, by and large, being considered no go areas. Procedures requiring intimate care of the female patient such as catheterisation coupled with areas relating to maternity care proved problematic and all because of gender. Therefore, for the man to progress in such areas in the Republic of Ireland seems almost impossible.

7.3. MASCULINITIES and IDENTITIES

Some participants equated masculinity with being in control and forceful. Participants felt that we behave in a way that is expected of us and are conditioned into expected behaviour, such as men not crying especially if they lost at a football match or men using 'blokey' language. This type of

language was seen as a way of not being considered gay. Nine of the ten participants discussed following traditional models of masculinity as embedded behaviours or cited examples of where it was imposed on them inside and outside of the profession from colleagues, patients and friends. Given that half of the participants came to the profession straight from school, the data suggested that younger males are perhaps even more susceptible to male conditioning based on traditional conservative views of what constitutes manhood and acceptable ways to behave amongst men.

Four participants cited their lack of exposure to the opposite sex during their formative years and even within their families as creating a difficulty for them in adjusting to being part of the world of nursing. Adjusting to a different social dynamic than they were used to posed a challenge for some. As a result, many participants followed traditional models of masculinity. Participant 3 described a patriarchal view of masculinity that he saw as less present in today's Ireland but still a surviving phenomenon in the health system. He drew on media representations to describe his understanding of 'ideal' masculinity – 'the very strong silent type, maybe the Gary Cooper kind of thing.' Hanlon notes that "To be a primary carer is to lose hegemonic masculinity and this is interpreted by many men as a moral judgement of their inferiority" (Hanlon, 2012. p 130). Participants in my research modified their behaviours both consciously and unconsciously according to when it was safe to do so and this appears to be universal but to a lesser extent amongst participants who cited their sexuality during the interview as being gay. This may be explained by the fact that gay men have to deal with issues of male identity much earlier in life and so come to nursing having already confronted issues of self and male identity.

Participants' testimonies and the language they used suggests a subtle process of them both buying into and yet battling with stereotypical images of the male gender as 'strong' and defined in opposition to the female gender as 'weak'. Participants cited behavioural changes as a result of

their exposure to the profession but were equally quick to point to no loss of male identity as a consequence of such changes in outlook. Despite the significance for participants of male identity in the images and roles of nursing, seven participants cited the primacy of nurse identity as significant to them. While participants were comfortable with their male identities, there was strong evidence in the data that they appeared to operate on two levels and modify their behaviours accordingly. These thinking processes were both overt and covert and appeared to operate at both conscious and sub-conscious levels. This phenomenon was expressed in the data under the headings 'the internal male' and the 'the external male', and examination of these categories pointed to a duality in the male experience between the inner world of thoughts and feelings, and outer world of the 'doing' or acting out of masculinity, and the on-going process of reconciling these two worlds.

The 'internal male' appears to be that part of the participant's psychology that is the inner world, separate and different from his performance as a man or indeed as a nurse. At this level, participants drew upon their own values and experiences to assess and contextualise the circumstances and situations in which they found themselves. Participants acknowledged their ability to inwardly assess and evaluate according to their own ideals but also their guardedness and careful attention as to how they present as a man to the external world. One participant described the experience of liberating some of the 'inner male' when it is socially safe to do so. In telling his story, he acknowledged that being socialised into the profession appeared to have been a catalyst to exploring this phenomenon and although it is not articulated in terms of internalised conditioning there does appear to be a recognition by some participants that the 'external male' does not always have to be in conflict with the 'internal male'.

7.4. STRATEGIES

Most of the participants consciously and sub-consciously applied different gender-based behaviours to the situation. Participants regularly toggled behaviours between traditional models of masculine behaviour to behaviours more frequently associated with feminine components. Participants frequently used their masculinity to gain a benefit when opportunities presented to accrue advantage. Most minority groups in any work environment feel they have to work especially hard to be accepted and four participants cited this strategy as one they used during their four years of training to be a nurse. Female nurses frequently quizzed participants as to their sexuality when they had newly arrived in a placement and two gay participants cited using this phenomenon to their advantage as a strategy to gain acceptance as they believed that female colleagues acted in a significantly more relaxed manner when they revealed their sexuality. One participant reported that he played the gay sisterhood card as one of his coping mechanisms. Other participants closely aligned themselves with the female nurses, especially the popular ones, and go out of their way to be helpful to them and to pander to them.

The uniform was referenced by participants as helping them enter a particular mode. One participant referred to this mode as making him a different and more confident person. Another reported the uniform as making him more effeminate whereby he loses his masculinity. The uniform assisted with the social awkwardness felt by some males when confronted with so many females.

7.5. SUMMARY

My research was about the phenomenon of being a male general student nurse in the feminized profession of general nursing in the Republic of Ireland where only 5% of staff is male.

Gender was a central part of the study and I wanted to explore if gender played a part in the participants' lives in helping them make the decision to become a nurse; in the reactions they got from people regarding such a decision; in their roles and activities since commencing the nursing programme almost four years ago; and on their preferred career paths.

My research aimed to find out what it was like for a man to inhabit a traditional female space. The participants shared distinct common features. They were all men and student nurses in their final year in general nursing in the Republic of Ireland. It can be assumed therefore that they identified with a masculine gender in a context that can be assumed to be one of femininity.

I was further interested in their perceptions of their masculinities and if their identities had been altered since commencement of the nursing programme.

Finally, I wanted to explore with them the strategies that they have used to work in the feminized profession that is general nursing.

The seven broad areas of the research were:
Influences; Reactions; Images; Roles and Activities; Career Paths; Masculinities and Identities; and Strategies

The ten participants were all white men: half of whom had entered the nursing programme directly following their second-level schooling and the other five entered as mature students having worked in other occupations.

The research methodology was that of IPA and the method used was 10 one-to-one face-to-face semi-structured interviews.

Florence Nightingale firmly established nursing as being feminized. When she assumed the mantle of organising nursing, there was the "popular perception of the nurse as inferior, immoral, and degraded, and therefore not meriting any authority" (Palmer, 1983. p 230) and within a strong patriarchal society that she firmly believed in, she saw nurses first and foremost as women whose work was analogous to that of a servant. Servants should 'do' not think and so nurses became women who obeyed rules and carried out tasks. Although the place of training was central, there was no room for anything beyond that hands-on instruction. Nightingale emphasised that nursing was an "extension of mothering, seen as the natural, biological expression of femininity" (Bradley, 1989. p 194). Therefore, in her view, if nurse equals mother equals woman, a male nurse was a contradiction in terms.

Participants in my research believed that the average person in society in the Republic of Ireland sees nursing as firmly linked to the female. Strongly aligned to the female are attributes such as caring, empathy and sympathy and as these are perceived to be female characteristics and associated as being central to nursing, therefore nurse equals female. In a study by Gray, it was noted that "Stereotypical images of nursing, which portrays nurses as 'angels' and natural care-givers, touch on the nature/nurture debate and form gender inequalities in the health services" (Gray, 2010. p 354). Since the time of Nightingale over 150 years ago, the allocation of patients based on sex of the nurse is mostly an issue for the male nurse as opposed to the female nurse. With the predominance of the female nurse, history has legitimised the role of the female in caring for the male body but the opposite is not without its issues. Unlike other men in the healthcare world, for example male doctors, touch, for male nurses, is charged with sexual undertones that

results in an environment whereby “the intimate nature of much of nursing places men at risk; the risk may become evident only retrospectively and on deliberate reflection; and the protective strategies men use can create an abnormal nurse-patient relationship” (Harding, 2008. p 32).

The centrality of nursing care involves the body: the social interaction of the body (and body products) of the patient and/with the body of the nurse. Bodywork can therefore be described as intimate and potentially emotional. This can be the case for either the patient or the nurse or possibly both. In a study by Evans, touch was considered an important component of caring. Some of the men in her study felt that touch is something that did not come naturally to them. One participant described his hands as rough hands before he started nursing and another nurse described touching as new to him “because that wasn’t part of my existence to that point” (Evans, 2002. p 443). In a study by O’Lynn and Tranbarger gender-based barriers included issues surrounding touch and caring with male students annoyed with their seniors that the subject of touch in nursing care had not been adequately dealt with and for “not recognising the discomfort they felt” (O’Lynn and Tranbarger. 2007. p 177). In a study by Harding *et al* regarding male nurses’ experiences of providing intimate care for women clients, the participants reported “greater levels of embarrassment and discomfort when providing intimate care for young women” (Harding *et al*, 2008. p 562). In my own research, the body of the woman in the maternity setting proved problematic for 80% of the participants. However, the participants were clear and articulate about understanding the vital importance of respecting the dignity of the woman. It was the female nursing staff who themselves considered the body of the woman or the new born to be not accessible to the male nurses. But the female nurses used the bodies of the female patients as a shield noting that it was for the good of the patient that the male nurses were not deemed suitable for such settings.

The female and male bodies are principally differentiated by the sexual nature of the body. The male body's muscle mass and strength is a significant factor in the gender division of nursing work, whereby, for example, men are seen as the doers of the heavy manual work in the general hospital (Evans, 2004a). Heikes refers to the 'HE-Man' role trap whereby the body muscle mass of the male nurses is sought after by colleagues (Heikes, 1991). In my study there were many accounts of where the male general students were used for their bodies and while some resented it and even refused others used it as a way of affirming their masculinity and of fitting in to the feminised world of general nursing in the Republic of Ireland.

In a holistic approach to nursing care, it is not just the physical care that is considered important but emphasis is also placed on the emotional care of the patient, which is often considered more readily accessible to the softer approach and not grounded in a rational and logical approach. Therefore, emotional care is more associated with the female as opposed to the male (Henderson, 2001). The emotionally supportive role of the nurse is seen as an extension of being a woman. Men, on the other hand, have by and large removed themselves from the emotional and instead have opted for a rational non-emotional approach (Seidler, 2006). Traditionally emotional labour has been associated with women's work and in a study by Gray (2010) participants "several respondents echoed Hochschild's definition and said that emotional labour was 'continuous contact', 'feeling like you're on-call 24 hours a day and always available to the public' "(Hochschild , 1983. p 351).

One way by which male nurses are actively assisted is by the facilitation of career ladder climbing. In the Republic of Ireland, whereas the overall percentage of male nurses working in a general hospital is just 5%, the percentage of those working as autonomous practitioners as Registered Advanced Nurse Practitioners exceeds 25% (NMBI, 2014). It has been argued that the female nurses actually contribute to the high status afforded the male nurses and that they strongly

encourage their male nursing colleagues to go for promotion (Williams, 1992. Evans, 2002. Evans and Frank, 2003. Abrahamsen, 2004. Curtis *et al*, 2009). The imbalance of men in senior position is echoed in other studies for example David and Woodward (1998) poses the question as to why there is an apparent 'glass ceiling' in the world of academia with so few women professors juxtaposed to the high number of male professors. But as well as a glass ceiling, men are facilitated on the journey to the top by a 'glass escalator' (Williams, 1992).

Reflecting back on the participants reported experiences in maternity in my research, it was disturbing to hear someone who really loved working as a nurse say for the first time he felt he did not belong in nursing. Male nurses experience feelings of isolation and difficulties in being accepted in nursing. Such difficulties include feelings of discomfort in the social settings of nursing (Williams, 1992. Evans and Frank, 2003. La Rocco, 2007) to being deliberately excluded from specific roles and responsibilities (Whittock and Leonard, 2003. O'Lynn, 2004). Male nurses may be made to feel as if they do not belong in the world of nursing. Consequently, male nurses may understandably approach their work in nursing as 'cautious caregivers' (Evans, 2002. p 441). In a study by O'Lynn and Tranbarger, gender-based barriers are noted including the lack of male role models and the isolation of male students: As well as the obvious small numbers of male general student nurses, this barrier is strengthened by the "overall feminine imagery of the nursing profession itself" (O'Lynn and Tranbarger, 2007. p 175).

Masculinity cannot just be black versus white or working-class versus middle-class. The concept of multiple masculinities was explored by Connell (2005) who refers to hegemonic masculinity. Hegemony is about the dominance of a particular form of power that is established and continued with the permission of those who are dominated or disadvantaged by it. It is, however, not stable and is subject to resistance or rejection. In order to explore the identity of a male, it must be viewed

against the backdrop of what it is to be female, and *vice versa*. Within each gender, this comparison also exists, between for example, the homosexual as compared to the heterosexual. "Theories of identity have come to value the concept of alterity. Alterity refers to 'otherness', one's status as an outsider. The implication is that identity formation occurs through a process of 'othering'–marking groups as different and excluded" (Whitehead and Barrett, 2001. p 22).

Connell posits that there is no single form of masculinity or femininity in Western societies, only different ways of being a man or a woman. She contends that there are culturally dominant forms of the gendered being including that of hegemonic masculinity (Connell, 1987). Hegemonic masculinity is a discursive norm and is thus invested with greater prestige than femininity or for that matter other lower status masculinities (Haywood and Mac an Ghaill, 1996). Hegemony is a social ascendancy achieved in a play into the organisation of private life and cultural processes. Ascendancy is achieved within a balance of forces, that is, a state of play. Although only a small number of men can live up to hegemonic masculinity, nonetheless a much great number benefit from "hegemonic masculinity's dominant position in the patriarchal order…complicit masculinity" (Giddens, 2001. p 120). Other patterns and groups are subordinated rather than obliterated. Hegemonic masculinity is constructed in relation to women and to subordinated masculinities. For many of the men in my research, they aimed for this holy grail of hegemony by doing 'manly' things in and out of work and by engaging in behaviours that could be seen to reflect a 'manly' state even when it was not what they wanted. As one participant noted he was judo when all he wanted was to do line dancing.

The participants in my research noted how their sexuality was continuously under scrutiny. For some this began when they first said they were interested and it continues up to the present both in the social and the work settings where they are vigilantly examined for any give-away signs such as a 'limp wrist.' Indeed, for some of the participants, they played the gay sisterhood card to their

advantage in ingratiating themselves with the female qualified nurses. This perception that male nurses must be gay has been implicated in the recruitment of men into nursing (Villeneuve, 1994. Meadus, 2000) and to marginalise or stigmatise those in the profession (Heikes, 1991. Evans, 1997). Consequently, role strain has been mentioned as a potential problem for male nurses and the assumption that the male general nurse must be gay has been implicated in some studies as contributing to role strain (Gaze, 1987). This stereotypical image has an obvious influence on the teenage boy deciding what academic course or career to pursue. This gender bias "is societal in scope and carries the message that anything…female dominated is unattractive and sissy for men" (Pringle, 1991. p 73). It is a not uncommonly held stereotype that male nurses are effeminate or gay (Boughn, 1994. Mangan, 1994. Williams, 1995. Gray *et al*, 1996). "Although there are a number of gay men in the profession, this stereotype forms a major obstacle to many heterosexual men who might otherwise consider pursuing a career in nursing" (Meadus, 2000. p 8).

The commonly held misconception that male nurses are gay can lead men to enhance or magnify their masculine qualities. Such behaviours include making a point of showing the wedding band on their finger and mentioning their wife and children (Williams, 1992). In a study by Fisher, similar findings emerge whereby participants noted that when caring for male patients, they were sure to be identified as heterosexual. They did this by acting in a way that represented the culturally dominant masculinity through words and actions. Even homosexual men deliberately emphasised a 'blokey' behaviour to cover up their homosexuality (Fisher, 2009). In his study, Tilman found that men in nursing were concerned in case they were perceived by others as being homosexual or part of the out–group (Tilman, 2006). Nursing is slow to neuter its image and that this has reinforced nursing as a female role and has also reinforced the perception that nursing for men is not normal (O'Lynn and Tranbarger, 2007).

Butler (1990) views gender as the result of repeated performative acts that create an illusion that masculinity and femininity are natural entities. Driven by the discourses that appear as a gender identity on the body, the person through repeated performativity carries out a sequence of acts in order to culturally survive. She argues that "there is no gender identity behind the expressions of gender; that identity is performatively constituted by the very 'expressions' that are said to be its results" (Butler, 1990. p 25). Butler's view is that there is a script that provides the compass or reference point for how we behave. It is this script that gives us ideals for masculinity and femininity that results in certain behaviours being acceptable but others not. Such a script can change throughout a subject's lifespan (Butler, 1997). The male nurse in my research often used a 'script' that became the norm for them as they negotiated their gendered-identities in the feminised world of general nursing in the Republic of Ireland. In his study, O'Connor (2013) notes that performativity of gender "whereby the constant rehearsing and duplication of a 'gender act' which can over time be altered or subverted may be useful in elucidating the tensions and contradictions evident in the presentation of men as nurses.

A strategy used by a number of participants was to remove themselves from the 'politics' of the ward by stepping back from the 'bitching' that goes on among the females. However, participant seven admitted to being part of this culture of "giving a little dig" despite his clearly demonstrated awareness of the internal and external male, and this is keeping with Kimmel's (1996. 2001) theory of the 'evaluative eyes' within male culture. Kimmel holds that within the traditional ideological construction of masculinity as 'strong' and superior to 'weak' femininity, acquisition of male identity involves taking 'flight from the 'feminine'– the project of acquiring status as 'real man' through proving that one is not 'sissy'. Thus in schoolyard culture, a crucial site of identity formation, denigration of 'the feminine' becomes the central organising principle in the bid for social acceptance. In this dynamic, hierarchies of masculinities are established through the 'evaluative

eyes' of the peer group, with those who fall short of the ideal being subordinated and marginalised through 'sissy' or 'gay' labelling, and sometimes through violence; a dynamic that sustains and reinforces hegemony for stereotypical masculinity (Kimmel, 1996. 2001). It can be seen from Kimmel's theory of the role of the 'evaluative eyes' in the reproduction of traditional models of masculinity that the labelling as 'sissy' or 'gay' of those who do not come up to scratch has profound negative implications for homosexual males as it can only perpetuate homophobic tendencies in male culture.

CHAPTER 8 LIMITATIONS RECOMMENDATIONS CONCLUDING COMMENT

8.1. LIMITATIONS

The research was carried out with a small number of male general student nurses in the Republic of Ireland. In line with IPA methodology used in the research, the number of participants was 10, which is at the upper recommended number for an IPA study. It was a small homogenous and purposive group and the research provided a snapshot in time, namely Spring 2009 and Spring 2010. At the time of commencing the research, there was no similar research with a group of general student nurse degree students on internship in the Republic of Ireland.

The participants provided a male perspective and within the context of being student nurses. As is in keeping with IPA they provided their interpretation of the images of nursing and their feelings about how they were treated by qualified nurses, both positively and negatively, and they indicated how they thought their female colleagues felt when the male students received preferential treatment. The interviews gave verbatim accounts of how the participants were treated by male and female patients. Therefore, a limitation of the study is that the research was with male general student nurses only and no one else's input was sought.

Whereas perhaps some or all of the analysis may be transferrable to other general student nurses in the Republic of Ireland, it was not a purpose of this research to make global statements about all male general student nurses in the Republic of Ireland or elsewhere.

Another limitation of the research may have been my own background and work position. Caution was needed to make sure that I did not influence the process and my novice research status had the potential to exacerbate the matter. Preconceived notions needed to be kept in check.

8.2. RECOMMENDATIONS

The suggested recommendations have emanated from my reflections on what I learned from the research and the implications for professional practice as it relates to the education and training of general student nurses in the Republic of Ireland.

8.2.1. Promotion and Marketing

The first recommendation surrounds the image of nursing, which has a potential impact as an influencing factor when a man decides he would like to enter nursing. Likewise, it has an impact on the reactions people have to male nurses. This first recommendation is concerned with the promotion and marketing of general nursing as a suitable career for men. The HEIs need to be actively involved in such promotion campaigns and suitable role models need to be at the heart of any campaign. Second-level schools and especially all-boys schools need to be actively targeted as do the career guidance teachers who have a potential influence.

8.2.2. Curriculum

The nursing curriculum needs to offer a forum to debate the findings in the literature as to how male students are treated. This needs to occur whether or not there are any males in the cohort. Teaching staff needs to be aware of the potential barriers to the males while in the classroom and periods of reflection and de-briefing need to be built into the programme.

8.2.3. Protocols

Underpinning any protocols must be the fact that gender discrimination is not tolerated. Both in the theoretical and clinical settings, all data including lecture notes, text books, policies, procedures, protocols and guidelines should reflect the complexity of both bodywork and emotional care with due cognisance to any gender implications.

8.2.4. Equality of Treatment

Registered nurses and midwives in the clinical settings should be given the opportunity to consider and reflect on how they may be treating the males differently than the females and to consider steps by which all students would get the same treatment.

8.2.5. Safe Space

There needs to a safe and workable mechanism for male nurses to express any concerns regarding how they perceive they are treated and appropriate follow-up must be taken.

8.2.6. Research with Female Student Nurses

Research with a group of female general students could prove useful in getting their perceptions of difference in how men and women are treated differently during the nursing programme.

8.3. FINAL REFLECTIONS

During my journey on the EdD programme I have faced considerable challenges, not least in my personal life. My professional paid work was often consuming and it was not always easy to 'fit in' the Doctorate. When I started the EdD programme and decided on the research topic, the type of work I was doing fitted well with the study. However, my role changed shortly after I had started the research and was no longer pertinent to the research. My work ethic has always been strong and

often, over my life and indeed to this day, I am inclined to put my work above all else, often to the detriment of other people and other events. As well as the learning curve required for the research, I was going through a very steep and rapid learning curve in my changing professional role. Both, coupled with the difficult events in my personal life, were at times quite overwhelming and my EdD study was sometimes forced into third-place for my attention. From the benefit of hindsight, if I was to ever do such a study again, I would definitely take a leave-of-absence from work as juggling all events was a difficult struggle. The distance of Keele University from where I live was another factor in the midst of everything and to attend for a supervision session or a tutorial involved leaving home at 5am and not returning until midnight or taking an overnight near the university. Because of my work and personal live and distance from Keele University, with hindsight I might have applied to a university closer to home, simply for logistical and timing reasons.

IPA was completely new to me as a methodology and at times the whole process was difficult and somewhat fraught. The volume of data emanating from 10 in-depth interviews proved difficult and at times seemed overwhelming. I believe that IPA was an excellent methodology in getting to the heart of the participants' experiences and would have served really well had it been a piece of research outside of a thesis for a doctorate. However, again with hindsight, as my research formed the basis of my EdD study, I think I may not have chosen IPA as a methodology. The number of interviews in an IPA research tend to be much smaller than ten. The rich data of each of my ten interviews was voluminous and in line with IPA I did very little talking but allowed the participants the safe space to speak about their experiences. But this led to a very large volume of data and in keeping with IPA I needed to represent this in the analysis without any reference to the literature. I was also aware that generally speaking, a thesis is written in the third-person but because of the nature of IPA, I needed to write mine in the first-person. Overall, on reflection, whereas I consider that IPA was an excellent methodology in achieving the aims and in answering the research questions, perhaps it may not

have been the best choice for a thesis. But I also acknowledge that as far as IPA was concerned, I was a novice with very little experience.

Another area that I would reconsider is the timing of the interviews. Because of the need to analyse each interview and read and re-read and listen again and again to each interview, I would have allowed a longer time between each interview. Within the timeframe of access to the participants within the optimum period coupled with the number of interviews, it was not possible to allow any more time than I did. However, with hindsight, if using IPA and carrying out ten interviews, I would have extended the timeframe in my initial negotiations with the HEIs.

The use of reflection and often painful self-awareness has resulted in a huge learning curve for me. An assignment during the first two years of the EdD programme involved self-assessment and a personal development plan. I was at the very centre of this assignment and needed to engage in a considerable amount of self-reflection. This was not something that I had been used to and indeed it felt uncomfortable. But I now really appreciate its value. In reading a review by Francis (2004) of a publication by David (2003) she notes that David "endeavours to take a reflexive approach...weaving her own experiences..." (p 646). My own efforts in using reflection, have, I believe, empowered the participants to tell their story. I have continued to use reflexivity in my work and although it is harsh at times to gaze through my inner mirror, it has also been liberating. What David (2002 and 2003) has done is to relate her own personal situation/s with the political event/s. In my reflections, especially in relation to work events, I have struggled with merging the two. Perhaps it is my nurse training whereby we were taught to separate the personal from all else. But I recognise the need to start merging in my reflection if I am to help realise change. I acknowledged my position as novice researcher but at all times endeavoured to be fully respectful to the participants and reflected both on and in the practice to ensure this was being achieved. I was

greatly humbled by the openness of the ten participants in sharing their experiences with me. I feel a professional responsibility to disseminate the analysis of the participants' accounts in the hope that we can learn to truly respect everyone in the work setting, regardless.

APPENDIX A. NURSING and MIDWIFERY PROGRAMMES IN THE REPUBLIC OF IRELAND

Programme	Level	Leading to Registration	Pre Entry Registrations Required
General Nursing: 4 year honours degree	PRE-Registration	RGN	None
Psychiatric Nursing: 4 year honours degree	PRE-Registration	RPN	None
Intellectual Disability 4 year honours degree	PRE-Registration	RNID	None
Midwifery: 4 year honours degree	PRE-Registration	RM	None
Children's and General 4.5 year honours degree	PRE-Registration	RCN and RGN	None
Midwifery	POST-Registration	RM	RGN
Children's Nursing	POST-Registration	RCN	RGN or RPN or RNID
Public Health Nursing	POST-Registration	RPHN	RGN
Nurse Tutor	POST-Registration	RNT	Any Division of the Register
Nurse Prescriber	POST-Registration	RNP	Any Division of the Register
Advanced Nurse Practitioner	POST-Registration	RANP	Any Division of the Register
Advanced Midwife Practitioner	POST-Registration	RAMP	RM

APPENDIX B. GENDER STATISTICS PERTAINING TO EACH DIVISION OF THE CANDIDATE REGISTER

General				
Year	Total	Female	Male	% Male
2002	1016	965	51	5
2003	1165	1096	69	6
2004	1091	1033	58	5
2005	1088	1032	56	5
2006	1155	1090	61	6
2007	1174	1119	55	5
2008	1148	1102	46	4
2009	967	919	48	4
2010	1010	938	72	7
Psychiatric				
Year	Total	Female	Male	% Male
2002	318	225	93	41
2003	389	308	81	26
2004	355	288	67	23
2005	347	293	54	18
2006	328	255	72	28
2007	369	310	59	19
2008	1148	237	81	7
2009	295	214	81	3
2010	313	213	100	3

APPENDIX B. GENDER STATISTICS PERTAINING TO EACH DIVISION OF THE CANDIDATE REGISTER (continued)

Intellectual Disability				
Year	Total	Female	Male	% Male
2002	177	156	21	13
2003	234	216	18	8
2004	244	223	21	9
2005	251	225	26	12
2006	233	210	23	11
2007	251	239	12	5
2008	220	200	20	9
2009	179	158	21	12
2010	203	187	16	8
Midwifery				
Year	Total	Female	Male	% Male
2006	142	141	1	Less than 1
2007	127	127	0	0
2008	140	140	0	0
2009	150	148	2	Less than 1
2010	162	162	0	0
Integrated Children's and General				
Year	Total	Female	Male	% Male
2006	107	106	1	Less than 1
2007	85	82	3	4
2008	98	96	2	2
2009	101	97	4	4
2010	97	92	5	5

APPENDIX C: LETTER TO HEIs TO DETERMINE TOTAL POPULATION

Dear Colleague

I would greatly appreciate your assistance.

I am planning to do research (in a personal capacity as part of a course) and I need to establish the total population so that I may determine my sample.

To this effect I would greatly appreciate if you could arrange for the following to be completed and returned to me via email by Wednesday 17 September 2008 if at all possible.

With Sincere Thanks

Maria

mneary@nursingboard.ie

In relation to the pre-registration **GENERAL student nurses from the 2005 cohort** and who are scheduled to commence **internship in January 2009**:

Question	Answer
1 How many females commenced	
2 How many females are scheduled for internship	
3 How many males commenced	
4 How many males are scheduled for internship	
5 Are any other male general student nurses scheduled to commence internship in Jan 2009	
6 If I was to include students from your HEI in the research, please give the contact details of the person whom I would need to contact regarding ethical approval	

(Repeated for cohort 2006)

APPENDIX D: GENDER STATISTICS OF GENERAL NURSE STUDENTS (2005 COHORT)

CODE for HEI	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**	**Tot**
Females commenced 05	37	99	64	34	57	30	89	57	160	142	172	60	49	1051
Females scheduled for internship 09	33	71	53	31	57	27	80	40	140	116	159	55	51	913 95.5 %
Males commenced 05	2	4	1	0	3	2	6	1	9	6	11	6	3	54
Males scheduled for internship 09	**2**	**4**	**1**	**0**	**3**	**0**	**4**	**0**	**6**	**5**	**11**	**6**	**2**	**44 4.5 %**
Other male general student nurses scheduled for internship 09	0	1	0	0	0	0	0	0	0	0	1	0	0	2

(Repeated for 2006 cohort with similar results)

APPENDIX E: INTRODUCTORY LETTER TO THE APPROPRIATE PERSONNEL IN THE TWO HEIs

I recently met with (head), Department of Nursing and Midwifery, regarding obtaining ethical approval to carry out research with 4th year male general student nurses at (university). He advised that I should write to you.

I am a doctorate student (EdD) at Keele University. The working title of my research is:

INHABITING A WOMAN'S WORLD: THE EXPERIENCE OF MALE GENERAL STUDENT NURSES IN THE REPUBLIC OF IRELAND.

I plan to carry out a one-to-one face-to-face semi-structured interview with the 2005 male general student nurses during their internship year, with a proposed timeframe commencing March-April 2009 if possible. It may be also necessary to interview the 2006 cohort during their internship in 2010.

Attached please find an information sheet encompassing a consent form that I would issue to the students together with a letter from the Professor in Keele University.

I would appreciate your consideration of my request.

Enclosed please find:

A letter from the Professor in Keele University

Information Sheet encompassing a Consent Form

Stamped Addressed Envelope

I look forward to hearing from you.

Sincerely yours

CC (head) Department of Nursing and Midwifery

APPENDIX F: LETTER OF INVITATION TO PARTICIPATE IN THE RESEARCH

Keele University

Keele

Staffordshire ST5 5BG

England

Tel: 0044 1782 732000

m.neary@ippm.keele.ac.uk

www.keele.ac.uk

Dear Colleague

Allow me to introduce myself. My name is Maria Neary and I am currently undertaking a Doctorate in Education at Keele University, Staffordshire, England. My supervisor is Dr Jackie Waterfield, who is Senior Lecturer at the School of Health and Rehabilitation at Keele University.

The working title of my thesis is: "Inhabiting a woman's world: the experience of male general student nurses in the Republic of Ireland."

I wish to invite you to participate in my research. Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read the attached information document carefully and discuss it with friends and relatives if you wish.

Ask me or my supervisor if there is anything that is unclear or if you would like more information.

I look forward to hearing from you and would appreciate if you could email by (date) if you are interested in taking part in the research.

With best wishes

Sincerely yours

MARIA NEARY

If you are interested in participating, please complete below and return to me using the enclosed stamped addressed envelope or email me at m.neary@ippm.keele.ac.ukbefore (date)

Question	Answer
Name	
Contact Details	
When would be a suitable time to contact you?	

APPENDIX G: INFORMATION SHEET (including interview guide)

Purpose of my Research

Male general student nurses form a small percentage of the national cohorts. My research has its origins in trying to find out what it is like to be a man in a female dominated environment. Student nurses, like other students, tend to socialize together. Traditionally this socializing together has continued long into the work life of the qualified nurses and I am also interested in this aspect. Men (and women) enter into the profession of nursing with an identity and I am interesting in exploring how that identity might have been altered by the experience of being a student nurse. We all use coping strategies when integrating ourselves into any situation and I am interesting in exploring this area.

Why have you been chosen?

The population that I am interested in talking to are male general student nurses who commenced the pre-registration four-year degree programme in general nursing in 2005 (and possibly 2006) and who have had at least two clinical placements during their internship period that commenced in January 2009 and 2010. I have contacted your University and requested that they would contact all the students within my proposed group of participants and give them a copy of this Information Document.

Do you have to take part?

You are free to decide if you wish to take part or not. If you do decide to take part you will be asked to sign two consent forms, one is for you to keep and the other is for my records. You are free to withdraw from this research at any time and without giving reason.

What will happen if you take part?

If you agree to participate in the research and complete a consent form you will be invited to share your experience of being a male general student nurse.

You will be invited to meet with me for an audio-recorded interview.

The interview will be semi-structured and on a one-to-one, face-to-face basis, lasting approximately 60 minutes.

Data will be collected at a convenient time and venue.

Interview Guide

The interview will start with my setting the scene and going over the process. I will clarify any issues. I will request you to re-read the information I sent you and if you are happy to proceed then I will request you to sign the consent form.

In exploring your experiences of being a male general student nurse, in an interview that will be semi-structured, the following are the broad topics that might be dealt with in the interview:

Influences:

Here I would like to find out about you and about the influences on you in deciding to become a nurse.

Reactions:

Here I would like to learn about the reactions of people when you told them of your intention to become a nurse. I would also like to find out about the reactions of people since you started nursing.

Images:

I would like to find out what you think is the image of nursing/nurses/female nurses/male nurses in the Republic of Ireland.

Roles and Activities:

I would like to explore what you perceive to be the practice of nursing. I would also like to find out what it is like for you to be a nurse.

Identity:

I would like to explore how you perceive your identity as a male nurse.

Strategies:

I wish to explore the strategies that you have used to fit in to/cope with the world of nursing.

Career Paths:

I would like to explore the career paths in nursing and I would like to find out about your desired career path.

What do you have to do?

If you are interested in participating in this research, please return the response slip, which is attached to the invitation letter, to me in the stamped-addressed envelope provided or if you wish you can email me, before (date).

I will contact you to arrange a convenient time and venue for us to meet and if you are in agreement, carry out the interview.

What are the benefits of taking part?

There are no expected benefits to you personally; however, it is anticipated that this research will contribute towards a greater understanding of the experience of being a male general student nurse.

What if something goes wrong?

There are no foreseeable discomforts, disadvantages and risks associated with this research. If you identify a discomfort, risk or disadvantage during the research, you are invited to bring it to my attention at your earliest convenience. I do not expect any problems to arise in this research. If you are harmed by agreeing to take part in this research, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of the research, you may address this to:

Nicola Leighton

Research Governance Officer, Research and Enterprise Services

Dorothy Hodgkin Building, Keele University

England ST5 5BG

Telephone: 0044 1782 733306. Fax: 0044 1782 733740. E-mail n.leighton@keele.ac.uk

What about confidentiality?

All of the research data that is collect will be kept strictly anonymous. Any information that has your name, address and any other identifying information, including your consent form will be kept in a locked filing cabinet.

Your interview will be taped, using a digital voice recorder, with a reel tape as a back-up.

The recording will be handed by me to the transcriber.

The recording will be encrypted on a safe stick and will be password protected

The transcriber is a person employed by me and who fully understands the importance of confidentiality.

As soon as the tape is transcribed, the written text will be emailed to me and checked by me against the recording for accuracy.

The transcriber will delete all evidence from her computer and will return the encrypted password protected safe stick to me directly by hand.

The transcriber will delete her transcription.

I will store the file that is password protected and known only to me, in an e folder with full cognisance to confidentiality.

A code will be allocated to each participant and I will be the only person who can match the code to a specific person.

Once the research is written up, my copy of the recordings will be deleted.

How will I use the information from the interview?

I will discuss the interview with my supervisors and with my collaborative group and will use it as part of my final thesis.

It may be used to inform presentations such as publications or conference papers.

It might be used for additional or subsequent research.

But please remember that the interview content will have been anonymised.

Who is organizing the research?

I am organising the research in my capacity as an EdD student at Keele University. I have given the letter, information document, and consent form to the administration in your University in order that they may send the documents to all the male general student nurses in your cohort currently on the internship placements.

Relevant Personnel

Researcher	Ms Maria Neary Keele University Research Project' Department of Education, Keele University, Keele Staffordshire ST5 5BG. England Tel: 087 2182789. m.neary@ippm.keele.ac.uk
Department Professor	Dr Ken Jones Professor. Department of Education Keele University. Keele Staffordshire ST5 5BG. England Tel 0044 1782 621111. k.w.jones@educ.keele.ac.uk
Research Supervisor	Dr Jackie Waterfield Senior Lecturer. School of Health and Rehabilitation Keele University. Keele Staffordshire ST5 5BG. England Tel 0044 1782 733537. j.waterfield@shar.keele.ac.uk

APPENDIX H: CONSENT FORM

Working Title of Project: "Inhabiting a woman's world: the experience of male general student nurses in the Republic of Ireland."

Name of Principal Investigator: Maria Neary EdD Student at Keele University

Aspect	Please √
I confirm that I have read and understand the information document for the above research and have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free to withdraw at any time.	
I understand that the interview contents: Will be used as part of the researcher's final thesis May be used to inform presentations such as publications or conference papers Might be used for additional or subsequent research.	
I understand that data collected about me during this research will be anonymised before it is used for any of the above purposes.	
I am happy for any quotes to be used.	
I agree to take part in this research.	

Name of participant	Date	Signature
Researcher	Date	Signature

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