12-15-2007

"W"- Men: Male Nurses' Negotiation of Masculinity in a Predominantly Female Profession

Deborah Yoder (Deborah Jane Yoder) Miranda

"W"- MEN: MALE NURSES' NEGOTIATION OF MASCULINITY IN A PREDOMINANTLY FEMALE PROFESSION

By

Deborah Jane Yoder Miranda

A Dissertation
Submitted to the Faculty of
Mississippi State University
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy
in Sociology
in the Department of Sociology, Anthropology, and Social Work

Mississippi State, Mississippi

December 15, 2007

"W"-MEN: MALE NURSES' NEGOTIATION OF

MASCULINITY IN A PREDOMINANTLY

FEMALE PROFESSION

By

Deborah Jane Yoder Miranda

Approved:

_____	_____
John Bartkowski Professor of Sociology (Director of Dissertation)	Jeralynn Cossman Associate Professor of Sociology & Director Women's Studies (Committee Member)
_____	_____
Lynn Hempel Assistant Professor of Sociology (Committee Member)	James Jones Professor of Sociology (Committee Member)
_____	_____
Xiaohe Xu Professor of Sociology Director of Graduate Studies in Sociology	Gary Myers Interim Dean, College of Arts and Sciences

Author's Name: Deborah Jane Yoder Miranda

Date of Degree: December 15, 2007

Institution: Mississippi State University

Major Field: Sociology

Major Professor: Dr. John Bartkowski

Title of Paper: "W"-MEN: MALE NURSES' NEGOTIATION OF MASCULINITY IN A PREDOMINANTLY FEMALE PROFESSION

Pages in Dissertation: 193

Candidate for: Degree of Doctor of Philosophy

This qualitative study explores male nurses' negotiation of masculine gender identities in the nontraditional work of registered nursing. Few registered nurses in the United States are men, and men leave the profession within the first four years after graduation at twice the rate of women. This study builds on previous work by seeking to understand why male nursing graduates of an institution formerly for women only, made the decision to become nurses, how they decided to attend a women's college over a more gender balanced campus experience, and in what ways they negotiate gender identities in the configuration of nursing practice careers. Though others have cautioned that active recruitment of men into nursing could be detrimental to women nurses' careers, the current nursing shortage has changed the terrain in health care creating a structural need for both women and men. In contrast to previous studies, which focused on elucidating mechanisms in the workplace that encouraged men nurses' rapid

ascendancy in the profession, this study explores socialization processes encountered in both educational and workplace settings to gain understanding of the meaning these experiences hold for male nurses in the negotiation of masculinity in a predominantly women's profession. By uncovering the salient meaning that socialization into the professional culture of nursing has for male nurses, an understanding can be gained of how best to recruit and retain men in the profession. Gender theory provides the lens with which structures of gendered educational and work relations among participants in this study were examined. Data were collected from thirty participants using multiple methods, and analyzed using an emergent themes approach. Participants identified themselves as competent, compassionate caregivers. Although relationships with female nursing colleagues were undergirded by horizontal reciprocity, tensions arose when male physicians communicated greater trust with male nurses. Interactions with nursing managers were regarded with caution. The male nurses in this study perceived that they were expected to respond with stoicism in crises, work excessive overtime, and were assigned the most complicated cases. They did not feel they could voice reservations about accepting complicated case assignments as did their female colleagues.

DEDICATION

I dedicate this work to the memories of Larry (1943 - 2006) and Darrel Lovely (1946 - 2006), two of the best hillbilly brothers a mountain girl could ever hope to have in her corner. Had circumstances been different, they both could have been exceptional nurses. Like the men in this study, they were both capable, caring, nurturing men. However, they placed their health and well-being on an altar of mountain masculinity and consequently succumbed to cancers that ravaged their bodies. They were gentle giants who inspired me to do my best, and they are missed.

ACKNOWLEDGEMENTS

Recognizing that it was a long-shot that I should ever get to this point, and that it took a host of "sponsors" who continued to push me to complete this work, there are a number of people to whom I shall forevermore be indebted. First, my family: and when I say family, I mean my large extended clan of origin including the Browns, Clarks, Lovelys and Yoders as well as my immediate family. To my husband, children, grandchildren, and mother-in-law, I hope I have not neglected you too awfully much in the process of accomplishing this work.

I am especially indebted to Dr. John Bartkowski, my major professor and the members of my committee for the professional interest and guidance each have given so selflessly. I appreciate you ever so much. I came to sociology much later than most, having been a nurse for thirty years prior to entry into doctoral studies. Thanks to you, I am a better nurse because of the sociological imagination with which you inspired me to take into my work each day.

I thank the men in this study for allowing me to enter their lives through this study. I salute each of them for their courage, tenacity and patience with a social order slow to acknowledge their contributions as competent caring men. I hope they will find my interpretations about their narratives agreeable, and forgive me in my failings.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Traditionally, nursing has been recognized as a female profession, characterized as non-representative of the general population it is purported to serve. Typically, nurses in the United States are conceived as being young, middle-class, Caucasian and female; and, excepting for age (on average the age of practicing nurses in the U.S. workforce is the late-forties) that picture of who a nurse is in the U.S. is very near the reality (Page 2004; Spratley, et al. 2001).

Currently, a severe nursing shortage threatens the healthcare system in the United States. The Bureau of Labor Statistics has established that less than ten percent of all registered nurses (RNs) in the United States are male (Bureau of Labor 2003). In whole numbers, less than 150,000 of the nearly 2.7 million RNs in the United States are men. Nursing leaders suggest the current nursing shortage could be somewhat relieved by aggressive recruitment of men into the profession (Page 2004; Spratley, et al. 2001). However, even with respectable salary increases in all areas of nursing, there has not been a corresponding increase in the percentage of men joining the ranks of the profession. Until a determination about why men enter and subsequently stay, it is unlikely current recruiting strategies will be effective in drawing more men into nursing to ease the shortage.

Recent studies indicate a number of men perceive practices of gender bias while in nursing school (Bernard Hodes Group 2003; Cude` and Winfrey 2007; Nursing's Pulse 2003). Yet, men do move very rapidly to prestigious position upon completion of formal study and passage of licensing examinations for practice as a registered nurse (RN).

Mississippi University for Women (MUW, the W) is one of only two state-supported universities in the United States, formerly for women only, that house a college of nursing.[1] The university campus body is composed overwhelmingly of females and is similar to the profession of nursing in regards to gender ratio in that men have never comprised more than ten percent of the students present on campus. The ratio of women to men on the W's campus approximates the numerical reality found in the nursing work force, thus the gender negotiations experienced by men who attended this formerly all-female university should provide unique insight into men's socialization into the predominantly female profession of nursing.

Although males decidedly constitute a minority among professional RNs in the United States healthcare labor market, men are over-represented among the elite leaders in nursing (Williams 1992). Noted gender theorists do not find it surprising that large numbers of men are located in leadership positions in careers numerically dominated by women (Connell 1995; 2002b; Kimmel 1996; 2000; Kimmel and Messner 1998). Robert Connell asserts that men display, perform, or do masculinity through "practice" or performance of scripted body movements in lived experiences each day (Connell 1995, 64-65). As leadership roles are underscored by acceptably masculine body movements and decisive, take-charge behaviors, men who work as nurses are culturally expected to

[1] Texas Women's University is the only other state supported university, formerly for women only, that houses a college of nursing.

favor management and leadership roles that allow the performance or doing of masculinity (Connell 2002b; Kimmel 2000). Cultural expectations for men to move into leadership roles contribute to an atmosphere of normalcy within the gender organizing institution of nursing when men nurses move from direct bedside care and ascend the healthcare industry's corporate ladder.

It is generally recognized that men and women often encounter latent barriers when they pursue career endeavors outside those deemed as gender appropriate in contemporary American culture (Connell 1995; Gardiner 2002; Gilmore 2001; Guggenbuhl 1997; Jesser 1996; Kimmel 2000; McElvaine 2001; Newberger 1999). Upon entry into masculine work careers, women are often met with profound harassment and discriminatory practices which hinder advancement to top positions within the chosen profession (Bourdieu 2001; Cassell 1986; 1998; Padavic and Reskin 2002). Yet, when men enter nursing, gender does not tend to hinder job success as it does for women who enter traditionally masculine careers (Addleston and Stirratt 1998; Cassell 1998; Williams 1995a). When males do enter predominantly female occupations, such as nursing, they often earn higher salaries and receive promotion more rapidly than do females who numerically predominate in the profession (Heikes 1991; Walsh and Borkowski 1995; Lewis and Snodgrass 1990; Williams 1995b). Male nurses have been characterized as being privileged with a virtual ride to elite career positions in the profession of nursing (Browne 1997; Evans 1997; 2002; Williams 1989; 1992; 1995a; 1995b).

Although the literature elucidates career advancements once men become licensed to practice as a registered nurse, it is less enlightening in regards to issues related to

recruitment and retention of men in the profession. Noticeably lacking are descriptors of the mechanisms and processes of gender negotiation that allow or discourage men's consideration of nursing as a career option. Additionally, exploration of how socialization and professionalization processes in nursing education and in workforce settings may serve as mechanisms to challenge and stimulate men's masculinity, or discourage men's participation in the profession as men-who-care, has not been undertaken. Likewise, the literature is unclear regarding how men in nursing actually perform, or do, the skilled care-giving practices that characterize the art and science of nursing care (Evans 1997). Finally, the literature only obliquely makes reference about how men in nursing negotiate a masculine sense of self in the predominantly female profession in which they work. Thus, my goal with this study is to add to the body of knowledge about the nursing profession by exploring these deficits noted in the current literature related to men in nursing.

Statement of the Problem

The paucity of men engaged in the practice of nursing establishes the background for this investigation. This study explores the processes men in nursing use to negotiate masculine identity in a predominantly female profession. I investigated men's recounted experiences of performing or "doing" masculinity in distinctly female oriented educational and work environments (West and Zimmerman 1987, 125-151).[2] The first purpose of this study directly explored the reasons male nurses provide for choosing a

[2] West and Zimmerman (1987) assert that gendered identities are constituted through patterned relations, interactions, and practices in tandem with others. They describe gender as an accomplishment, something that is done or performed in social life through social exchange, thus a negotiated act.

career in nursing. I asked men in nursing to recount the processes that resulted in their decision to enter nursing, a predominantly female profession, traditionally deemed to be women's work. I also explored how male nurses formulated the decision to attain their nursing education at MUW, a university with a predominantly female student body versus a more gender balanced student body. The knowledge produced by this study is expected to ground future research endeavors related to gender negotiations in the health care professions. Why men choose nursing as a career and what they perceive as having drawn them to the profession, as well as what influenced their decisions for a particular type of university experience, may illuminate effective nursing recruitment and retention efforts for the future.

A second purpose of this study explored how male nurses experience the processes of socialization into the nursing profession and negotiate successful careers in a profession culturally viewed as women's work. I also explored the meaning of recalled experiences encountered during nursing education that were perceived to have encouraged or discouraged male nurses' continued participation in the profession. Likewise, experiences encountered in male nurses' respective workplace settings perceived to have influenced professionalization into nursing were explored for the meaning they hold for the men participating in this study.

It is unclear how men in nursing actually perform, or do, the skilled caregiving practices that characterize the art and science of nursing care; therefore, a third purpose of this study was to explore and describe the labor practices of men in nursing as they care for patients and interact with others in the work environment. This study illuminates themes male nurses provide regarding how they negotiate masculinity in a health care

profession perceived to constitute an overtly feminine work environment and one that is often referred to as a woman's world (Sullivan 2002; Williams 1995a). The overarching purpose of this study was to explore how men in nursing negotiate masculinity in the predominantly female profession in which they work.

Though Christine Williams' study of men in predominantly female occupations explored the problem of men's scarcity in nursing, and has provided the foundation upon which this study builds, key distinctions between her previous work and mine herein can be drawn.[3] First, the current nursing shortage has dramatically changed the terrain in healthcare since Williams conducted her study. Nurses are voicing growing concern for the safety of vulnerable persons who are jeopardized due to lack of trained, experienced professional nurses. A recent study conducted by the Institutes of Medicine demonstrated that the primary means for keeping patients safe is consistent surveillance by experienced RNs (Page 2004). A structural need for men in the female-gendered organization of nursing has been created by this latest shortage. The skills that both women and men caregivers bring to the bedside are needed to provide care to aging, sick, and vulnerable populations. When surveyed, men and women both respond in equal numbers that they choose careers based upon the desire to help people (Bernard Hodes Group 2003). Additionally, men in nursing who participate in direct, bedside-nurse care have been shown to be as skillful and nurturing as their female colleagues (Nursing's Pulse 2003).

Second, Williams studied the outcomes for men who entered predominantly female occupations including nursing, and focused on elucidating mechanisms in the

[3]See Williams (1989) for the complete analysis of her initial study.

workplace that encouraged men's rapid advancement in fields where they comprised a numerical minority (Williams 1989; 1992; 1993; 1995a; 1995b). In contrast, my study explored the processes of socialization and professionalization encountered by men nurses in both educational and workplace settings and how these processes are influenced through gendered interactions or gender negotiations. My exploration of gender negotiation permitted the voices of men in nursing to be heard regarding what they perceived as having promoted their professional growth in a career deemed outside the masculine norm; and provides clues as to how better meet the educational needs of men in nursing schools as well as how to subsequently retain men in the profession.

Third, Williams interviewed male nurses from large metropolitan areas who had graduated from gender-diverse educational settings. In contrast, my study focuses on men nurses from a rural, southern state who graduated from a formerly all-female institution. Religious tensions are woven into daily activities in the southern regions of the United States. In nursing, religion has served as a historical cornerstone as evidenced in the symbolism and imagery of caring (i.e., angel-in-white; angel-of-mercy). Additionally, nursing has roots in the ministering of religious monks in medieval Europe (MacKintosh 1997). Though Williams did not approach religious imagery in her study of males in predominantly female professions, such imagery is noted in my study because of the contextual and cultural significance religion holds for the profession and the southern region of the U.S. Theory provides another distinction between Williams' work and this one. While Williams relied on the feminist psychoanalytic theory of Nancy Chodorow (1980; 1989) to support her study and interpret her findings, gender theories as outlined by Robert Connell (1987; 1993; 1995; 2000; 2002a; 2002b) and Michael Kimmel (1996;

2000) are utilized as the undergirding frameworks for excavating meaning from the data supplied men in my study.

The problem of men's scarcity in nursing is complex, yet only a paucity of literature exists regarding male nurses in general. Although literature related to men in nursing tends to describe rapid ascendancy of men in the field to prestigious positions, some male nurses charge reverse discrimination has truncated the careers of a number of male nurses (Cummings 1995; Porter-O'Grady 1995; Sullivan 2002). Because we know very little about male nurses and their impact on the nursing profession and the quality of patient care they deliver, the concern herein is with how the processes of socialization and professionalization influence masculine interactions (with patients, co-workers, physicians and administrators) in the sex segregated work of nursing.

Background

Since Williams' original study of men nurses, the nursing shortage has dramatically changed the healthcare terrain. Among professional nurses in the United States the critical shortage of registered nurses is a dominant topic (Diers 2004; Feldman 2005; Page 2004). Though periodic nursing shortages have occurred in a cyclic manner, the current shortage of registered nurses presents itself much differently from shortages encountered in the past. The Health Resources and Service Administration (HRSA), Bureau of Health Professions describes the current shortage as being extremely deep, in that the undersupply of registered nurses is due to diminished recruitment and retention of nurses at a time when the demand for nursing services is rising dramatically secondary

to the aging of and onset of chronic illnesses among members of the baby-boom generation (Spratley, et al. 2001).

Unlike their mothers and grandmothers, young women today have a variety of options from which to choose a professional career; thus, fewer young women study for careers traditionally identified as women's work, including work as a nurse, secretary, or teacher. An additional related compounding factor is a deepening nursing school faculty shortage that has curtailed education's ability to keep pace with a supply of new graduate nurses in sufficient numbers to meet the growing demand in the healthcare workplace (Koff 2004).

To stem the crisis in the U.S. healthcare workforce resulting from the nursing shortage, a number of nursing leaders contend that nursing should be promoted more attractively as a healthcare career option for young persons, both men and women (Diers 2004; Feldman 2003; Koff, 2004; Spratley, et al. 2001). A proposal has been made for repositioning nursing in the health care arena as a challenging and diverse health career option "…where young people can learn science and technology, customer service, critical thinking and decision-making" (Sigma Theta Tau July 2001, paragraph 22). The goal is to package the profession as a more desirable field of study for young people who are entering college in order for nursing to compete with academic paths deemed less traditional or for women only. Also, intensive recruitment into nursing of mature persons seeking a second career, ethnic persons of color, and men of all ages and ethnicities has been suggested as a remedy for the current workforce shortage, as well as a strategy for making the profession more reflective of the richly diverse U.S. population (Feldman 2003; Page 2004; Spratley et al. 2001; Nevidjon and Erickson 2001).

Women in the United States are about as likely as men to participate in the paid workforce; likewise, the same applies to the health care workforce (Bureau of Labor 2002). However, medicine has traditionally been cast as primarily a male work domain and nursing a female domain, making for gender-separate professions within the health care arena. In general, literature related to the issue of occupational sex segregation tends to focus on women's exclusion from medicine while ignoring the numerical scarcity of men in nursing (Cassell 1998; Nye 1997), though Williams' works offer notable exceptions (Williams 1989; 1992; 1993; 1995a; 1995b). It is worthwhile to acknowledge that among physicians, gender-separate career tracks also exist. Even though women currently make up nearly half of medical school entrants, they are more numerous in specialties associated with women's nurturing activities, such as pediatrics, general medicine, and obstetrics; subsequently, women physicians encounter lower status and pay as compared to male physicians (Farrell 2005; Powell and Graves 2003). Thus, even though women have gained access to medical careers, they still tend to be maneuvered into working situations that are compatible with women's traditional caring roles.

Less attention is placed on analyzing men's under-representation in traditionally female-dominated nursing. When men do venture into nursing as a career path, we know little about why and how they decide on doing so. Likewise, once accepted into a college of nursing, we understand relatively little about the mechanisms and processes men encounter and undergo in their educational socialization into professional nursing. The practices that men in nursing use after graduation to become successful caregivers remains documented to a lesser extent. Though male nurses seemingly do not experience detrimental discriminatory practices similar to those described by female physicians

(Cassell 1998; Nye 1997), we do not know why they leave nursing within four years of graduation at almost twice the rate for their female colleagues (7.5% versus 4.1% respectively) (Page 2004, 70). We do know, however, that men in nursing simultaneously challenge the culturally gendered norms of what American men should "do" as a life-work as well as violate the American cultural ideal of what a nurse should "be," particularly as portrayed by powerful institutions such as the military and media (i.e., "young," "white," "middle-class," and "female") (Connell 1995; Williams 1989). With my study I explored how men in nursing reconcile the caring work associated with nursing practice, and negotiate masculine gender issues during nursing school and in the workplace.

In the U.S., few public universities housing a college of nursing retain in their mission statement, as well as in their name, the distinction of being universities that focus on higher education for women. Graduates of these universities frequently refer to their alma mater as the "W." Men who attend one of these colleges comprise a gender minority to begin with; and being enrolled in the college of nursing (CON) on one of these campuses doubly magnifies their masculinity, making it difficult to ignore gender-related societal issues. My study explored the experiences of men in nursing who have attended Mississippi University for Women, and who subsequently practice as "W-men" in the nursing profession.

CHAPTER II

RELEVANT LITERATURE

To adequately review the relevant literature regarding men in nursing, I shall necessarily include both social science and nursing research. Although each respective body of literature tends to overlap, underscore and highlight the other, their focuses differ significantly. Social science discourse tends to evaluate larger social structures and processes while the nursing literature utilizes a more micro-structural approach by concentrating on the paucity of men in nursing and how best to recruit into and retain men in the profession. Though some men in nursing have made anecdotal assertions that men nurses encounter difficulties maneuvering successfully in the profession, social science research does not support these assertions (Porter-O'Grady 1995; MacKintosh 1997; Williams 1995b). Disagreement between the two bodies of research is most noticeable in the metaphor used to describe the professional experiences of men nurses. One metaphor used by male nurses to describe the experiences of men in nursing has included the depiction of a "concrete ceiling" barring men from leadership roles in nursing (Porter-O'Grady 1995, 56). Yet, the metaphor used by prominent social scientists characterizes the movement of men within professional nursing as a "glass escalator" carrying men to top leadership positions in the field (Williams 1992, 253-268). While nurses generally discount or ignore gender relations in healthcare, social science researchers assert that male nurses, in collusion with their female counterparts, use a

number of strategies to establish and maintain masculine spaces within the nursing profession (Evans 1997; Campbell 2000; Simpson 2004). Social science experts contend that men carry the privilege of their gender into nursing and tend to monopolize positions of power in nursing (Williams 1993).

With this review of the relevant literature associated with men in nursing, I will first provide an historical overview of how nursing became a predominantly feminine endeavor, including how masculine honor codes in medicine and science assured the sex segregated career paths of medicine and nursing in healthcare. Caring work and the intersections of gender, race, class and religion will be reviewed. A discussion of masculinities theories as outlined by Connell and Kimmel will be followed by an overview of current understanding about how men nurses negotiate masculinity in the predominantly female occupation of nursing. Finally, I will close the review of relevant literature with a case review of male integration into the college of nursing at Mississippi University for Women, a formerly state supported university for women. However, to begin, an overview of historical processes that have influenced the engendering of nursing will help to illuminate how past practices continue to inform current gender relations in the healthcare workplace.

Historical Perspective

Engendering Nursing

Until the Nightingale reformation of nursing, males performed many nursing tasks (Burns 1998; Laroche and Liveneh 1983; Poliafico 1998). Religious orders played a particularly hardy role in defining nursing as a career for men during the Middle Ages.

Detailed records of the monastic movement preserved the history of men caregivers as evidenced by the Saint Antonines, an order founded in 1095 to care for mentally ill persons and the Knights of Lazarus, founded in 1490 to care for persons with leprosy (MacKintosh 1997). Historical documents demonstrate that men also doubled as soldiers and caregivers for the sick and wounded during wars, from the Crusades, the U.S. Civil War up to and including the present war in Iraq (Boivin 2005; Burns 1998; MacKintosh 1997; Painton 1994; Poliafico 1998). Even today, in many Islamic countries, where women are not well integrated into the workforce, men primarily function in the role of nurse (Burns 1998).

Modern discourse regarding nursing, centers almost entirely on the study of a predominantly female occupation based on the essentialist philosophical assumption that the caring role performed by nurses is an inherently feminine one. Although men have had a place in nursing as evidenced by records maintained by religious orders, the military, and labor intensive industries such as mining, the numbers and roles for men in nursing have declined. In the mid-nineteenth century Florence Nightingale introduced training reforms for nursing that marked the profession as a distinctly feminine one:

> A non-religious nursing sisterhood [developed] which allowed no room for male participation in nursing . . . . What emerged . . . was the reproduction of the wider Victorian class structure, based on preconceived notions of the division of labor between the sexes and between women of different classes (MacKintosh 1997, 233).

Based on the essentialist view that women are biologically endowed with a nurturing, caring nature, Nightingale secured a place for nursing as an acceptable career for white, elite Victorian women. Nightingale firmly believed that nursing was a natural extension of virtuous womanhood. Concurrently, men came to be viewed as "clumsy"

and inadequate or incapable of caring adequately for persons experiencing sickness or an injury (Burns 1998, 695). Under a structure of patriarchal capitalism, which was advanced during the Nightingale era, the work of men became elevated and women's caring work was devalued and subsequently relegated outside the domain of all considered worthy or masculine (Hartmann 1971; Padavic and Reskin 2002).

Williams' discussion of the changing status of males in nursing during and after the Second World War revealed the American military to be virtually an all male domain until World War II when a surge of women enlistments moved into the war effort (Williams 1989). Women especially made headway into the military ranks by filling nursing and secretarial positions, thus freeing for combat men who had previously served in such positions. Williams demonstrated that the military's vision of and preference for nurses included only "young, single, white, females" and served to perpetuate and reproduce an ideology excluding men as nurses (Williams 1989, 35). Although a shortage in the supply of nurses at the time meant there were insufficient numbers to meet both civilian and military staffing needs, African-American female registered nurses (RNs) and male RNs were not recruited even though segregated schools were producing qualified graduates from both race and gender categories. According to Williams (1989), military nurses were temporarily commissioned as officers until six months following the war's end, were denied retirement benefits, dependent's allowance, and comparable pay. Arguably, even if men had been allowed into the military as nurses, few would have accepted military nursing assignments with so few benefits. Although the Navy did allow admission of a small number of male nurses, they were not granted entry into the Nursing Corps; nor were these men caregivers called nurses. Additionally, male

caregivers in the Navy who functioned as nurses earned greater monetary compensation than did commissioned female nurses (Williams 1989).

The military did not stand alone in perpetuating the essentialist vision of gender bias in nursing. Even the premiere United States nursing organization, the American Nurse's Association (ANA), inadvertently endorsed the essentialist ideology through its efforts to increase men nurses in the military. The ANA lobbied to change the military's policies to permit men into the Army and Navy Nursing Corps and to train men in the Cadet Nursing Corps, a federally funded all-expenses-paid training program for young nurses. However, the argument used by the ANA reinforced gendered stereotypes by calling for strong men to work in specialties such as urology, psychiatry, supervision and teaching (Williams 1989).

Though women did join the ranks of the military in greater capacity and numbers during the Second World War; and there was participation by male nurses in the war effort, albeit meager, essentialist ideology about men and women continued to be firmly entrenched in the military. Williams concluded: "The experiences of women in the military and the Nursing Corps in World War II illustrate that the erosion of occupational sex segregation does not necessarily challenge [constructed] gender differences" (Williams 1989, 42).

Simply adding more women to the military ranks did not automatically result in reduction of dichotomous labeling of what was deemed appropriate work for men and women in the military. Military men often depicted female military nurses by using either virgin or whore imagery. Williams provided cogent explanation for this phenomenon:

> Because the military was so closely associated with masculinity, the presence of women was particularly threatening to men. If women would perform tasks previously only "masculine" men could do, the activity itself was devalued in men's eyes because the masculine goal of separation from feminine identification is challenged (Williams 1989, 42).

Likewise, male military leaders' preconceived notion that nursing could only be performed by females, precluded allowance of a category for men. According to Williams, to place men in a female role (nursing) would have threatened the bastion of masculinity for which the military stood. The military, though a traditional historical site for male nurses throughout the world, became profoundly disconnected from the profession in the United States. Just as the essentialist ideology espoused by the military served to disconnect men from nursing, masculine honor codes deepened this disconnection in both the military and civilian domains.

Masculine Honor Codes in Medicine and Science

One scholar describes a historical development influencing further separation of health professions along gender lines. He describes medicine as a "field of honor" for men only (Nye 1997, 60-79). Honor codes developed initially during the Middle Ages and provided a means for the aristocracy to settle disputes.

Nye contends that the honor codes of antiquity were transmitted nearly intact to modern culture. He insists they have made up the sociability fabric woven among physicians, scientists and other professionals:

> In the professional and academic associations that flourished after 1800, honor codes served as a basis for male social relations and as guides for intraprofessional etiquette. . . . . [In] medicine, honor was an indispensable component of the informal and written ethical codes of all modern professional groups. . . . Possession of personal honor was also an important criterion for

> ascertaining and maintaining the reliability and truthfulness of gentlemen as witness to natural events; judgments about honor became an important part of the process of science itself (Nye 1997, 60).

Nye's exposition underscores the implication that a masculine honor culture encouraged the gendering of scientific and medical practice in the modern era and did not bode well for the inclusion of women. In addition, his work highlights implications regarding the engenderment of nursing as a profession for virtuous women.

Though chivalrous honor codes originated among the nobility during the late Middle Ages, honor culture boundaries expanded to the social settings of men in education, medicine, and science, granting them power and independence characterized by bravery and loyalty and the control of capital assets (Nye 1997). Violence inherent in the "duel" represented the tool used by "brave, chivalrous men-of-honor" to control their assets (Nye 1997, 62-63). Honor codes both stimulated and regulated male conflicts and social interactions through the duel. Once the duel disappeared in the early years of the twentieth century, the cultural ethos governing it continued operating male associations in public spheres by evoking aggression and violence (Nye 1997).

Nye asserts that professionals in medicine accrue high public esteem not because they are always economically endowed, but because they are invested with more power through independent practice, personal assertiveness and control of assets. The majority of men, however, are restricted from the attainment of power and independence because they do not possess sufficient honor. In effect, most men are not considered the right kind of man because the majority of men do not approximate the "hegemonic[4] masculine

[4] Antonio Gramsci (1971; reprint, 2003, 12-13) defined hegemony as the ability of the ruling class to maintain dominance not through force or coercion, but rather by attaining cultural and moral ideological

form" (Gramsci 1971; Nye, 1997, 68). Honor codes exclude not only women, but also marginalized men from professions because of culturally constructed dependence. As a result, females and marginalized males can be assessed as incapable of participating in the honor culture of medicine and science because they do not possess honor naturally. This essentialist ideology asserts that masculine and feminine qualities are endowed by birth; and are naturally acquired as opposed to earned. When obstacles arise, women and dependent men must defer to the gallantry of independent, virtuous men-of-honor. Parallels exist in the health care arena: Nurses are placed in a dependent role as salaried employees who must defer to a physician for medical orders and therapy regimen readjustments when conditions of vulnerable clients change. Therefore, in accordance with Nye's conception of honor codes, males would not be expected to desire association with a career path that may deny them of masculine honor; and, thus would most likely be reluctant to enter nursing.

A compelling conclusion drawn by Nye posits that male honor codes have acted as an unappreciated factor in the exclusion of women and marginalized men from honor cultures such as medicine, education, and science. Honor codes prohibit entrée to the formal and informal settings where professional sociability controls behaviors, expectations, and opportunities. He asserts the following:

> When a specialized field has been historically dominated by men and is structured by the protocols of an oral honor culture, a man and a woman who enter it for the first time experience it differently. The man may proceed immediately to the task at hand…. For him the social is "natural" in the sense that it is gendered [as] masculine and reflects his previous experiences. The woman, however, must [first] work through … choices about identity and appropriate behavior because

---

ascendancy. Here Nye (1997) has expanded the use of the term to include dominant ideology about masculinity that results in the status quo appearing normal or the natural order.

> women internalize the cultural contradictions to gender in a constant ongoing process of mediating opposing cultural demands (Nye 1997, 77).

Nye's assertions provide greater understanding of mechanisms that continue to permit medical and scientific practices be treated as gender neutral professions. Although masculine honor codes and the violence inherent in these codes do not undergird professional nursing, men nurses are expected to relate to other men, particularly male physicians and male hospital administrators, both socially and professionally, by utilizing the ethics of masculine honor culture. Men nurses, unlike women nurses, communicate more appropriately within the masculine honor culture in health care because they recognize the masculine honor code for what it is and can readily respond to the rules that perpetuate the culture of male honor.

Caring Work as Problematic

A number of authors refer to caring labor as women's work (Browne 1997; Elliott 2002; England, et al. 1994; Hartmann 1981; Sullivan 2002). Padavic and Reskin contend that gendered work is the result of three interrelated components, namely the "sexual division of labor", the "devaluation of women's work" and the "construction of gender on the job" (Padavic and Reskin 2002, 3). They contend these three components became interwoven into the social fabric in such a way that they appear natural and thus are easily taken-for-granted. The sexual division of labor, coupled with the devaluation of women's work and gender construction at work carry implications for the caring work of nursing, in that these phenomena may latently hinder the entry of men into nursing.

A number of scholars have offered "patriarchal capitalism" as a cogent way to frame the valuation of "masculine labor" over "feminine caring" (Elliott 2002, 57-58; Hartmann 1981, 674). As capitalism flourished during the industrial age and workers, particularly men, were drawn into jobs offering paid wages, work for which wages were attached became considered "real work" (Padavic and Reskin 2002, 2). Subsequently, unpaid labor (such as child-rearing and nurturance of family members, housework, laundry, meal preparation) performed primarily by women in their own homes became "devalued" and "invisible" (Padavic and Reskin 2002, 2). The allocation of work into categories of "real" and "invisible" jobs according to gender led not only to the devaluation of caring work but also encouraged the construction of gendered jobs through the production of ". . . [masculine] gender displays[5] of bravado and muscle indicating women do not belong" in the work place (Padavic and Reskin 2002, 13). Likewise, Nightingale's trained nurses engaged in feminine gender displays that reproduced the ideology of "virtuous womanhood," effectively commercializing caring work and securing nursing as a career for "nurturing" women (MacKintosh 1997, 233).

Employers organized jobs on the assumption that workers (men) had a wife at home who "took care of them" and therefore paid men enough to support a family (Hartmann 1981, 675). Therefore,". . . during the Victorian era, an employed wife signaled a husband's inability to support his family" (Padavic and Reskin 2002, 23). In part, this may explain why as recently as the 1960s, many nursing schools barred married women from admission and many hospital policies made very clear that marriage would

[5] The authors define "gender displays" as "language or rituals so characteristic of one sex they mark the workplace as belonging to that sex" (Padavic and Reskin 2002, 13).

result in termination of employment (Elliott 2002). Upon marriage, women nurses were expected to leave the paid work-world not just to create a caring "haven" for their husbands and families but also to avoid bringing embarrassment to their husbands with continued employment (Padavic and Reskin 2002, 23). With such strong expectation that wives must care for their husbands and families, women workers, such as nurses, were subsequently viewed as temporary, non-committed workers undeserving of a "real breadwinner's wage" thereby justifying employers' suppression of nursing salaries (Padavic and Reskin 2002, 41). Although the low wages earned by female nurses undoubtedly repelled men from the profession, the undervalued caring work associated in our culture as women's work (work that must be performed when attending the needs of vulnerable persons) so "marked" the profession as "belonging to" women it obliterated the possible image of a masculine nurse (Padavic and Reskin 2002, 13).

Caring undergirds the practice of nursing. The concept of caring is listed as the first of six values by which professional nurses commit to model and pattern work practices (American Nurses Association 1999). The American Association of Colleges of Nursing (AACN) defines caring as a concept encompassing ". . . the nurse's empathy for and connection with the patient,[6] as well as the ability to translate these affective characteristics into compassionate, sensitive, appropriate, care" (AACN 1998, 8). The remaining values epitomize caring, professional nursing practice and serve to guide ethical behaviors in the profession. These remaining values include personal altruism, respect for client autonomy, respect for human dignity, personal and professional

[6] Caring as defined in this manner is much akin to Weber's conception of verstehen, of casting oneself into the situated circumstances of another and taking on the feelings of that person in order to better understand (Gerth and Mills 1958).

integrity and promotion of social justice for all (AACN 1998, 8-9). In the ongoing process of nursing socialization, both in education and practice settings, these caring values provide an organizing framework for providing "… empathic, sensitive and compassionate care … directed to individuals, groups, and communities" (AACN 1998, 9). To nurses, caring is a moral act in response to human suffering. Though noble, caring work remains undervalued primarily because it has been constructed as "women's work" (Browne 1997, 114; Elliott 2002, 57- 58; Hochschild 1983; Padavic and Resnik 2002, 144; Porter 1992, 510-527; Trentham and Larwood 1998, 11-12; Walsh and Borkowski 1995, 264).

A noteworthy study by Lamont (2000) about working men uncovered a connection between caring and the work of some men. She demonstrated that structural forces such as gender, race and class profoundly influenced identity, self-worth and the meanings inherent in men's work. Lamont (2000) found that black working class men were driven by a need to care for family, friends and community. She characterized the work of black men as underpinned by an ethic of caring which was emotive rather than rational in origin. In contrast, the white working class men who participated in her study were described as displaying a self-disciplined and rational ethic regarding work. Her work infers that larger social forces will have molded workers' skills prior to workers' entry into the workplace. Lamont's work (2000) is compelling in that it connects cultural constructions and the meaning of work for the men in her study and provides a mechanism for understanding what may lead men into a line of work considered as gender inappropriate for men.

Four Structures of Gender Relations

Robert Connell, a leading figure in masculinity studies has defined "hegemonic masculinity" as: "The culturally idealized form of masculine character in a given historical setting" (Connell 2000, 69). He based his conceptualization of hegemonic masculinity on Antonio Gramsci's formulation of ideological hegemonic power (Gramsci 1971). Hegemonic power, according to Connell's interpretation of Gramsci, illustrates invisible power dynamics, which seem, on the surface to be the natural ordering of life activities. For Connell, hegemonic masculinity, therefore, represents an invisible, taken-for-granted power that seems inherent in maleness.

According to Giddens (1976), it is through social action or practices (the things people do) that social structures (e.g., the division of labor) are produced, reproduced and changed. Patterns of behavior arise through social interaction. Social structures can be understood as structured action, which circumscribe experiences by limiting or permitting future action. Connell borrowed from Giddens' concept of structured action in formulating his masculinities theory.[7]

Race, class, and religion interact with gender and influence (rather than determine) the meanings individuals give to social structures: "Structures are real in the

[7] Connell (1995, 71) asserts "Masculinity… is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experiences, personality and culture . . . ." Connell models the structure of gender by distinguishing: ". . .(a) power relations [as] the overall subordinaton of women and dominance of men. . . . (b) production relations [as the unequal] gender division of labor (c) cathexis [as] sexual desire . . . [or] emotional energy attached to an object. . . . " In a later publication, Connell (2002, 67) added a fourth element to his model: "Symbolic relations … [because symbolism and language] include the rules for 'gender attribution'. . . . [and] move below the level at which gender categories normally appear, to consider how a person (or action) gets assigned to a gender category. . . [thus making them] normally taken for granted in everyday life."

sense that they act as resources and meanings, and people construct identities from the structure around them" (Snider 1998, 5). Thus, a number of masculinities (as well as femininities) exist. A recurrent theme found in men's studies that ties the masculinities together is the concept of power-violence (Collier 1998; Newburn and Stanko 1994; Kerston 1996; Liddle 1996; Sabo, Kupers, and London 2001; Tomsen 1997; Winlow 2001). Not just that men maintain power and dominate women, rather the idea of the power in hegemonic masculinity denotes structured patterns among men collectively rather than individually. Hegemonic forms of masculinity underscore the presence of a hierarchal ordering of men: There are men who dynamically dominate ("hegemonic masculinity"), men who form alliances ("accommodating masculinity"), and men who are "subordinate" (Connell 2000, 3-14; Messerschmidt 1993, 119). Presently, characteristic exemplars of hegemonic masculinity in Western culture include "white," "middle-class," "heterosexual," and a "powerful athletic" physique (Connell 2000, 39-56). Subordinated masculinities include ethnic "men of color," "homosexual and effeminate men," "physically challenged men," and "men of poverty" (Connell 2000, 39-56). Challenging the physically powerful hegemonic form is the business executive who controls global markets (Connell 2000, 39-56).

A number of scholars agree that men, as a group, have been historically and culturally privileged in the areas of power, authority and prestige (Connell 1987; 1995; 2002; Kimmel 1996; 2000; Segal 1990; Bourdieu 2001). This advantage in larger society elevates masculinity, causing it to appear as a patriarchal monolith. Though dominant or hegemonic forms of masculinity appear to be permanent, stable, or natural, they are in actuality fluid, socially constructed and changeable (Connell 1995; 2000; Kimmel 1996;

2000; Segal 1990). Hence, there is no single masculinity, but rather a number of masculinities, which challenge the hegemonic form in any era.

Connell defines masculinity as: ". . . simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture" (1995, 71). Recently, Connell (2002) underscored the importance of symbolism, the process of communication as a fourth structural piece of his definition of masculinity. In an earlier work Connell (1987) gave symbolism a broad brushstroke by not separating it from the relations of power, labor and cathexis. Instead he preferred to approach relations of power, labor, and cathexis as having both practice and symbolic components. Connell (1987; 2000; 2002b) uses his conception of power, labor, cathexis or emotion, and symbolism as tools for examining the structure of gender and gender relations. By utilizing these four structures, he contends that analysis of gender order in the whole of society as well as analysis of gender regimes in particular institutions may be undertaken while tying together structure and practice in a given historical context.

Power

Connell (2002b) describes two general approaches to the structure of power relations: (1) organized institutional power (as with patriarchal power) and (2) diffuse, discursive power in the form of regulation and discipline (Foucault 1977). Organized institutional power, he asserts, can be overt and direct or indirect as well as latent. Individuals may directly use violence or coercive force to achieve their will or indirectly and impersonally by using violence through hierarchies of the state (laws enacted by the

government) and business (policies and procedures). Additionally, organized institutional power can be latent as described by Antonio Gramsci's hegemonic power. Another important part of the structure of gendered power (acknowledged by Connell as having been borrowed from Foucault) is power that is widely dispersed, discursive in nature, and operates diffusely in intimate ways on bodies in the form of regulation and discipline. This type of structured power can often seem to be natural and thus can easily be taken-for-granted because it "… operates discursively, through the ways we talk, write and conceptualize. This diffuse but tenacious power operates close up, not at a distance" (Connell 2002, 59). Connell describes this type of power as particularly insidious because it is often associated with pleasure and reward for adherence to disciplining regimes that form practiced bodies. An example illustrative of this type of power would certainly be an athlete at the height of training for an event such as a marathon. Another example is that of the "Iron Surgeon" ethos Cassell (1986) characterized as a denial or disregard of bodily needs by surgeons in the United States which elevates the surgeon to the status of "swashbuckling surgical hero " (Cassell 1986, 14).

Labor / Production

The sexual division of labor is viewed by Connell (1987) as only one part of a gender-structured system of production, consumption and distribution. For understanding the gender relations in production, consumption and distribution Connell offers five organizing points (as opposed to firm conclusions) that seem particularly important to him. One point has to do with the cultural insistence about what constitutes work to be done by women or by men, in spite of the irrationality and impossibility of

totally excluding one gender from performing a particular task. A second point highlights sexual demarcations related to profits and labor control in the workplace setting. The third centers on the exclusion of women from wealth accumulation, particularly in relation to missed opportunities educationally and in career counseling for young women. As a fourth point for consideration, he cites practices similar to Nye's male honor codes that promote male solidarity across class lines in maintaining the sexual division of labor. Finally, the social insistence to allocate childcare to women and the limitations this allocation has for career advancement and accumulation of wealth is listed as a fifth organizing point.

Connell's description of labor and production carries an imprint of the works of Pierre Bourdieu especially in relation to how both scholars meld structure and practice. Bourdieu insists that the seemingly permanence of masculine privilege has to do with the recreation and reproduction of the masculine order from age to age not necessarily through the family, but rather through ". . . *agents and institutions which permanently contribute to the maintenance of these permanences,* [namely] the church, the state, the educational system, etc. . ." (emphasis in the original) (Bourdieu 2001, 83). He goes on to describe what he calls three practical principles people apply in their choices particularly in relation to work secondary to conditioning of one's habitus through the above agents and institutions:

> The first is that the functions appropriate to women are an extension of their domestic functions – education, care and service. The second is that a woman cannot have authority over men, and other things being equal, therefore has every likelihood of being passed over in favour of a man for a position of authority and of being confined to subordinate and ancillary functions. The third principle gives men the monopoly of the handling of technical objects and machines (Bourdieu 2001, 94).

For both Bourdieu and Connell, visible changes such as the increased numbers of women entering the work force masks the seemingly intractable and invisible structures that link domestic work to sex segregated labor markets. Both scholars agree that women are not being complicit in maintaining male privilege when choosing a career that is predominantly for women, but rather the structures maintaining it are difficult to apprehend because they are below the level of conscious recognition (Bourdieu 2001; Connell 1987; 2002b). Once work becomes gender-divided, clear differentiations within the work force related to sexual politics seem to operate as natural phenomena. For example then, it may seem quite natural for business management to be associated with forms of masculinity while direct caregiving may be associated with femininity. In this manner identity (who I am) becomes fused with work (what I do).

Cathexis / Emotion

Connell refers to structures that organize an individual's emotional attachment to another as the "structure of cathexis" (Connell, 1987, 112). He views sexuality as an important element of socially constructed and enacted emotional dimension of all social relationships. Connell generalizes the concept of cathexis to the construction of emotionally charged social relations with other people in the real world which can be "positive, negative or ambivalent" (Connell 1987, 114). He notes that emotional objects of desire in our culture are generally defined in terms of heterogeneity (masculine and feminine), include sexual practices that are most often organized in couple relations (heterosexual or homosexual), and has basis in some kind of reciprocity. He asserts

heterosexual reciprocity is based on unequal, vertical exchange and is therefore of concern to Connell.

Emotional relationships in the workplace are also of interest to Connell in that many occupations, including nursing, require the production of a particular relationship with a customer. In nursing, the required relationship with a patient is a therapeutic one based on empathic understanding. Connell (2002) refers to Hochschild's (1983) scholarship regarding the occupational requirements for specific types of managed emotional practices in social relations with clients.

Symbolism

Symbolic relations make up the fourth and latest component of Connell's (2002b) gender framework. He asserts that all social relations and practices involve interpretation and meanings, discourse, language and symbols, which are produced by social processes. Borrowing from Lacan, Connell contends that "the place of authority in symbolism and communication is always with the masculine" (Connell 2002b, 65). Connell contends that when we use words such as "man" or "woman" such words imply much more than just biology. Words (both written and spoken) can provoke powerful images, and whole sets of meaning when used in differing contexts. Equally interesting to Connell are gender "symbolic markers" observed in fashion attire, body comportment, make up, and in art, architectural design, and the media (Connell 2002b, 115). One example of clothing as a powerful symbolic marker can be found in the differential head coverings used by men and women in the operating room setting: Women opt for loose fitting "bouffant" covers over their hair while men wear tight-fitting "cunt" caps.

Connell (1987; 2002b) is quick to note that the four main structures of what he calls the modern system of gender relations, as described above, operate in practices by constantly intermingling and interacting. Only for the sake of analysis does he so painstakingly distinguish the four structures of gender relations: Power, labor, cathexis and symbolism. In reality, there is tremendous overlapping of each structure.

Identities, Interactions and Institutions

Kimmel (2000) asserts that exploration at three levels must be utilized in order to apprehend the social negotiation of gender relations: (1) identities, at the subjective or intrapersonal level; (2) interactions, at the interpersonal level; and (3) institutions, at the cultural level.

For Kimmel, both interpersonal relationships and institutions simultaneously structure the myriad ways in which group members actively construct identities. In accordance with Connell (2002b), Kimmel views gender as being plural, suggesting that a number of masculinities and femininities exist and are held in comparison to normative constructions of hegemonic masculinity and emphasized femininity, respectively. Additionally, Kimmel asserts that gender is relational, and is always situated in time and place. Therefore, to be identified as masculine or feminine varies in differing social contexts. Likewise, differing institutions require differing forms of masculinity and femininity at differing times. In this way: "Gender, like race and age, is deeper, less changeable and infuses the more specific roles one plays. Thus, a female (nurse) differs from a male (nurse) in important . . . respects such as income, credibility and status"

(Kimmel 2000, 89)[8]. Kimmel's three I-constructs include identities, interactions, and institutions. These three elements provide a framework for connecting culture and identity through interactions, including both practices and symbolic relations of power, labor and emotional attachment.

Like Connell (2002b) and in the spirit of West and Zimmerman (1987), Kimmel asserts that identity as a man or woman is not a characteristic one possesses, but rather a set of activities that one engages in or performs. Additionally, Kimmel and Connell agree that gender is performed in relation to others who subsequently evaluate, validate and legitimate one's gender identity. "Gender then is less a personal characteristic than it is a product of interaction with others" (Kimmel 2000, 106).

Kimmel views interaction (within institutions) as the site where identities are formed. In the process of interacting in patterned, practiced ways one's identity as male or female is negotiated and crafted by what one does. He insists that it is in the ". . . do[ing] of gender in each interaction, in each situation, in each institution [that] we find ourselves. Gender is a situated accomplishment . . . and the result of interaction" (Kimmel 2000, 106).

Kimmel asserts that institutions such as families, schools and workplaces create gender differences and reproduce gender inequality. He insists we ". . . do gender in a gendered world, in gendered institutions . . ." that are built on systematic structured inequality based on gender (Kimmel 2000, 106). Through interactions with others in the workplace gender inequality can be observed in relations of power, labor and emotional attachment. Kimmel embraces the view of gender as a system for classifying, identifying

[8] In the original the word "teacher" appears. For emphasis I have substituted nurse.

and structuring relations of power. For him, "valuing men's work over women's work . . . , is not inevitable; it is an artifact of cultural relationships . . ." that are negotiated within the context of specific institutions (Kimmel 2000, 172). Power, however, is a characteristic of social life and is not an individual characteristic. Thus, individual men most often feel powerless.

The workplace, according to Kimmel continues to provide a site for men to confirm masculine identity as breadwinners and family providers. Although the workplace provides a site where men can create themselves as men, Kimmel points out that the vast majority of American men are unhappy in their jobs and goes on to suggest the following as reasons why:

> [I]n corporate life men rarely . . . experience any ability to discuss their inner lives, their feelings, their needs. . . [The] workplace . . . is a treadmill, a place to fit in, not to stand out – a place where a man sacrifices himself on the altar of family responsibility. [Thus] many men say they lose sight of what they are working for, [begin to] . . . feel they are supposed to be tough, aggressive, competitive . . . [and] . . . measure masculinity by the size of a . . . paycheck (Kimmel 2000, 175).

Certainly, men in nursing have ample opportunities to examine their feelings and needs, especially if they adhere to professional practice values. They stand out in the profession because of their rarity, and once in the profession they fit in well as evidenced by their rapid advancement (Williams 1989). Kimmel's three I-elements of identities, interactions and institutions provide ample opportunity for exploring the meanings inherent in the work of men in the caring profession of nursing.

Negotiating Masculinity in Nursing

A number of authors characterize men who engage in traditionally female professions as challengers of cultural norms (Evans 1997; Hawke 1998; Haywood 1994; Kingma 1999; Lewis and Snodgrass 1990; Okrainec 1994; Painton 1994; Poliafico 1998). According to Williams (1993), male nurses configure their labor practices in nursing utilizing a number of strategies to overcome being stereotyped as culturally deviant. She examined the issue of male under-representation in predominantly female professions (including nursing) by systematically exploring, "…the barriers to men's entry into women's professions; the support men receive from their supervisors, colleagues and clients; and the reactions they encounter from those outside their profession" (Williams 1992, 254). She conducted in-depth interviews with seventy-six male and twenty-three females from 1985 to 1991 in four metro areas: San Francisco/Oakland, California; Austin, Texas; Boston, Massachusetts; and Phoenix, Arizona.

Many of the men in Williams' study perceived their numerical minority as an advantage in hiring and promotion. For example, when asked if he encountered any problems getting a job in pediatrics, a Massachusetts nurse told Williams: "No, no, none. . . . I've heard this from managers and supervisory-type people with men in Pediatrics: 'It's nice to have a man because it's such a female-dominated profession'" (Williams 1992, 256). In some facilities however, policies actually barred men from certain jobs such as in birthing and women's surgery units – especially in private Catholic hospitals (Williams 1992, 256). Other facilities have used more latent tactics to exclude men from women's and children's health care settings (Cude` and Winfrey 2007). Some men described being encouraged, even tracked into areas within the profession deemed more

legitimate for men. For example: “A nurse interested in . . . family and child health said he was dissuaded from entering in favor of adult nursing” (Williams 1992, 256). Such tracking, Williams contends, directs men to become upwardly mobile because jobs in specialty areas are more prestigious, better paying, and legitimize masculinity. The effect of tracking, results in the opposite of the “glass ceiling” effect reported by women in male-dominated professions. Women often experience invisible barriers to advancement in male dominated professions. In contrast to the “glass ceiling” experienced by women in gender atypical professions, many of the men Williams interviewed seemed to encounter a “glass escalator” effect of invisible pressures to move up (Williams 1992, 256).

Williams (1992) revealed men in nontraditional occupations, unlike women (in non-traditional occupations), were more likely to be supervised by members of their own sex, as males were over-represented in administrative and management positions. In the case of nursing, positions in the organizational hierarchy are often governed by men physicians and male hospital administrators. Many of the men reported having good rapport with their male supervisors. Troubling, however, these same men were more likely to report that their male bosses discriminated against female nurses, as evidenced by the following statement:

> When asked if he thought physicians treated male and female nurses differently one . . . nurse said “. . . I think the women seem like they have a lot more trouble with the physicians treating them in a derogatory manner. Or . . . in a very paternalistic way . . . or there’s some sexual harassment component to it” (Williams 1992, 259).

Williams found women nurses generally welcomed men entering the profession, even though some voiced resentment of the effortlessness with which men advanced.

Remarkably, this "d[id] not seem to translate into the 'poisoned' work environment described by many women who work in male-dominated occupations" (Williams 1992, 260). Though there were no accounts of sexual harassment, male nurses were often requested to perform male catheterizations and lifting procedures.

The most compelling evidence of discrimination against men nurses was a result of the general public's perception of men as nurses. Unlike women who enter traditionally male professions, men's movement into nursing was perceived by the general public to be a downward step in status. For example: "'My daughter the physician' resonates far more favorably . . . than 'my son, the nurse'" (Williams 1992, 262). This type of stigma presented the major barrier for men upon entry into the profession. Once in the profession, however, negative stereotypical images about men who do women's work, push men away from bedside nursing and channel them into more lucrative specialized practice areas, adding to the "glass escalator" effect (Williams 1992, 263).

Williams (1992) concluded that both men and women who work in gender atypical professions encounter discrimination, but the forms and consequences of this discrimination are very different. Also, men tend to take "masculine privilege" with them when they enter nursing, translating into resultant career advantage (Williams 1992, 263). Another conclusion drawn by Williams' work placed emphasis on the inadequacy of affirmative action to promote male integration into nursing because, once in the field, men nurses do well. Instead she underscored the need to address negative cultural sanctions applied to men who perform caring work, for such sanctions restrict men's consideration of nursing as a career option.

Cassell's (1998) ethnographic account of female surgeons contrasts starkly with Williams' (1992) study of male nurses. The men surgeons denigrated the female surgeons in Cassell's study to the point of misogyny. Cassell asserts that female surgeons are often in possession of the "wrong body in the wrong place" (Cassell 1998, 98). In much the same way Nye (1997) described male honor codes in medicine, Cassell (1998) attributed the phenomenon of "wrong body in the wrong place" to a social order in the operating room (OR) that scripts specific movements as having meanings and values about women's bodies in relation to men's bodies of which female surgeons are unaware. Female surgeons, "walk a tight rope" because their chosen career path "valorize[s] manhood, manliness, manly courage" (Cassell 1998, 128). Though female surgeons must incorporate this masculine ethos in order to perform their job successfully; they must not do it so well that they become identified as too man-like (Cassell 1998). Cassell suggests that female surgeons must learn the "habitus"[9] of the masculine honor code inherent in the occupation, yet, when they do so, they are often ostracized.

None of the men nurses interviewed by Williams (1992) reported being demeaned or demoralized in the manner as were Cassell's (1998) women surgeons. Though male nurses were stereotyped and viewed as having challenged cultural norms regarding what is deemed appropriate work for men, such stereotyping tended to contribute to the glass escalator effect by tracking men into higher paying areas in nursing. The double-bind experienced by male nurses served as a positive motivator that moved them into better

[9] Cassell, borrows from Pierre Bourdieu to define habitus as: "embodied social structure. . . passed on from generation to generation. The habitus shapes the body; at the same time, the body expresses the habitus. Habitus is not something you think but is something that you are, and what you are is based on what you do, on the actions and reactions of your body. The habitus is composed by activity through time . . . . [It is] lived anatomy" (Cassell 1998, 39).

paying, higher status positions. However, the double-bind experienced by female surgeons presented as a no-win situation for them.

A variety of reasons are suggested in the literature regarding why some males choose the culturally ascribed inferior status occupation (for a man) of registered nurse (Haywood 1994; Heinkes 1991; Poliafico 1998; Porter 1992; Ryan and Porter 1993; Squires 1995; Villeneuve 1994). However, ideas about alternative masculinities as outlined by both Connell and Kimmel are most compelling. They assert a number of masculinities exist in hierarchal ordering, with alternative masculinities challenging and competing with the hegemonic form of masculinity in any historical period (Connell 1987; 1995; 2000; 2002b; Kimmel 1996; 2000). Thus, in keeping with conceptions about masculinities as outlined by both Connell and Kimmel, men nurses can be expected to utilize a variety of strategies when "doing" nursing in a masculine way based upon past experiences, social milieu, and incorporation of professional nursing values into their taken-for-granted daily practices.

Masculinity is always defined in opposition to femininity, regardless of the particular form it takes. "Men use differing strategies to 'maintain' hegemonic masculinity in female occupations" (Williams 1995b, 124). By distinguishing and segregating themselves into safe masculine spaces, what Evans calls "islands of masculinity" (specialties, management, and academia) men nurses emphasize the performance of masculine elements of the job, thus maintaining a sense of elevation beyond women's work (Evans 1997, 26 -29). In this way, "[m]ale-identified areas help them resolve inner conflicts about masculinity caused by being male in a predominantly female occupation" (Williams 1995b, 124). Cassell (1998) would argue that men nurses

have the wrong body (masculine) in the wrong place (bedside nursing) which subsequently pushes them into specialty areas in nursing: Men nurses do not have the culturally accepted body type for nursing.

According to Evans (1997) men negotiate, configure, and accomplish the practice of nursing by developing "islands of masculinity" within specialty areas and management. A number of authors suggest that masculine configurations of nursing practice may be undergirded by a need to distance from anything considered overtly feminine (Chodorow 1980; Heikes 1991; Lewis and Snodgrass 1990; Okrainec 1994; Villeneuve 1994; Williams 1989; 1992; 1993; 1995a; 1995b). Likewise, the need to distance from feminine tasks may be a function of male "homosociality"[10] or the need to avoid gender stereotyping and sexualization of men's touch (Addleston and Stirratt 1998, 213). For male nurses who choose bedside nursing, this means that they must configure their practice by walking a fine line between being too masculine and not masculine enough. In order to avoid the discomfort of being in the "wrong body in the wrong place," men nurses often opt to ride a "glass escalator" to the top echelons of the profession where "islands of masculinity" are located, because, according to Connell (1995) and Kimmel (2000) they are primarily concerned with how they are perceived in relation to other men (in the case of male nurses, male physicians and administrators), rather than how they may be perceived in relation to the women nurses with whom they work.

Hegemonic patriarchy in western culture is often cited by scholars as a latent structuring force in producing overt power, labor and emotional effects in educational

[10] These authors define homosociality as social gender-segregation characterized by social and personal activities centering among members of the same gender (Addleston and Stirratt 1998, 213).

and career settings (Bradby and Soothill 1992; Burns 1998; Chodorow 1980; Connell 1995; Evans 1997; 2002; Heikes 1991; Kimmel 2000; Trentham and Larwood 1998). When researchers focus on issues of segregation and discrimination in occupational settings using a traditional singular analysis lens of gender, or race, or class, or religion, the mediation effects of these social factors are obscured. Hegemonic structures are constructed by the intersectionality of these cultural factors.

Evans equates specialization and management in nursing practice to "islands of masculinity" (Evans 1997, 228). Like Williams (1995a), she argues that the small number of males in the largely female profession of nursing, which is undergirded by a virtue of caring, "facilitates . . . women nurses' complicity in nurturing and furthering the careers of men colleagues" (Evans 1997, 227). In specialization and management areas, male nurses do access higher wages, prestige and status, and are provided a pathway to redefine care in more acceptably masculine terms. Male nurses may then more easily shed stereotypical images of deviant desire, effeminity or homosexuality (Evans 1997). Unlike Williams, however, Evans asserts that specialization and management allow male nurses to be masculine in a more active way. Rather than merely escape performance of feminine acts such as touch, specialization and management permit men nurses to "do masculinity" through practice or performance of scripted body movements (Connell 1995, 68), most accurately described as "gender displays" that mark specialization and management as masculine domains (Padavic and Reskin 2002) . Technical specialization[11] and management permit the display of technical prowess, autonomy, and

[11] See Pierre Bourdieu , "Masculine Domination," Richard Nice, trans. (Stanford, California: Stanford University Press, 2001, 94) for his description of three practical principles through which the sexual division of labor operates, the third being "men get to monopol[ize] … handling technical equipment".

detached rational decision making which tend to reduce the association of male nurses with feminine nursing traits such as intimate touch delivered at the bedside of sick and injured persons, but concurrently they serve to signal conformity with culturally appropriate masculine performances. These insights provide a more multidimensional description of how men nurses may negotiate masculinity than the unidimensional psychoanalytic assertion made by Chodorow (1980; 1989) that boys identify themselves as separate from their mothers and, as men, continue to deny association with elements identified as feminine. Evans' (1997) metaphor of "islands of masculinity" is a compelling one, especially when combined with Connell's (1995) thesis that men define their identity through what they do. Additionally, non-nursing related studies reveal that men who work in predominantly female worksites often construct male spaces for themselves distant and apart from the females with whom they work (Dellinger 2002). Though Evans (1997) uses her "islands of masculinity" metaphor to describe safe places in the profession of nursing that are protective of men-nurses' masculinity, she fails to illustrate that "islands" can also rigidly limit choice of practice setting and the full development of one's caring potential.

In a more recent study, Evans (2002) explored the ways in which gender relations structure differing work experiences for male and female nurses. She made the assertion that many men report going into nursing because of humanitarian desires to help and care for others, though they do not often stay in the bedside nursing role:

> Once in the profession, . . . prevailing gender stereotypes of men as sexual aggressors and men nurses as gay, negatively influence[d] the ability of men nurses to develop comfortable and trusting relationships with their patients (Evans 2002, 441).

This concern would certainly account for the need to move up (and away) from intimate caregiving. The men in Evans' (2002) study acknowledged the importance of touch to nursing practice but reported it was something new for them. They reported being able to comfort others through touch, was a rewarding experience for them. However, an overriding theme shared by these same men was that touching patients, especially women patients, was dangerous for them because of stereotypes of males as sexual aggressors and the sexualization of men's touch in general.

The concerns about touching patients revealed by the participants in Evans' study are supported and underscored by the work of Guiffre and Williams (2000) who studied strategies used by health care workers for desexualizing patient physical exams. The researchers contend an ". . . unstated assumption that men will act on sexual desires and women will not," has led to ". . . institutionalization of chaperone use" by male care providers (Guiffre and Williams 2000, 466).

When Evans (2002) questioned participants in her study regarding how men nurses know when touch is considered safe, they reported they used accepted masculine norms regarding touch. For example, when the patient was also male, the men nurses in this study initiated ". . . [a] code of understanding: Large men don't wash a healthy man's back – code!" (Evans 2002, 441). Even if patient comfort were compromised, they reported hesitancy in hugging another man because such a hug could be seen as breeching the code; and breeching the code would cause the patient to reject them as nursing care providers. Evans (2002) concluded male nurses are faced with a difficult conundrum; on one hand their career calls for offering comforting touch, but by doing so the patient's trust may often be undermined. The code described by these men nurses is

grounded in the homophobic idea that male nurses are gay because men do not touch other men without due cause and prior assessment of complex factors regarding sexuality (Connell 2000; Guiffre and Williams 2000; Snider 1998). In general, the men found it more comfortable to provide touching comfort measures to older men and less comfortable to provide touch to adolescents, women, and young adult men. Strategies used by the men to protect themselves from accusations of inappropriate touch included the following:

> Building trust with patients before touching. . . .
> Maintaining formality by shaking the patient's hand. . . .
> Projecting a traditional nursing image by wearing white. . . .
> Working in teams with female nurses to avoid unsafe situations. . . .
> Delegating tasks requiring intimate touching of female patients to female nurses. . . . Modifying procedural techniques to minimize patient exposure. . . (Evans 2002, 449).

When male nurses move into management or into highly technical specialties requiring little touch, the stereotype of man-as-non-nurturing and incapable of caregiving is reinforced. Though men enter nursing with a desire to provide compassionate care their ability to express compassion through caring touch is attenuated because such activities expose them to accusations of inappropriate sexual behavior. Men nurses' touch is regarded with suspicion while female nurses' touch is regarded as an extension of Nightingale's "womanly art of caring" (MacKintosh 1997, 288). The practices of male nurses in Evans' study were shrouded in "…complex and contradictory gender relations that situate[d] them in stigmatizing roles vulnerable to accusations of inappropriate touch" (Evans 2000, 447).

Ekstrom's (1999) study supports the assertion that nurses' caring work is gendered as a feminine project; and, therefore, forms the problematic: Caring is

inherently viewed as women's work. He demonstrated that men and women nurses, patients, physicians, and administrators view the care delivered by male nurses differently. Through use of a self-administered scale, Ekstrom (1999) revealed that the male nurses in his study, demonstrated avoidance of self-identification with stereotypically feminine work and the stigma of being in a nontraditional occupation. Yet, these same men did not avoid identifying with feminine caring work when asked to report on actual work performed. Unfortunately, in the actual performance of caring measures (bathing, hygienic care, comfort measures such as backrubs, effleurage) patients, female nurses, male physicians, and administrators tended to view the men's performance of care delivery as anomalous and inadequate (Ekstrom 1999). Notably, Ekstrom's findings are supported by a number of authors reviewed (Burns 1998; Cummings 1995; Okrainec 1994; Painton 1994; Poliafico 1998; Roberts 1983; Sellers, et al. 1999).

"Gender apartheid" can be conceptualized as privileging one gender over another (Guggenbuhl 1997, 206). However, gender apartheid diminishes as "…women increasingly enter male-dominated professions, [because] feminine perceptions …confront masculine understanding" (Guggenbuhl 1997, 206). The preceding statement forces the question as to whether the opposite might also occur: Do men who enter the predominantly female profession of nursing confront their own masculinity through a feminist lens? If they do, is it because they come to nursing already as feminist men or are they changed during socialization into the profession? Perhaps professional nursing could extend the promise of a career path for women and men, allowing for creative, holistic, and egalitarian self-expression; and serve as a unique occupational setting devoid

of the "misogyny of western patriarchy" (Gilmore 2001, 6). However, if male nurses should engage in a feminist backlash politic, the nursing profession could prove to become another workplace arena where dominant and privileged males assert authority by subjecting female nurses to subordinate roles within a profession where women numerically predominate.

Although Guggenbuhl (1997) describes the attenuation of gender apartheid as women enter masculine domains, he is mute in relation to the effects of men entering predominantly feminine domains. In the next section I present a brief summary of a Supreme Court case that opened a gender-apartheid, for-women-only university, to men. The case provides a source for illuminating some effects of masculine movement into a female segregated place.

Hogan versus Mississippi University for Women

In 1982, the U.S. Supreme Court ordered Mississippi University for Women (MUW) to admit a male student to the nursing program, thereby opening admission for qualified males into what had been traditionally a public supported college singularly for women (Cushman 1989). Joe Hogan, the man who brought forth the lawsuit, was simultaneously hailed as the man who destroyed MUW and the man who saved MUW (Aaron 1981; Rogers 1988; Smith 1981). Either way, Mr. Hogan certainly was the first man to break the gender barrier at what had been a traditionally all female institution.

Mr. Hogan was an operating room nurse, credentialed with an associate degree in nursing (ASN), who sought to enhance his education by attaining a baccalaureate degree at MUW, the university located in his community of residence. At the time the W was an

all female institution with nearly one hundred years of distinction for producing female graduates for leadership roles. Though academically qualified, Mr. Hogan was denied admission to the university on the basis of his sex. He was successfully supported in his lawsuit by the American Civil Liberties Union (ACLU) and in the fall semester of 1981, under a court injunction, he began course work in the baccalaureate nursing degree program, as the lone male student among nearly two thousand females enrolled campus-wide. Unfortunately, Mr. Hogan never completed his degree at MUW, citing the strain encountered by the lawsuit publicity as the locus for his withdrawal from the nursing program (Rogers 1988; Smith 1981).

Addleston and Stirratt (1998) studied the gender politics surrounding the admission of women to the historically all male, public supported, military school, The Citadel. Just as Joe Hogan dropped out of MUW, so did Shannon Faulkner, the first female admitted to The Citadel. Faulkner, like Hogan, cited the long battle for entry into The Citadel as having taken a toll on her emotional health, resulting in a physical illness during her first week in the corp. Addleston and Stirratt assert that Faulkner, and the women who followed her ". . . upset the homosociality of the organization and disable[d] them (the men) from propping their social identity on the crutch of an excluded and denigrated female out-group" (Addleston and Stirratt 1998, 217). The men at The Citadel used homophobia as a tool to promote the homosocial bonding it required to create ". . . the whole man" (Addleston and Stirratt 1998, 217). The authors assert that homophobia is an essential component used to maintain "patriarchal organizations." Addleston and Stirratt (1998) demonstrated homophobia to be accentuated in same-sex institutions because it firmly establishes boundaries between social and sexual interaction

in homosocially stratified cultures. These findings suggest that homosociality may also serve as a facet comprising the foundation for gender negotiation problems inherent for males in nursing. Connell's gender relations of power, labor, emotion, and symbolism along with Kimmel's three levels for analyzing gender relations (identities, interactions, and institutions) are partnered with the concepts of homosociality and masculine honor, to provide heuristic tools so that I may better understanding the phenomena regarding the attenuated presence of men in nursing.

CHAPTER III

RESEARCH DESIGN

In this chapter, I will briefly reiterate the purposes and benefits inherent in this study. A description and justification of the methods selected to conduct this qualitative study, will follow. Next, procedures for selecting participants and collecting data will be discussed. Finally, procedures for analysis of the data utilizing the gender theories of both Connell (1987; 1995; 2000; 2002b) and Kimmel (1996; 2000) will be discussed. This study utilizes an approach from the phenomenologic tradition in gathering data from participants.

Purposes and Benefits

This study explored the processes men in nursing use to negotiate masculinity in a predominantly female profession. The purpose of this study centered on gaining insight into how men nurses who graduated from a predominantly gender opposite institution negotiated masculine identities in the context of educational and work environments perceived as overtly feminine spaces. This study adds to the body of knowledge about nursing by highlighting how the contours of masculinity are challenged and negotiated by men nurses as they provide care to vulnerable citizens. By uncovering the meaning of the experiences of males in socially perceived feminine places, our understanding of the

latent consequences of continuing to construct dichotomous gendered career paths may be enhanced.

An unprecedented nursing shortage has threatened to replace the bedside nurse with less educated non-licensed personnel, under the banner cry of efficiency as health care labor markets restructure. Intelligent bedside nursing care, undervalued as feminine labor, is shrinking and creating a looming threat for vulnerable, hurting patients as intelligent action provided by the bedside nurse is withdrawn. The need for intelligent women and men to meet the health care needs of aging baby boomers has become even more obvious in the wake of the current nursing shortage. The results of this study may serve as a catalyst to facilitate changing the way we dichotomize health care labor by gender so that caregiving can become an acceptable, challenging, and satisfying life-work for both smart women and men, as well. (See Appendix A for letter from Mississippi State University, Office for Regulatory Compliance granting permission to proceed with this project.)

Description and Justification of Methods

Data collected for this research study were obtained by multiple methods including pre-interview surveys, audiotaped, semi-structured, in-depth interviews and participant observation data. These methods had not previously been used in combination to explore issues of gender imbalance in the nursing profession. Because we know so little about men in nursing, and because the methods of in-depth interviewing and participant observation are purported to ". . . provide a plethora of rich data, which facilitate a better understanding of the participants' beliefs, values, struggles, and

triumphs throughout the trajectory of their experiences," selection of these methods appeared most useful for the purpose of gaining a better understanding of participants' experiences as men in nursing (Martens and Emed 2007, 56). Additionally, when the desires of the researcher are to establish human-to-human relations with the respondent and to understand rather than to explain, then interviews and participant observations provide the greatest utility (Denzin and Lincoln 2000).

Among the male nurses who graduated from the W's baccalaureate (BSN) program, thirty agreed to participate and were subsequently asked to complete a brief, self-administered pre-interview survey prior to the actual interview. The pre-interview survey asked for demographic, family structure, educational history, and work history data (Appendix B). Responses from the pre-interview surveys were used to quantify data about the nurses interviewed and provided a catalyst for further topic development and exploration during the interviews as well as during participant observations in the work setting.

Audiotaped, in-depth interviews consisting of open-ended questions were utilized to elicit data for analysis (Appendix C). Participants were encouraged to elaborate on topics of interest or concern for them through the use of subtle conversational cues and/or follow up prompts and probes. With the use of in-depth interviews, respondents were given voice and provided a forum for articulating narratives focusing on motivations for entering nursing and about career moves as well. With the use of semi-structured, in-depth interview techniques the desired outcome is to understand rather than to explain, and thus provided greater "breadth" to the data obtained (Denzin and Lincoln 2000, 654).

In addition to in-depth interviewing, participant observations at the worksite were utilized to actively view the performance of social practices while participants engaged in the process of delivering nursing care. Observations of eleven, participants in the daily execution of work activities were completed. Through these participant observations in the workplace setting, information was gathered to assist in understanding how men nurses negotiate gender relations when performing skilled caregiving tasks and when interacting with other health care personnel. Semi-structured, in-depth interviewing and participant observation ". . . go hand in hand and many of the data gathered in participant observation come from informal interviewing in the field" (Denzin and Lincoln 2000, 652). In essence the data collected through the use of participant observations served to corroborate, clarify and verify data obtained through use of pre-interview surveys and in-depth interviews.

In addition to adding value to the study by authenticating the accounts shared by the male nurse participants, participant observation of body practices was found to be useful in capturing the meanings that emerged through social interactions of participants with clients, physicians, and co-workers. Particularly helpful was being able to view the touching behaviors exhibited by the men as they delivered care to clients. Participant observation provided a more "naturalistic approach" allowing this observer to catch participants in action and view the way men nurses practice, perform, or "do" nursing (Denzin and Lincoln 2000, 674-677). In this way, participants' actions were more easily linked to professional "identity" and nursing "culture" (Denzin and Lincoln 2000, 674-677).

Data Collection Procedures

The general sampling frame included all living male nurse graduates of the W's baccalaureate nursing program. MUW graduates were targeted for study for two reasons. First, I am a W faculty member teaching in the BSN program, so access was a decided issue. Second, though open to men, few actually pursue their education at this institution, so that the ratio of men to women on campus is very similar to the ratio of men to women in the nursing profession, thus providing a uniquely homogenous group of study participants.

When I began data collection, I had concerns that my gender and my status as a nurse might affect the interview process. My first concern centered round my being a female nurse conducting interviews with men nurses. Specifically, I was fearful that my sex would tend to color the ways in which the men might respond to the questions I asked. I found the literature to be mixed on this account, with a number of scholars suggesting sex opposite interviewer could be problematic (Evans 1997; Heikes 1991; Williams 1995b) while others viewed female interviewers of male participants as an advantage and a means for "interviewing up"(Denzin and Lincoln 2000, 654). When interviewing participants of the opposite sex, Williams (1995b, 192) encourages female interviewers to be aware of "sex-of-interviewer effects" which may cause research participants to adjust their statements so as to avoid offending the (female) interviewer. However, this particular bias, when identified, can reveal additional insights regarding how men nurses negotiate gendered communication (symbolic) issues. Williams contends that in-depth interviews are especially helpful:

> [Because they] . . . allow respondents to clarify their beliefs in [a] diplomatic way [which] is one of the strengths of this method. [Participants] are able to communicate even hostile and sexist views without directly challenging the sensibilities of the interviewer. In contrast, studies that use a forced-choice answer format may provoke [participants] to give misleading replies so as not to insult the interviewer (Williams 1995b, 193).

In this way Williams is suggesting that gender-opposite interviewers can achieve better data quality through in-depth interviews than through self-administered surveys.

Another cause for concern was because of my former statuses as a nursing department manager employed at one large facility and as the nursing administrator at another smaller hospital in the area. Currently, I serve as a nursing instructor at MUW. Though these experiences provided me greater access to participants as well as a degree of insider trust and rapport, many of the participants in this study were my former students, or may have worked in peer or subordinate positions with me at area health care facilities. Therefore, I expected a degree of "social desirability bias" to be present in many of the interviews (Williams 1995b, 192). Because of both gender-of-interviewer bias and social-desirability bias, I observed for these. For the most part, I found my concerns to be unjustified; however, I shall point out the sparse examples of these as I present findings in the next chapter.

An incident occurred during data collection that was also of concern and involved a participant, currently in medical school. The participant, who was at home for Christmas break requested the interview session be conducted at my home while he was shopping in my town. His request produced a bit of anxiety for me. I was concerned that in my home territory he might not respond frankly and openly. First, I feared that I might represent either too much of an authority figure (I had been one of his former nursing

instructors), or that I might be viewed as a friendly, albeit matronly, colleague which might prevent the interview from advancing beyond a sociable reunion. Second, what to do with my family in relation to the problem of confidentiality was a concern.

I decided to go ahead with the interview and sent my family off to an afternoon movie. When he arrived with his mother, with whom he had been out shopping for Christmas gifts for the family, I was presented with another set of concerns. I placed her comfortably in another room of my home distant from the dining room where the interview took place and made available a variety of magazines and the television remote. After conducting the interview, I invited his mother in (also a W grad, though in education rather than nursing) to join us for some baked goods and informal conversation around the dining table. What presented as a near fiasco ended as one of the best and most informative interviews conducted for this study. He was very relaxed, open and frank with our interview. Certainly, his request to be interviewed at my home suggested that he was very secure in his masculinity and that I was indeed no threat. In retrospect I was pleased with the outcome, but undoubtedly did not invite another participant into my home because the logistics for providing confidentiality were a nightmare.

A listing of addresses and phone numbers for potential participants was obtained from the W's Alumni Relations Office (Appendix D). Additionally, a snowballing technique was employed, utilizing word-of-mouth, workplace, professional nursing meetings, and nurse-to-nurse contacts. Both procedures were employed in order to maximize the number of study participants for recruitment and selection into the study. From among the sixty-eight graduates matriculating the program (Appendix E), forty-

seven had available contact data sufficient for making contact during the data collection period which extended from mid-December, 2006 through April, 2007.

Among the forty-seven potential participants approached, thirty agreed to participate. Selection into the study was merely on a first-come, first-interview basis until a maximum of thirty participants was reached. Although I anticipated saturation[12] to be achieved with twenty-five participants, thirty participants were desired for inclusion in this study in order to fully explore and clarify themes that emerged at interview.[13]

Initially, potential participants were approached through the use of a letter, telephone call, e-mail or face-to-face meeting requesting participation in the study (see Appendix F). When necessary, a follow up contact was made by phone and/or e-mail to schedule and/or verify time and place for data collection using the pre-interview survey and semi-structured, in-depth interview.

Pre-interview surveys and in-depth interviews were conducted at a site selected by the participant for their comfort and convenience. After informed consent was obtained (Appendix G; Appendix H; Appendix I), each participant was asked to complete a brief, self-administered, pre-interview survey. Participants were informed of their right to refuse to answer any question on the pre-interview survey and of their right to refuse to answer any question during the interview without incurring any penalty. Additionally, participants were advised that I would retain for a period of five (5) years completed pre-

[12] Saturation is defined as having been reached when new data become redundant and fit easily into previously devised categories (Denzin and Lincoln 2000, 520).

[13] Emergent themes are processes that describe patterns of the phenomenon being studied that surface during analysis. Though Glaser and Strauss (1967) are the most referenced scholars regarding this approach in qualitative research analysis, Marcellus (2005) proves an easier read and has a more practical focus for nursing.

interview survey questionnaires in a secured file after having entered de-linked data onto a spreadsheet document.

Because of the nature of this study, I could not guarantee anonymity. Thus, a number of measures to ensure participant confidentiality regarding the information collected were instituted. First, participants were advised that other than myself only my faculty advisor would have access to the initial data collected. Second, the audiotaped interviews and subsequently transcribed documents of the interviews would be housed in the nursing oral history section of the MUW Fant Library and at the Oral History Collection at Mississippi State University Libraries unless participants refused. Participants were advised that if they chose to decline consent for archival of audiotapes, the tapes would be destroyed after transcription of the interview was completed and that written transcripts would be held in a secured storage space in my home for a period of five years, at which time they would also be destroyed. (Only one participant declined archival of tapes and transcripts for future study). Third, consent forms as well as signed forms indicating refusal to house audiotaped interviews and transcription documents at the universities respective libraries, would also be secured in a locked file in my home.

As discussed above, though participant names were changed, the historical context of this study precluded the granting of anonymity. If someone really wanted to track down the true names of the men nurses who graduated from each class, it could be a remote possibility. However, it would not be possible for someone to determine exactly who said what in this study with the above confidentiality measures in place.

Each participant was asked to choose a pseudonym, other than names of historical or contemporary popular figures, prior to actual taping of the in-depth, semi-structured

interview. In some years, only one man graduated with a particular class cohort. Therefore, participants were asked to avoid references about graduation dates during the interview as an additional effort to maintain participants' confidentiality. Additionally, at interview, participants were cautioned not to mention the name of their particular workplace as a condition for the facility to allow me to observe the participant at work (Appendix J; Appendix K; Appendix L). Each interview lasted approximately one hour, though they ranged from a little over one-half hour to just under two hours. As anticipated, after the recorder was turned off, a number of participants continued our meeting as a general conversation.

Field notes and memos related to each of the interviews were elaborated upon immediately after completion of each interview at a site distant from the interviewee. These elaborations included description and assessment of the general attitudes, gestures, and environments encountered during each of the interviews conducted. Frequently, these notes included comments made after interviews had been completed and as we were conversing. In combination with transcribed interviews, field note elaborations facilitated coding for emergent themes. For a five-year period, I will retain these notes of participant observations in a secured file separate from the locked file containing actual names linked with pseudonyms. After five years, I will destroy these field notes along with the pre-interview surveys.

At the conclusion of the semi-structured, in-depth interview participants were asked for permission to be observed at each respective place of employment for a two-hour period in order to apprehend the practices male nurses employ at work. Only

participants who worked at facilities that granted institutional permission for me to observe them were eligible for worksite observations.

Unfortunately, a home care agency and industrial site declined consent to allow participant observations on-site. Therefore, participant observations were conducted only at hospital-based work sites. At these sites, however, participant observations of interactions with superiors, subordinates and clients were made in richly diverse environments. Scheduling of actual worksite observations was arranged at the convenience of the participant and only after having obtained voluntary consent from each participant and consent from the facility or agency to conduct the observation on-site. At the conclusion of each observation period at the worksite, participants were given a post-card-size copy of the Oregon Center for Nursing poster: "Are You Man Enough . . . To Be A Nurse?" (2002), and asked to comment on the image and what the image conveyed to them (see Appendix M for letter granting copyright permission for use in this manner).

The participants in this study were also employees; therefore, a number of precautions were taken to ensure their protection. First, consent to observe the participant in the work setting was secured prior to any participant observations of work practices (Appendix G; Appendix H; Appendix I). Second, consent was secured from the employer of each consenting participant prior to any participant observations of work practices (Appendix J; Appendix K; Appendix L). Third, employers were advised that employees constitute a "vulnerable" research group and that I was not permitted to reveal individual actions or communications of employee participants to anyone, including the facility administration. However, once identifiers linking participants to specific

institutions were removed and the data had been analyzed, employers were advised they were welcome to request a summary of the research results. Employers were also advised that participation in this study must not impact employee(s) status at their institution.

Data Analysis Procedures

Throughout the process of collecting and reviewing data, the various documents were analyzed and coded using theory-based sensitizing concepts and an emergent themes approach (Denzin and Lincoln 2000, 780-783). First, the data were scrutinized utilizing the three broad categories suggested by Kimmel (2000) for analyzing gender relations: identities, interactions, and institutions. Then, theory-driven sensitizing concepts derived from Connell's (2002) four dimensions of gender relations: (1) power; (2) labor/ production; (3) emotional attachment; and (4) symbolism, were used for data coding purposes from which themes were determined. The figure in appendix N depicts the conceptual framework I devised from partnering the work of these two scholars and which I used to guide analysis of the data collected (from pre-interview surveys; semi-structured, open-ended interviews; participant observations, elaborated field notes and memos) for this study. The framework depicts the concepts of power, labor and cathexis in constant interaction at all levels of identity, interaction and institutions, fused together with the glue of symbolism and communication. In this manner, symbolism is an inseparable part of the practices of power, labor and cathexis at the levels of identities, interactions and institutions.

The framework provided a succinct pictorial aid for thinking about how the major concepts used by both Connell and Kimmel interact. Identities are made through

interactions within institutions such as schools, the family, churches and workplaces. And, there can be no interactions without symbolism or communication, including verbal, written and gesture. All interaction involves two components: the symbolized and the practiced. Practices, what Connell also refers to as relations of power, labor and emotional attachment or cathexis, are produced through interactions and infuse and influence identities, institutions and the patterned ways in which interaction is ordered and gendered.

The semi-structured interview questionnaire used for conducting the in-depth interviews was devised so as to focus on eliciting responsive reflection regarding institutions, identities, and interactions (Appendix C). Seven questions focused on the following three institutions: the profession of nursing, MUW, and the workplace. One question focused on the institution of nursing in order to elicit influencing factors accounting for participants' decision to become a nurse while another focused on recounting decision making for attending the W's nursing program. Three other questions focused on eliciting responses about socialization experiences while at the W. Two items focused attention on work experiences and professionalization in the workplace. Three questions aimed at identities attempted excavation of meanings, influences, and challenges participants recounted as having encountered as men working in a caregiving profession. Five items focused on eliciting responses about interactions in the workplace and with W faculty.

Kimmel's three I-elements were helpful in connecting the participants' "identities" as male nurses and the "institutional" cultures inherent in educational, professional and workplace environments through the process of "interactions." He

asserts that identity as a man is not a characteristic that can be possessed, but is the result of "a set of activities that one does" (Kimmel 2000, 106). He insists that gender is the "product of interaction" with others because activities performed in the presence of others are legitimated and evaluated by others as being gender appropriate or not (Kimmel 2000, 106). Likewise, Kimmel contends that gender is not created in a vacuum, but rather in the context of social institutions such as the family, schools and workplaces through interaction with others. Therefore, in order to explore how male nurses who graduated from the W negotiate their way through the problematized definition of being a man who graduated from a (female) gendered university and who now works in a (female) gendered profession, gender relations were readily apprehended by following Kimmel's lead.

Connell's four relations of gender provided the lens through which the levels of identity, interactions and institutions were acutely focused. Thus, theory-driven sensitizing concepts used in this study for coding purposes were derived from Connell's (2002) four dimensions of gender relations: (1) power; (2) labor/ production; (3) emotional attachment; and (4) symbolism. (See Appendix O for a tool devised to aid with thematic coding.)

Because power relations can be expressed either through overt physical prowess or diffuse and subtle discursive means, sensitizing concepts related to this dimension included: (1) displays of overt physicality, coercion, or intimidation of another; and (2) concepts, terms, or communications indicating leadership, management, regulation, discipline, certification, career progression, teaching-knowledge sharing, and pursuit of

advanced educational degrees. All of these are indicative of power resources and required they be coded as relations of power.

Sensitizing concepts related to the dimension of labor relations included: (1) projects business versus social focus at work; (2) tasks and procedures identified as gender dichotomous duties or as being best performed by one gender over another; (3) definitions of nursing work as a means to a respectable wage versus a "calling;" (4) references to touch being limited or bound; (5) preferences for specialty over bedside nursing; (6) seeks/gives consultations or asks for/gives assistance; (7) notes or attends to clinical practice strengths.

The emotional dimension of gender relations is often intimately interwoven with power, the sexual division of labor, and symbolism (Connell 2002b). Sensitizing concepts which served to alert of cathexis or emotional patterning of attachments included the following: (1) relations with coworkers, physicians, administrators, and clients as viewed with positive regard, negativity, or ambivalence; (2) demonstrations or verbalizations about connecting with clients through use of empathy, compassionate, or sensitive care; (3) verbalizations of emotional attachment to the profession of nursing, the workplace, or the W; (4) comparisons of self in relation to "the good nurse;" and (5) verbalizations or symbolic imagery that evoked spiritual components of nursing, the meaning of life, or religious belief. Likewise, (6) evocations regarding the nursing values of caring, client autonomy, altruism, human dignity, integrity, and social justice were considered sensitizing concepts for relations of emotional attachment.

Inherent in the relations of power, labor, and emotion reside concomitant dimensions of gender: gender symbolized and gender practiced or performed. Thus it is

difficult to tease sensitizing concepts that signal relations of communication and symbolism from the relations of power, labor and emotion. Therefore, the following sensitizing concepts signaling communication and symbolism were analyzed as they appeared within the relations of power, labor, and/or emotion: Sensitizing concepts which alerted of symbolism included: (1) body comportment; (2) voice tones; (3) differential attire (e.g. suit, necktie, scrubs differing from attire worn by female employees); (4) verbalizations, behaviors or symbols that evoke spiritual or religious imagery; and (5) verbalizations, behaviors or symbols that are marked as gender displays such as displays of muscle and/or bravado; (6) masculine term usage (e.g., he, his, manly, manhood) when gender neutral terms could just as easily be applied; (7) sporting facial hair; and (8) use of makeup, jewelry, and/or body art.

The assertion made by both Connell and Kimmel that a number of alternative masculinities exist, is a most compelling theoretical stance. They suggest that a number of masculinities challenge and compete with the dominant form of masculinity during any historical period (Connell 1995; Kimmel 2000). Therefore, in keeping with the conception of masculinities as outlined by Connell (1995) and Kimmel (2000), the data were subjected to a second round of analyses for themes regarding reasons for choosing a female educational institution and career. At this round of analyses themes were coded: (1) traditionally masculine; (2) traditionally non-masculine or feminine; and (3) non-determinant or ambivalent. As sub-themes emerged in each category, they were noted.

How men negotiate, configure, and accomplish the practice of nursing has been described using the metaphor “islands of masculinity” to depict places where men nurses carve out masculine spaces within specialty areas and management (Evans 1997, 228). A

number of authors suggest that the masculine configuration of nursing practice is undergirded by a need to distance from activities considered overtly feminine (Chodorow 1980; 1989; Heikes 1991; Lewis and Snodgrass 1990; Okrainec 1994; Villeneuve 1994; Williams 1989; 1995a). And, many view the need to distance from caregiving tasks as a function of either male homosociality (Addleston and Stirratt 1998) or male honor codes (Nye 1997), indicative of preference for the presence of other men over women in the work environment. Therefore, at second-round analyses, themes emerging regarding gendered practice configuration were coded as: (1) distancing from feminine acts of caring behaviors; (2) non-distancing or feminine acts of caring behaviors; and (3) non-determinant or ambivalent. Sub-themes related to male homosociality or male honor codes that emerged through analysis of men nurses' practice in the profession were addressed.

Masculine hegemony has been cited as a latent structuring force for the production of gender inequities in educational and career settings (Bradby and Soothill 1992; Burns 1998; Chodorow 1980; Connell 1995; Evans 1997; Heikes 1991; Kimmel 2000; Lewis and Snodgrass 1990; Okrainec 1994; Walsh and Borkowski 1995). Therefore, special attention was given to emerging themes regarding issues of power, labor, emotion and symbolic expressions made by participants in relation to professional nursing socialization and professionalization while at MUW and in the workplace setting. These themes were coded as follows: (1) traditional hegemonic masculine displays; (2) alternative masculinity displays; (3) traditional feminine displays; or (4) non-determinant or ambivalent.

Throughout the process of interviewing, transcribing, observing, and reviewing participants' responses and behaviors, I used thematic analysis. I utilized elaborated field note commentaries and memos, in conjunction with transcribed, in-depth interviews to facilitate coding for and analysis of emerging themes among the data sources. Close attention to detail provided rich data for narration that underscored and highlighted themes and added depth to the varied accounts encountered at interview and during participant observations at worksites.

CHAPTER IV

STUDY FINDINGS

In this chapter, I will discuss the findings of this study. I will discuss the demographic and background information about the men nurses in this study as procured from the pre-interview surveys. Next, I will discuss the themes that emerged from the data collected in regards to the gender relations of power, labor and cathexis inherent in the institutions of professional nursing, the educational setting of the W, and in the workplaces where participants are employed. Themes emerging related to the meanings inherent in interactions and these men's identities as nurses will be presented and discussed.

Among the sixty-eight men who have graduated from the W's BSN program, forty-seven men were contacted and thirty eventually participated in this study. Each presented at interview an attitude of conviviality, genuinely agreeable to sharing their experiences as men-in-nursing.

Participant Background Information and Demographics

As I began analyses, I found that the participants fell into three general groups that aided exploration of the meaning of socialization and professionalization issues into nursing among these men. The first group included novice nurses with less than five years of experience, those still considered to be situated in the critical early years of

practice when men are most likely to leave the profession (Page 2004). A second group of participants included men at mid-career with five to ten years of nursing practice experience. Finally, a third group of participants included men with seasoned careers in nursing, with each having more than eleven years of practice. Thus, among the group of novice nurses, nine graduated between 2003 and 2006 while nine mid-career participants graduated in the years between 1997 and 2002, and the seasoned nurses graduated from the W between 1984 through 1996. Participants who graduated from the W during the 1980s included five men, graduates from the 1990s, thirteen men; and graduates after 2000, twelve men.

The table in appendix E demonstrates the number of males entering and graduating with each class from 1982 through 2006. Because so few men have attended in each class cohort, if I reported the year each participant graduated it might aid in identifying participants. Therefore, to protect participants' identities, I am reporting herein only the number of men in the class cohort (including themselves) by the number of participants with that number of other men in their cohort:

Cohort Size	Number of Participants
1	1
2	5
3	11
4	5
5	4
9	4
Total	30

While all eleven participant observations took place in hospital settings, more variety was noted among participants' choice of setting for conducting respective interviews. Half of the interviews took place at the men's respective places of employment. This did not surprise me because scholars have established that men are most comfortable in the public or work domain (Connell 1987; 2000b; Kimmel 2000; Bourdieu 2001; Feldman 2005). Likewise, I was not surprised when three requested interviews take place at a university library, one at a public library, one at a W satellite education center, and three at the W's school of nursing. Nor was I surprised that seven participants chose to be interviewed in the comfort of their own homes. One participant was interviewed in my home at his request, which was a surprise to me.

Age

The current ages of the participants ranged from twenty-three to fifty-nine years, with a median age of thirty-four years and a mean of thirty-five. These men represented a much younger age group than the nursing profession as a whole, which has a mean age of nearly forty-seven years (HRSA 2004, 5). The relatively younger mean age for men in this study is most reflective of the prohibitive policy regarding the admission of men at the W until the 1980s. At the time of graduation from the W, the men's ages ranged from twenty-one to forty-two years, with a median age of twenty-four and a mean of age twenty-seven. Thus, while in the process of matriculation, these men were slightly more mature than the average age of twenty-six years for BSN nursing students in the nation as a whole (HRSA 2004, 12).

Martial and Family Ties

Current marital status among participants reflected the conservative sexual paring expected in rural southern communities. Married participants comprised almost two-thirds (19, 63%) of the study group. While seven of the thirty were single (23%), two were engaged and anticipating marriage in spring, 2007, and only three were divorced (10%). One participant described his relationship with a male partner as a long-standing, committed and stable cohabitation.

In relation to participants' family of origin, 80% reported their parents as having been married during their growing-up years. Among the remaining participants, four men reported their parents had been divorced. And, while one was reared by a never-married, single mother another was raised by a widower father.

The majority of participants (28) reported having grown up with siblings present. Among those with siblings, participants' birth order ranged from first to seventh. Two men reported being one of a set of twins: One had an identical twin brother, while the other had a twin sister. One participant was adopted. Fourteen had only male siblings, nine had only female sibs while five others had both brother and sister siblings. Three had siblings that were deceased, one whom had a brother who had committed suicide.

Race and Ethnicity

Few ethnic men of color have graduated from the W's BSN nursing program. Thus, it was not surprising that only three African-American men and no Asian or Hispanic men participated in this study. African-American nurses, regardless of gender, comprise less than 5% of the registered nurse workforce in the U. S. Likewise, nurses of

Asian descent comprise only 3%, while nurses of Hispanic roots comprise less than 2% of the workforce (HRSA 2004, 7).

Prior Knowledge of Nursing as a Career Path

An overwhelming majority of participants (26, 87%) reported having had previous knowledge of the nursing profession and that they were familiar with what nurses are expected to do: (1) : by having worked with nurses at their former jobs; (2) through experiences with family members or friends; or (3) both. Only four participants reported having no previous contact with nurses or the nursing profession prior to entering the W to become a nurse.

Among participants with immediate family who were nurses, one reported his mother was a nurse while another reported his twin sister was a nurse. Two men reported their wives were nurses prior to their entry into the profession. Another two reported their fathers were nurses, while two more said their grandmothers had been nurses. Four had extended relatives (aunts or cousins) who were nurses; and seven reported they knew family friends who were nurses prior to entering nursing.

Education

Several participants held degrees prior to entering nursing, including one with a bachelor of science degree in laboratory science, two with a bachelor of science degree in biology, and two with a bachelor of arts in business management. One participant held a Master of Arts degree in English prior to entry into the W's nursing program.

In relation to highest educational degree, twenty-one had not progressed in nursing past the Bachelor of Science in Nursing (BSN) degree. Two men, however, were

pursuing medical school, with one having nearly completed medical school and anticipating his internship, while the other had just been accepted into a medical school, and was planning to begin in the summer of 2007. At the time I conducted participant observations, six more men had applied to and had been accepted into Master's degree programs in nursing (MSN) for role development in the following areas: nurse anesthesia (2); nurse practitioner (2); clinician (2).

Employment

All of the men, except the one in medical school were employed full-time in nursing at the time I conducted interviews and participant observations. A definite pattern was noted in that thirteen (43%) currently worked in emergency room settings: nine as staff nurses, one as nurse administrator of the ER at the hospital where he was employed, and three as nurse practitioners. Interestingly, ten men had worked as paramedics with ambulance services prior to entering nursing. Additionally, the medical school student had worked as the nurse coordinator of emergency and ambulance transport prior to attending medical school, and prior to nursing school, had worked as a paramedic with an ambulance service. For many participants in this study, the ambulance service served as an entrée into the profession of nursing and emergent care remained a career focus for them after completing nursing school.

The remaining participants currently worked in a variety of settings including medical-surgical (2), intensive care (2), operating room (2), anesthesia (2), hospital admissions (1), special procedures and cardiac catheter laboratory (1), hospital personnel management and recruitment (1), family nurse practitioner (1), occupational health (2),

home care (1), and campus health (1). Differing nursing jobs or positions held by participants since graduation ranged from one to seven with a median of two different job positions being held over the course of respective career trajectories.

Identities: The Masculine Nurse

At the level of identities analysis, the major theme identified centered squarely in the relations of cathexis or emotional attachment. Overall, the men who participated in this study viewed themselves as caring, compassionate men and took great pride in their accomplishments as skillful nursing caregivers, providing a needed and useful service. Five sub-themes also emerged at follow-up analyses of the data. The five sub-themes concerned: (1) providership; (2) technical competencies; (3) communications with female colleagues; (4) personal health promotion; and (5) confronting stereotypes.

When asked what meaning nursing held for them, the majority (22) first discussed nursing as having emotionally laden meaning for them. Only eight mentioned instrumental providership and a way to make a living income prior to discussing emotionally-laden satisfaction that accompanied competency in caring for vulnerable people.

Because family providership is traditionally a primary marker for instrumental masculine caring, I was surprised to find the majority of participants discussed income only secondary to their work competencies. For them, the essence of nursing meant a professional avenue for providing competent physical, emotional and spiritual care, with a compassionate attitude, to people in need. Additionally, seven men specifically cited nursing as a ministry or "calling" for them, and stated that they routinely prayed with the

patients and families with whom they provided care. In this respect, the male nurses in this study did not conform to the hegemonic masculine image.

Caring and Compassionate Men

The majority of male nurses in this study defined themselves first by the emotional value inherent in their work rather than by the income earned through their labor. Participants most often identified themselves as compassionate caregivers who happened to also be men. Twenty-two (73%) of the participants said nursing had made them better persons by influencing them to be more attentive to the needs of others, more patient, better listeners, and more emotionally demonstrative with family and friends. Several (20) stated that as nurses, the care they provided to and for others had a deeply spiritual component. And, a number also stated they pray with patients.

Descriptors of becoming "better men" because of nursing experiences were frequent across narratives shared by participants as the following illustrates:

> Nursing has made me . . . more of an open person . . . to realize where you have the opportunities to be more compassionate as a man. As a guy you're supposed to be the rock-hard person that never feels emotion. As a nurse you're able to see people's emotions, and it really helps to see that there are emotions about being a man, and it's normal to have those emotions, and to feel those emotions . . . . As a nurse you're exposed to emotions in more of a real sense. People's lives: When you start dealing with people living and dying and their health; and the things they will say to you when they would never say to anyone else, you're able to be there and experience those things and see life from a different perspective. That shows you that it's really OK. It's really better for you as a man just to have whatever emotions you have . . . and not have to put on any front. (Brad Jones)[14]

What Brad's narrative has described is a reconnection to his feelings in a way that his self is made more whole and authentic.

[14] All names are pseudonyms chosen by the respective participant.

A number of participants also shared that nursing experiences encouraged them to become more demonstrative with their own families as Joseph Brown suggests with the following: "There are times when you . . . go home and hug your kids . . . because you've seen something that day that you thank God it wasn't you."

Likewise, nursing experiences provided participants opportunities for understanding spouses and future partners:

> Just being in a female dominated profession, I guess I've kind of learned to interact differently with females. Other jobs that I've had in the past, has been mostly males. And we just have a different way of interacting with one another, and so I've kind of had to learn that. But that has been a positive thing. It's been a growth and learning experience for me to, to be more in touch with feelings and just to learn how to deal with the female gender on a more consistent basis. And, . . . it can't do anything but help me. I mean it has helped me in my marriage, even. You know, at times to just not be as harsh . . . and just not be quite as much as a male, a man all the time. I mean we are just more abrasive; and not quite as gentle as women are. It's just something else that's been positive for me that I've been able to address and work on. (Dan Owens)

> Life isn't always about me. Interacting with families up here has made me a lot more understanding . . . knowing that could be your family member. [I]t's important to have good relations with your family and friends. And working with a lot of women . . . [has] . . . given me a perspective on how they think, how they feel and how sometimes we do stuff, where we don't see it as such a big deal, they see it as a big deal. Being single and not having any children and not being married, I think when I do get to that point [in life], I'll have a lot better understanding because I hear a lot of things women complain about their husbands. And, it kind of makes me say, "Well, you've got a good point." I'm taking lots of notes (grins). (Jackson Jones)

Most of the participants said nursing and providing care to sick and vulnerable patients carried spiritual and religious meaning for them. Several shared that nursing was a calling for them as Bob Flowers shared: "I think God put me here to help others and to do things that other people can't do for themselves." Likewise, the following narrative expresses similar sentiments:

> I do believe in God and I do go to church, and I do have a relationship with God. And [nursing] gives me an opportunity to carry out and give back some of the things I've learned through that relationship with God. If I wasn't a nurse I don't know that I'd get a whole lot of opportunity to practice that kind of stuff and to try to become a better person. (Dan Owens)

Several men confessed they offer to pray with patients:

> When I first got out of school, it was going to be a paycheck. And, now . . . I think "Man! It's amazing how God has a plan," and we don't even realize it. You make a difference . . . whether speaking to them . . . or even praying with them. …[A] lot of times when I want to pray over patients and I ask them if it's OK, it surprises them and they are real positive about it – like, "Yeah, let's pray." That makes a real difference in them and there's a lot of times that our hands are tied as far as the healing process. So, we have to bring in measures that only God can do. If that will help the patient, we need to do it and prayer's just one of those things that I know that helps. (Dan Jones)

Dan and other participants who offer to pray with patients and families have incorporated into their identities a view that the practice of nursing is a ministry. The following narrative from a seasoned nurse, and veteran of the first Gulf War, demonstrates how caring work is so intricately infused with emotional attachment:

> There's an old Buddhist saying and I've quoted [it] many times and that is: "Work is love made visible." I read this in a nursing textbook, I don't remember what class. Nursing. I've had a lot of occupations in my time. This is the only job that I've ever been able to make love visible while I work. (Rusty Shackleford)

The male nurses in this study attached a great deal of emotional energy to the skillfully crafted caring labor in which they engaged. They identified themselves as compassionate, understanding care providers who saved lives everyday. Each one viewed their work as important and assessed themselves as making a difference in people's lives. Owen Wellons expressed this with eloquence: "I have to love the patients on a certain level. By helping them increase their self-worth and their physical health and psychosocial health, I end up strengthened myself."

Providership

Interestingly, family providership emerged as a sub-theme of caring and compassionate men and did not surface as a major theme among the participants in this study. Being able to support themselves and their families, though the primary reason given for motivating them to enter nursing was identified first by only eight of the participants when asked what meaning nursing held for them. Making money, a livelihood, was mentioned as a second-place means of identifying themselves as nurses for the remaining twenty-two participants. Among the participants who cited providership first were comments like the following:

> It's my career. This is what I do. (Steve Thompson)
>
> It's what I do. It's a living. (Colin Monseur)
>
> This is a profession that makes me money, makes my house payment, puts food on the table, and pays for my kid's education. That's what nursing is for me in part. (Preston Jones)
>
> It means my livelihood. It means my paycheck, the roof over my head, the food in my mouth, the socks on my feet. It means all those things, but it also means that . . . people are counting on me. (Carson Hyde)

These comments represent a traditional and utilitarian or instrumental masculine view of labor, which was the minority view among participants. However, as Preston and Carson both hint with their comments above, conversations quickly pivoted back toward "being of service" to others, demonstrating an expressive element at play as well.

Technically Competent Men-Who-Care

For the men in this study, acquiring and maintaining competencies emerged as a sub-theme. They viewed competency as a way of showing they care. An examination of

identities for power relations demonstrated continued accumulation of knowledge in an ever changing health care environment as a concern for maintaining an identity as a competent, caring, and successful nurse. Acquiring and maintaining competencies and skills as a professional nurse as well as advancing in the profession underscored participants identities. Save for one, all participants viewed continuing education and keeping up with the learning curve a major challenge facing nurses regardless of gender. Certainly, the power of knowledge is of concern to both men and women nurses so this aspect of power relations was assessed not as a singularly masculine trait but rather as a non-determinant or ambivalent one. Typical of the narratives shared in relation to continued learning were the following:

> The learning curve, there's so much to learn. And, just to come in here every day and get out and on top of it [you have] to go home and keep open those books and keep learning. (Nick Wilson)

> I think one of the challenges . . . everybody faces in nursing is training, continuing training. With knowledge, people that are properly trained, you get better outcomes for patients. (Spock Andrews)

One participant, drawing from an essentialist view of male-female differences, suggested that male nurses are more committed to continued learning. He believes more is expected of men in general and are therefore pressured to advance more so than women:

> When men get into [nursing] they try to learn it more and they study it more. Whereas, when a woman gets into it, that's what she knows. And then, she starts doing other things with her life [like] having kids, doing the things at home, whereas men seem to keep on studying the area, the field. (Mark Willis)

For Mark, female nurses are naturally endowed with skills for nurturing and providing care. But for men like him, he feels compelled to work at continuing to learn

and advance because he defines himself as the breadwinner and provider for his family. It did not occur to him that as a man he could also do things at home in relation to childrearing and homemaking or that his wife, who coincidentally also worked outside the home, was indeed a co-breadwinner.

The following participant's comments indicate that episodic career interruptions like the ones Mark suggested as "natural" for women nurses when they engage in childbearing or childrearing activities can be dangerous for ones career:

> . . . [Acquiring] new knowledge . . . I find to be a challenge. Of course . . . when you're working it's continual, and when you're not working it's rusting. (Spock Andrews)

Studies do indicate one's skills and knowledge rust while off work for six-to-twelve weeks for maternity leave (Farrell 2005; Feldman 2003), thus male nurses who do not disengage from the workplace can continually add to their skills repertoire. Not one of the participants suggested he had ever considered taking family leave for the birth of a child or to care for an ill family member.

Continuing to learn and continuous improvement on practice skills were also a way these men identified themselves as good nurses. Related to providership and also power-knowledge was a concern the participants raised regarding advanced education and becoming better tooled for their respective work environments. Doing hands-on nursing was in essence how these men identified themselves as caring men. Returning to school presented a dilemma for them in that they recognized they must forego a good income for an extended period of time. Also, they were concerned about skills becoming "rusty" when not working for an extended time period. The following comments represent the anxiety felt when faced with this dilemma:

> I wish there was another avenue that I could go and hit another pathway to do more versus quit and go back to school three or four years and have to start all over again. I wish I could learn more and more and do more. I wish it was easier to get a doctorate . . . in the clinical practice setting [and] actually impact practice. (John Smith)

Another young man who had just been accepted into anesthesia school added the following comment when I observed him at his worksite:

> I'll be twenty-seven months without a paycheck and will deplete my bank account. . . I have a house here. I want to stay here. But, we can't work while in this program. (Colt Cox)

Colt is not married and is without children, yet he is definitely aware that the size of his bank account will dwindle rapidly without his labor to replenish it. And, for men like John, who is the father of four young children, returning to school for a nursing doctorate is not a possibility.

Cautious Communicators with Female Colleagues

Another sub-theme that emerged centered on symbolism issues, specifically in relation to female colleagues. The participants identified their communications with female nurses with bewilderment and inadequacies. Participants identified their communications as often being misunderstood or misinterpreted by their female cohorts. The following narrative best represents what many participants identified as most difficult for them when communicating with female nurses. This particular narrative was chosen because the participant also shared his strategy for correcting his attempted communication:

> I probably tend to be a little bit more confrontational than some of my female counterparts. And, I think, even if that situation occurs and it's occurring, I'm trying to figure the best way to phrase this. I may not even be aware of it, whereas some of my female counterparts might perceive that as being

> confrontational, when I'm just trying to ask a question, and become defensive about it. I have to realize that sometimes when I want to ask a question or I want to make a statement, I have to be very careful to phrase it in such a way that it does not appear to be a threat. (Kendi Alded)

What Kendi suggests he must do in order to communicate more effectively and avoid misunderstandings, especially as a man in a predominantly female profession, is to adjust his communication style so as to be respectful of the feminine habitus. Although refreshing and non-characteristic of traditional masculinity, it can be energy draining for him. Likewise, the following participant shared, in a playful way, how forgetting one is in the habitus of women may lead to saying taken-for-granted "guy things" that could result in serious legal consequences:

> Sometimes when you're the only guy around, you get a little wanting to be around guys and you may say something . . . . And, there is a double standard. A nice looking man can go by and the nurse, a woman, can say, "Wow, look at that!" And, if a guy says it [about a female], it can turn into harassment real easily. . . . As one of my [female] co-workers said, "Sometimes you just have to let your testosterone out don't you?" And, I said, "Yes!" I mean, I'm not a macho guy; but now that I am in a supervisory position, that's even more important because there is a zero tolerance for that. I'm sure other guys have that problem because there are people that are sensitive about things around us and we have to be more aware of that even more because of legal ramifications. (Rusty Shackleford)

Rusty seemed to be correct in his certainty that many other male nurses have this same concern, because a full one-third of participants in this study made specific references identifying communications with female coworkers as a challenge for them. Several men made reference to being more business-like or at least more guarded in their communications than the women with whom they worked. The following narratives best demonstrates these types of references:

> There's a lot of bickering . . . and back-stabbing that goes on. One of the biggest things I have to deal with is to separate and not get caught up in all the gossiping

> and other negative energy that just goes around, and bring my focus back to just take care of this patient right now. (Dan Owens)
>
> People have a tendency to judge a group by what one person did, though the whole group is not that way. And, I always keep that in mind. As a man it is very, very important to me to be the role model, to keep it professional, because the last thing I want to do is make it harder for other men in this profession. (Joseph Brown)

In the above narratives, Dan identifies himself as a caregiver and focuses on his work in order to avoid what he calls "negative energy" that could deflect from his being at his best when delivering patient care. Joseph, as a personnel manager does not want to communicate anything that might negatively reflect on male nurses as a group and guards his communications.

Self-Disciplinary and Non-Risk Taking Personal Health Promotion

An interesting sub-theme related to power-knowledge emerged, which revealed that the men in this study used self-disciplinary constraint in their personal lives with regards to risk taking behaviors in order to protect and promote their personal health. The following narratives best illustrate this sub-theme:

> As a twenty-five-year-old, a lot of young men don't think of their mortality. As a nurse, I've seen people born . . . die . . . . I've seen beautiful young ladies, who were beauty queens in the morning and were 50% burned by that evening. As a young person, [nursing] has made me look at my mortality . . . it's made me appreciate the health that I have, the youth that I have, and it's made me prepare for what's ahead. So, I definitely think that as a young person, it has made me actually aware of all stages of life and all the things that can happen. (Carson Hyde)
>
> I guess [nursing] just plays into everything else . . . from the way I drive to the way I think. You know when you're younger, you're carefree, you can fly down the highway at eighty-miles-per-hour and ignore the traffic. I won't say I never did that, but I think I stopped a lot sooner than a lot of folks. I even started wearing a seat-belt before seat-belt laws became mandatory. I never got into

> drinking or drugs. It influenced my decision on how I live and deal with those kinds of things in my own personal life. (Joseph Brown)

For both Carson and Joseph, nursing influenced the way they view their personal health vulnerabilities. They assessed many of the risk-taking behaviors that are often emblematic hallmarks of traditional masculinity, such as thrill-seeking disregards for health and safety, as youthful indiscretions inconsistent with the serious business of "taking care." Nick Wilson put it in succinct terms: "Nursing has grown me up. I am a lot more responsible person."

Negotiating Stereotypes

Stereotypes about male nurses were described as having been confronted either at the time participants decided to attend nursing school at the W or early on in their careers. The following narrative illustrates many of the stereotypes recalled as having caused concern:

> I think it was a real challenge in the beginning. I think just the simple emotional challenge, like it's more of a attack of your manhood to say, "Oh, I'm going to school to be a nurse." That was more of a thing I dealt with prior to actually becoming a nurse . . . . Male friends just didn't understand why you wanted to do this . . . "You're a guy; you want to be a nurse? That's weird." (Brad Jones)

For some participants, stereotyping of male nurses continued to be problematic as the following participants at mid-career described:

> Especially when I first graduated it was kind of a challenge. But now, I just know what to say to them . . . . Actually, my girlfriend's father, he still kind of looks at me kind of crazy. He went to Mississippi State University where he got his degree in agriculture; he's a farmer. And, I think in his mind, he thinks men are just not supposed to be nurses; that men are supposed to be farmers or lawyers or doctors, whatever society says men are supposed to be when he was growing up. When I tell him I went to MUW where I got my bachelor's degree in nursing, maybe he thinks that's not manly enough. (Jackson Jones)

> With age and maturity you get over it. You just hope people look past the stereotypes and if they don't they're not the kind of people you want to associate with anyway. . . . OK, *Meet the Parents,* I remember the scene when they're all at the dinner table: The doctor [says], "Oh what do you do, Greg?" "Oh, I'm a nurse." Everybody dies out laughing. That's probably the hardest I've ever laughed at a movie, because that's similar to what I was trying to describe. (Steve Thompson)

Another participant described why such stereotyping of male nurses concerned him so much:

> You had a few folks in the public . . . the first thing is always they ask if you're gay. It didn't bother me that people were thinking that. It bothered me that people weren't getting into nursing because of that. I've had people actually say that. Traditionally, men go to med school and women to nursing school. That old thing of the man goes off to work and the woman stays at the house, it's hard to get the old attitudes out of people. (Dave Wayne)

Essentially, stereotyping bars access to a potentially satisfying career in nursing and that upsets Dave. Regardless of sexual orientation, as Dave contends nursing needs men who "just like nursing."

One participant who described himself as having been in a long standing same-sex relationship had the following to say about dealing with stereotypical images of men in nursing:

> Well I am gay and my ideas about masculinity versus femininity aren't the stereotypical, societal picture. . . . My role as a man, not having a stereotypical male gender role because of my sexuality, and coming to terms with me being a man and my sexuality has been a long process. . . So I've been working diligently to come to terms with my gender role, within myself to keep it from splitting me apart. Nursing . . . has given me just a wealth of information about gender roles by dealing with others, being seen as caring, and that [it is] OK [to care]; and that it is valued by my patient s and the staff around me. But women are different. They do a different gender . . .than I do, but I don't think that much of it is DNA programming. I think a lot of that is societal. Males and females can both care. (Owen Wellons)

Owen describes nursing as having provided a form of safe haven for him professionally as well as having provided tools for better self understanding. And, he points out very well that the problem actually resides with societal norms and not with his biology. Nursing has allowed him to live his life with greater authenticity.

Interactions with Others at Work

Each of the participants evaluated their work interactions as positive overall with everyone in their respective workplace environments. Interactions with patients and fellow nurses were described most favorably, though tensions were described on occasion with female colleagues when male physicians approached them differentially. Tensions were more frequently encountered in relationships with physicians, management and faculty even though these relationships were also identified by participants as being positive and satisfactory overall. Because communications with patients were discussed in greatest detail, they will be discussed first, followed by interactions with nursing colleagues, physicians and managers, respectively.

Patient Interactions

Interactions with patients were undergirded by labor practices involving compassion, directive communication and touch. Thus, the major theme here was again compassionate caregiving. Emotional connections with patients using empathy and compassion were described at interview as well as observed directly during participant observations on various hospital units. Sub-themes included: (1) empowering patients through directive and teaching communications and (2) touch as a point of tension for participants.

Compassionate Caregiving

When asked what they found to be most meaningful about taking care of patients all thirty men said they found meaning in helping others and making a difference in people's lives as the following illustrates:

> Taking care of patients . . . . Making a real difference . . . . That to me, is an amazing responsibility that only the nurse has. The nurse is the only person on the health care team that has that type of responsibility. . . . I am here for this many hours and I am the sole responsible party for what happens . . . during this time; and I am going to be here for the entire time. I'm able to have a trusting relationship, they trust me with their life; they trust me to do anything for them. You know, that is something that I take to be most meaningful, because it's not taken lightly when someone gives you that kind of trust. In a lot of jobs, in a lot of environments, these people would never allow anyone the kind of trust they give [me]. (Brad Jones)

Underlying perceptions of positive patient interactions and when participants voiced that they felt most rewarded, was when their helping was acknowledged and appreciated:

> It's nice to get feedback. . . . The other day I went upstairs to get a clip on my beeper and the lady [at the desk] said, "My husband really was impressed with how you took care of him." [That] makes me feel good . . . that's really satisfying to me. (Steve Thompson)

However, even when such appreciation was not granted or forthcoming, these male nurses took satisfaction in knowing they did a good job, exhibited technical competence, and that experiences were gained in the process as the following demonstrate:

> I get more satisfaction in seeing someone get better . . . . You can get them in and you save their life; they may not know it, but you know it. I don't look so much for the open gratification as I do knowing that I did the right thing. . . . I don't care if he comes back and tells me thank-you. Knowing what you are doing, and doing it right, and seeing the effects. To see results from what you're doing is pretty satisfying. (Preston Jones)

When I observed Carson Hyde at the orthopedic unit where he worked I witnessed him connecting with empathy while feeding an elderly man who had suffered a massive stroke. Carson shared that Mr. D's family had declined a feeding tube as well as extenuating or heroic measures for him and were awaiting placement in a hospice facility. The following is an excerpt from my observation notes:

> Upon entering Mr. D's room, Carson notes the dinner tray has been delivered: "Hello, Mr. D, you ready to eat a little bit?" Of course there is no reply and Mr. D continues to stare blankly into space. Carson continues speaking conversationally to Mr. D as he gently spoons some applesauce into the elderly man's parted lips. "OK, good. Another big bite." But with the second spoonful, Mr. D pushes the applesauce out with his tongue and Carson wipes the old man's chin with a moist towel. On the way to the nurse's station, Carson is silent. At the desk he finds a nursing assistant at the computer posting patient vital signs. He rubs her shoulders and makes his request: "Dorothy, will you feed Mr. D for me?" She replies, "I did already. He won't eat for me; just a few bites of chocolate pudding and a little applesauce." Carson, thoughtfully and mostly to himself says, "His grandson comes up to feed him sometimes and he eats good for him. Maybe he will eat a little better for me." He tries a second time unsuccessfully, and returns a third time armed with ice cream that he has fortified with high calorie protein powder. Mr. D seems to enjoy the first few spoons of ice cream and Carson is encouraged: "Is that as good as you remember it, sir?" Though Mr. D cannot respond verbally, his eyes seem to sparkle a bit and focus on Carson. This makes Carson smile broadly: "Take another good bite. That's good." He gets it all down Mr. D using a process of spooning into his mouth, massaging from chin-to-clavicle to stimulate a swallowing reflex. When Mr. D finishes the ice cream, Carson is triumphant: "Want some milk? I'll get you some."

Certainly Mr. D's family would never know about the patience, empathy, and compassion Carson expended in feeding Mr. D just one meal, but Carson knew he did the right thing and satisfaction for him came with actually getting Mr. D to take nourishment using therapeutic caring skills. The ever-so-brief visual connection offered by Mr. D was a reward, a gift exchanged for a job well done.

Empowering Patients through Teaching and Directive Communications

Interactions with patients in regards to power relations centered on comforting, teaching and directive communications in order to empower clients toward positive outcomes. When asked that participants tell me what the phrase, "Patients with high-tech needs, require high-touch nursing care," meant to them the majority (21) of participants responded that patients with multiple problems required even more, the skillful presence of a professional, competent nurse as the following narratives suggest:

> That means don't nurse the machine, nurse the patient. (Rusty Shackleford)

> You need to take care of the patient and not just the machines. If you're not careful, you may let that machine take care of your patient instead of you . . . . All those bells and whistles, wonderful technology; but, it scares the heck out of our patients. . . . You need to explain those bells and whistles to them and what it all means and why. Basically, high-tech equipment; it's no substitute for high-touch. (Joseph Brown)

> The more that a patient is disoriented by technology, the more the nurse needs to have a presence that is not technology, whether it's a physical touch or just conversation . . . . (Kendi Alded)

The following narrative demonstrates how a number of participants view teaching communications as a means to empower patients toward positive health behaviors:

> Teaching, it's a way to empower people . . . . Your health; you have to take control of it. And, as a nurse that's what I try to do. I try to help people to make their health their own. I think that is nursing . . . the fact that you can empower people, you know [teach]: "Take care of yourself." "Eat right." "Take your blood pressure medicine so you don't have to go on dialysis." You can teach. Knowledge can . . . empower you. (Spock Andrews)

Communications with patients were directive and easy to understand as I observed following Tay Diggs for two hours at his unit. He was working a few hours each day in the pre-anesthesia testing (PAT) area while orienting in his new job in the operating room with the heart team:

> Tay, moving across the hall from the nurse's desk to the patient in room B: "Ms. W, go with me to this room across the hall, we need some lab work." He is indicating across to the phlebotomy room. Once in the chair the patient seems pretty nervous, grimacing, and looking away while taking short, fast breaths. Her companion offers that, "She hates needles and the lady out there said she'd not have to get stuck today." Tay responds, "Yeah, but we're gonna have to. It's been too long since the last set of tests." He is very methodical and patient while checking for a vein, taking his time and moving the tourniquet to the right after having examined the left and not finding a perfect vein. "Gonna feel a stick, now," as Tay performs the phlebotomy. Without Ms. W becoming alarmed, he secures the specimen on the initial attempt. After taking off the tourniquet, cleaning the site and putting on a band-aid, as if all one fluid motion, he smiles up at Ms. W: "OK, you can go now. I hope all goes well for you."

Another example of short, directive statements as used by participants is made obvious in the following except from participant observation notes of Colt Cox who works in an ICU setting. He is conducting the neurological section of his initial assessment of Ms. T. his seventy-five-year-old, black female patient who was brought from home to the hospital's ER in asystole. A big red DNR (do not resuscitate) sticker flags the front of her chart:

> Colt is speaking loudly and leaning closely over the patient's chest toward Ms. T's right ear, yet directly in her line of vision, "I'm going to shine a bright light in your eyes, Sweetie. That's OK? Good." He tells her everything before or as he does it and then follows with, "Good" as he completes each particular part of his assessment. "OK, squeeze my hand, real hard, now. Good. Hold up your thumbs. Good. Wiggle your toes," as he inspects her feet, "Good. What year is it? Good. Tell me where you are. That's right!" He turns on the over-head light, brightening up the room and begins a full head-to-toe assessment.

Both Tay and Colt demonstrate how the men in this study communicated primarily through short, directive verbal statements or commands with patients. Not surprisingly, they communicated even more so through the use of nonverbal communication techniques including touch.

Touch: A Tension Point

The men in this study were not hesitant to use touch. Though some tension reverberated with regards to intimate procedures with female patients the men devised strategies to deal with such concerns as evidenced by the following scenario also observed while shadowing Colt Cox:

> While examining Ms. T's breath sounds, he uses a full hand over the bell with fingers full onto the patient's chest. He's not hesitant about touch; he can feel thrills, rubs and fremitus easier this way. Colt commands Ms. T to, "Breathe deep." His chest and lung exam is very thorough. Through the patient's gown, he listens for bowel and abdomen sounds. While pressing on Ms. T's abdomen with the flat surface of all four fingers of his right hand, he asks, "Are you sore? Is your belly sore?" He leans closely to the patient, within 8 to 12 inches of her face: "All over? Yeah, Sweetie." He checks the oxygen Venturi-mask and the mechanical set up and tubing as well. When checking for peripheral edema through Ms.T's TED (Thrombo-Embolic Device) hose, he turns off the thrombo-embolic device to inspect her legs: "Let me see your leg right here," and he lifts her left leg off the bed and examines the underside. After a thorough check of Ms. T's leg circulation, he then reapplies the pneumatic stocking and allows them to re-inflate. Ms. T had been placed in soft wrist restraints during the last shift because she had been "restless and picking at her equipment." He checks them and then removes them. The look on his face says he disdains these. He gives Ms. T oral care using suction and a sponge device with lots of oral fluids. To Ms. T, "That feels better don't it, Ms. T?" Colt washes her face. Placing emphasis on her comfort, "OK, now pucker up for me," as he slathers Vaseline lip balm onto her lips.

Colt demonstrated a frequently observed strategy used by participants for resolving female patient modesty concerns: The use of the patient's gown or other clothing as a barrier between skin-to-skin touch. When women patients needed assistance with bowel or bladder elimination, other family members or female nurses were enlisted to assist. One patient Bob Flowers was caring for in the ER, on the afternoon I observed him, was accompanied by her husband. She needed to produce a

clean catch urine specimen for testing, so Bob enlisted the husband in helping to get her to the bathroom:

> "Mr. B will you help her take them clips off her chest?" She's being monitored for cardiac arrhythmias. "They just snap off like clothespins; there's about ten of them. Yeah, that's it." Once all are off, "Now slowly stand up Ms. B. I'll help you. We'll swing you around into the wheel chair. I'll hold onto you." Once seated in the wheel chair, "Now Mr. B, the bathroom is right here down the hall. You carry this," as he enlists the help of Mr. B in carrying the intravenous bag of fluids. He pushes the wheel chair to the bathroom. In the bathroom he helps Ms. B up and onto the commode, "Can you handle it from here, Mr. B?" Mr. B nods affirmatively, and Ms. B asks: "Where's my cup?" Bob answers, "Right here behind you." Retrieving and handing the specimen cup to her, "You just couldn't see it, could you?" Mr. B nods again that he can handle it from here, and Bob backs out of the bathroom and closes the bathroom door.

With male patients, touch was best characterized as efficient, though minimal as evidenced with the following scenario observed while shadowing Nick Wilson at the trauma center ER where he works. The patient was a young black male with an evulsion, soft tissue injury to his left forearm that could not be sutured and would have to heal from the inside, out by primary intent. Nick received orders to infuse intravenous antibiotics after having cleaned the wound:

> Between treatments for one patient with a gunshot wound to the face and another patient with a stab wound to the back, Nick ducks into Suture Room-1, "Ready to start the IV, man?" He magically pulls from his pocket the antibiotic piggyback and quickly flips out a ten milliliter syringe filled with normal saline that has a reflux valve attached on the end. After applying the tourniquet, he swipes the site with a cleansing solution and flicks the vessel in the patient's right forearm with his right forefinger. Without looking at the patient, intent on the vessel, "It's gonna stick now." The patient turns away and grimaces. "OK, it's done; 'bout 30 minutes to go in." Now with eye contact, while covering the site with a transparent dressing, flushing the IV catheter with normal saline, and attaching the piggyback to infuse, he says, "Man, you OK? Thirsty, still?" Nick has accomplished all this in less than sixty seconds and without loss of one drop of blood.

Analysis of participants' interactions for relations of cathexis, power, labor and symbolism revealed primarily non-traditional masculine behaviors. Participants did implement successful strategies for reducing culturally imposed gender tensions specifically in regard to female patient modesty issues and male patient homosocial touch concerns. Empathy, acceptably expressed as making a difference, empowering patients, and therapeutic utilization of touch were strategies employed by participants to render nursing practices gender-neutral. The participants of this study regarded their interactions with patients as enjoyable and immensely enriching work endeavors.

Interactions with Nursing Colleagues

The interactions with other nurses at work as described by participants when interviewed as well as observed at participant observations at various worksites, were characterized not by hierarchal ordering of power relations, but by horizontal reciprocity or lateral exchange (Connell 2000).[15] Thus, the major theme identified among interactions with nursing colleagues was an undergirding ethic of horizontal reciprocity. Two sub-themes emerged, including: (1) references to coworkers as family or team players; and (2) socializing after hours with nursing colleagues.

Horizontal Reciprocity

The best example of horizontal reciprocity occurred while observing Harley Weewak in the ER where he worked. He was approached by JD, a female nurse, carrying a unit of blood that she needed to infuse into the patient for whom she was caring. She asked Harley to witness the correctness of the blood for her patient:

[15] Connell (2000, 218) briefly used this term to underscore equities inherent in mutual exchange between equals and to contrast with inequities in hierarchal ordering inherent in hegemonic masculinity.

> The two verbally read aloud the data on the lab form and on the bag of blood. Confirming that this is the appropriate unit for the patient, both sign the lab form. Shortly after heading into the patient room, JD beckons Harley again: "Harley, help me. I need you to show me what you did earlier with this new blood set. I need you to show me, not tell me so I can do it. I tried; but, just show me again." Harley takes a five millimeter syringe and attaches it to the blood tubing port and withdraws air from the line: "These darn pumps won't do a thing if there's any air in there at all," looking from JD to the line. JD says, "Thanks two times now, Harley. I really appreciate your help. You're the expert!" (Both laugh.) After washing his hands, he checks on Ms. H in Room-2, who is on the bedside commode. Pulling the curtain aside he asks, "Would you do better with a lady; if a lady nurse would help you?" Ms. H indicates that would be desirable. He locates LS who says she will help after she does a procedure with another patient. As JD comes to the desk, Harley asks: "J, will you do me a big favor? L is tied up doing something with one of her patients; can you help Ms. H off the bedside commode? She'd be more comfortable with a lady nurse helping her." JD responds, "Sure, Harley." "Great," Harley says with relief, "Let me get a fresh brief and put it up here for her," motioning to Room-2.

While observing Bob Flowers a very amusing scenario occurred when one of his co-workers, GS, a tiny white female nurse asked him to assist her male patient, a large Jerry Clower-look-alike, to stand up beside the stretcher to use a urinal. The patient, a Baptist minister, was accompanied by his daughter, whom he would have never allowed to help him with such an activity:

> GS says to Bob, "I can't stop him if he goes down and he's shy about a 'girl' (motioning quote marks in the air as she says the word) helping him." Bob does not hesitate and pulls the curtain closed behind him. As he introduces himself, he scurries Mr. C's daughter out of the room. Through the pulled curtain, GS, the patient's daughter and I hear Bob say, "OK, now let `er rip, Mr. C. If it goes down your leg or mine, we'll know it's not in there." Both men and we three women are cracking up. In short order, Bob says to Mr. C, "OK, all done? Now you lay back and I'll swing your legs up for you. That was easy, wasn't it?"

Bob effectively used humor to deflect gendered power tensions as he assisted his co-worker in delivering culturally appropriate care for the patient and the patient's family member. Humor worked well for a number of participants and was used frequently in order to diffuse very tense situations.

Family and Team Players

Many of the participants referred to the relationships they had with other nurses at work as a team or even as a family as the following narratives indicate:

> Our relationships, on our team [are] very, very strong. I mean we have a great working team together. We kid around together, we work in a serious field and you have to kid a little bit. You have to slack off and pick at each other sometimes and we're able to and we don't take offense to it. We're a real strong team, a real tight, close-knit team. (George Wright)

> We try, for lack of a better term, to try to act like a family up here. Certainly, you work in such close proximity and under such strenuous circumstances, that you need to be cohesive and have a good understanding of each other. After awhile we know each other. I know you do things before you do them, and vice versa. (Preston Jones)

> We're like one big family because we see each other more than we see our own families. Act like you do around your own family: joking, loving, caring, fussing, fighting; the whole deal. (Colt Cox)

As with any close-knit team or family-like group, tensions arise. When asked if there were certain things that irked them about their co-workers, laziness or sloppiness tended to raise the ire of participants as the following narratives illustrate:

> Things that irk me at work: Being lazy kind of irks me. Not doing something that they said they did . . . saying there's coarse breath sounds on a sheet and they didn't even listen. Or, saying they suctioned a large amount and they didn't suction at all or saying they gave a bath when they didn't. (Colt Cox)

> I believe in doing things the right way. I don't like to see people take short cuts . . . . When you take short cuts either one of two things will happen: Either somebody will have to pay for it, and in health care that usually means the patient, or you're gonna have to re-do it, or both. (Joseph Brown)

What both Colt and Joseph underscore is that patient care is compromised when nurses do not perform at their best and that reflects poorly on them and the profession in

general. As they perform professionally, so too do they expect the same from their colleagues:

> In the ER where I work, it's important to have people that technically know what to do and when an emergency comes in and they know exactly what to do it's like a concert. And, if every part goes right we can accomplish the goal. I've seen where we have to get something done quickly and it was done because everybody worked together. It's a concert, a beautiful concert. The nurses I work with; you know exactly what they think, how they feel, and how they will respond. (Spock Andrews)

What Spock has characterized with his narrative is an important outcome when horizontal reciprocity replaces hegemonic masculinity as the driving force undergirding relationships in the workplace; goals can be accomplished, elegantly.

Socializing After Hours

Among participants, fourteen said they socialize with both men and women nurses outside the workplace, usually by going out to eat, attending parties and the like. Seven of the thirty said they socialize with only other male nurses with whom they work, usually engaging in sports activities, hunting or fishing, or assisting with building projects and yard work. Eight said they do not socialize with co-workers because they do not think it to be a good business practice or they have family responsibilities that preclude them from socializing after hours.

Among the eight participants who said they did not socialize after hours with nursing colleagues, because they thought it a poor business practice, narratives typical of the following, were frequent:

> I shy away from a lot of that and I guess the reason is because you just open a can of worms in my mind when you start mixing friendship outside of work. With friendship and work it always makes me nervous to do that . . . I feel the same way about people dating and they work together. I don't think that's good

> business practice. I like to get along well at work, but when I go home I like to leave my work relationships at work. (Marion Jones)

Marion's narrative illustrates a minority viewpoint expressed by participants regarding nursing co-workers and is one that is more of a traditional approach to business relationships.

The following narrative illustrates typical family reasons shared by participants regarding why they did not socialize with nursing co-workers outside of the work setting:

> There's not much time to do that . . . of course with my son, in the summer my daughter is here, so it's really hard to set aside time to just spend with my co-workers. (Spock Andrews)

> Me and my wife (also a nurse) hang out. We don't have a huge social schedule. We don't go out a lot. If I take the boat out or something, she'll go with me. [We] look forward to weekends off together. (Steve Thompson)

Both Spock and Steve demonstrate that spending time with family and balancing time with family was very important to these participants and something they did not choose to forfeit. Although all the men acknowledged they had positive interactions overall with their nursing colleagues at work, they did not always choose to socialize with co-workers outside of the workplace.

Interactions with Physicians: Masculine Respect

The major theme identified by participants in relation to interactions with male physicians in the work setting was masculine respect. A sub-theme also emerged related to hierarchal ordering of interactions with physicians.

Although twenty-eight of the thirty participants in this study said their relationships with physician were positive overall, only eight said they routinely socialized after work with them. Additionally, many (28) said they did attend occasional

holiday or formal parties where all hospital personnel, including physicians were present while the men who said they routinely socialized with physicians did so by going hunting, fishing, golfing or to other sports events and attended informal dinners with their families as well. The following narratives illustrate the kind of relationships described:

> That relationship is very strong. The staff physicians [and] ER docs, definitely hunting, fishing, golf, sporting events, going to games, whatever. We do all kinds of stuff together. Let's just leave this place behind, go out and have a drink and just relax or sit by a bonfire . . . just leave this place behind. (Preston Jones)

> One of the physicians I work with, we both ride road bikes and we went out to Texas this last, this past August and rode in the "Hotter-than-Hell-100" at the Century. And, we spent basically three days with nobody else just me and him. You know, I will always have that . . . friendship. (John Wright)

It was not surprising to find that the male nurses who socialized most frequently with physicians were themselves nurse managers or nurse practitioners, nurses with higher education and prestige than the staff nurses. Whether their access to socially and economically more powerful men (physicians) helped them move into those positions or whether moving into management and/or practitioner roles put them on a more nearly equal social level with the physicians was unclear. However, the narratives of fourteen participants better illuminated probable career trajectories as evidenced by the following examples:

> There's one in particular that he actually helped me get the surgery job. I'm going to be working for him. I really like him, he's very personable. . . . We don't really socialize outside the workplace but we can carry on a friendly conversation at work. (Tay Diggs)

> Interactions with the physicians are very good. Most of the physicians are male. All our heart surgeons are males. I have great interactions with them. I think that has played a big part of having the job that I do now. One or two have played a real big key in my advancement so far. They've really seen that I was willing to work hard and do my job. (George Wright)

Both Tay and George are very aware that their positive working relationships with the physicians with whom they work helped move them into more prestigious work roles within their respective institutions. The following narrative provides additional clues regarding an underlying mechanism for this phenomenon:

> I think there is a difference, however, in the interaction with physicians as a male nurse versus a female nurse. I think that physicians; it goes back to almost the unwritten, unspoken word of respect between the group of males at the W. It's almost a parallel to this situation with male nurses and physicians. It's an unspoken respect of, "OK, you're a man; I'm a man; even though you're a nurse and I'm a doctor, we're both men so we do have that aspect in common," versus, "Oh, I'm the doctor, I'm a man and you're a nurse and you're a woman: We're not any, we're not on the same level in any way." . . .[M]ost of our physicians in the South are men, so the male physicians, the male nurses, it's a little like less of a power struggle between the two, because you have that one gender thing in common. And, I think there is an underlying respect there that doesn't exist between the physician-nurse relationship when you're dealing with a male physician and a female nurse. (Brad Jones)

Mr. Jones' description of an unwritten, unspoken respect is emblematic of the male honor codes described by Nye. And, he describes the very structures of Bourdieu's male habitus, a lived anatomy recognizable by other men, symbolizing and communicating an entire system of meaning hidden to women. The following narratives implicate negative outcomes for female nurses in environments where they lack awareness of the existence of male honor codes and masculine habitus:

> From the staff nurse angle, I think men have an unfair advantage with the physicians. [Physicians] . . . will listen to what the male nurse has said more than what the female nurse has said. And, some think it's that sexist thing out there: You know, where men will talk to men and won't talk to women on the same level that they talk to men, type of thing. But, I've seen it. I've had women point it out to me that, "Well he listened to you because he's a man." (Joseph Brown)

> At times I have noticed somewhat of a difference . . . . There . . . have been times when I felt like they may have given me a little bit more respect, maybe just because I was a man. . . . [S]ome men just don't maybe have enough respect for women. (Dan Owens)

These two participants pointed out that their female colleagues' communications with physicians are discounted more often than their communications. The following narrative is very specific and carries implications regarding possible negative patient outcomes when male physicians discredit female nurse's assessments:

> . . . [T]he patient was sitting up on the side of the bed, diaphoretic and confused. The doctor happened to be sitting out there and the female nurse came out and said, "The patient is sitting on the side of the bed, diaphoretic and confused. I think it's either his blood sugar or it's respiratory. I'd like to get respiratory and a blood sugar check." He's like, "Owen, will you go look," sending me to check up on another nurse's work. I should have refused but I didn't. I went and looked and I said, "We need respiratory now and we need lab in here now." And, he says, "OK, go ahead." So that totally devalued the other person, the other nurse. (Owen Wellons)

Owen's narrative illuminates that male physician discrediting of female nurses' communications inhibited a faster response to meeting clients needs, thus jeopardizing the client's health.

Male Order: Physician to Nurse

A notable sub-theme emerged regarding interactions with male physicians, when a number of participants suggested that physicians were tougher on them than on their respective female colleagues. The following two narratives best illustrate this sub-theme:

> Sometimes they are rude to me on the phone and even have used profanity with me on the phone. Generally I don't get an apology, but generally the females will get an apology. And, I think this is just a male-female thing because sometimes when you got guys . . . we just overlook it. The rudeness and the way they act like that because we don't let it get to us as much as some of the females. Probably what a lot of it is, is just as men, we just don't show it, even if we do get our feelings hurt. We just kind of blow it off and just keep on going. (Jackson Jones)

> Some doctors are easy to talk to and some ain't. I don't think it has anything to do with male-female. It's just some of them are jerks, and are hard to talk to,

> period. I don't think the female nurse gets yelled at as much as we do. Seems like if I call a doctor in the middle of the night about something, he fusses at me a little bit and then gives me the order. If it's a female, especially young,[and] attractive [making the] call, "Oh, how ya doing, yeah, yeah." They are real nice to them. They don't get away with murder, but . . . getting cussed at . . . where a young attractive female won't get yelled at. I've seen that a few times. (Colt Cox)

Jackson and Colt describe a phenomenon that Connell refers to as "systematic, institutionalized bullying," very much akin to hazing, that men often use to toughen up newcomers and to maintain order (Connell 2000, 95). This type of bullying helps maintain honor and respect among men. Rudeness, cussing, and ribaldry are expected markers of the male habitus, as is the sexualization of women (young, attractive females). Jackson went on to tell me that, "I have had physicians come right out and tell me that they'd much rather talk to a pretty, young girl on the phone in the middle of the night instead of me. And, I can understand that; I would, too."

The following narrative provides further illumination of both masculine respect and relational ordering among male nurses and male physicians:

> The female nurses probably socialize more with the physicians on just an everyday level like, "Oh, how are your kids doing," and stuff like that. The male nurses and physicians seem to be more on a level that's more of a business type level. Its more, "I'm here to do my job; you're here to do your job, let's do our jobs." Because of that, there's a real respect . . . Females have more of a social network with the physicians . . . they're not so much on the business level, so that's one reason why I think [they] lose a tad bit of respect. . . . (Brad Jones)

Brad discusses how men and women nurses gain and lose respect with physicians in the workplace. Though men are expected to act in masculine ways at work, e.g., keeping it on a business level, and are rewarded for doing so, their female colleagues who are also expected to act in feminine gendered ways, e.g., be attractive and expressive regarding family and home, are punished by having their communications discounted,

discredited and viewed as not capable of possessing respect. As Joseph Brown said so succinctly, “Men have an unfair advantage.”

Interactions with Administration and Management: Tenuous and Strained

Among the thirty male nurses in this study, seventeen perceived their relationships with managers and administrative persons in their respective facilities to be positive. However, only three said they socialize with management and administrative persons beyond formal occasions or only once or twice a year.

The major theme identified among participant interactions, with administrative and management personnel, was tenuous and strained relations. Interactions with management were mostly characterized as relations charged with tension and suspicion, and thus, were assessed as ambivalent at best. Unequal hierarchal power relations tended to prevent meaningful social exchange among managers and the men in this study. One man described the relationship with administrative persons and nursing staff on the unit where he worked in the following manner:

> Administrators, they’re kind of like up the next story, if you might call it a house or whatever. They’re kind of upstairs and we don’t get to see them a whole lot. . . .[S]ometimes I feel like our voice isn’t heard as much . . . I just wish we had more [of a]working relationship [with them]. (Bob Flowers)

Bob’s analogy of administration being upstairs (higher-ups) speaks volumes about where he views the ER staffers downstairs (low-downs), and certainly says that he knows where power resides in his institution. Comments from other participants about institutional leaders had a similar ring to Bob’s narrative, especially in regards to lack of communication or miscommunication from leaders:

> I don’t know who our president and vice president is. (Colt Cox)

> The hospital administrator and the hospital CFO . . . I haven't seen them since my first day of orientation with the hospital. (John Wright)

> Our . . . administrator took the job a couple years ago . . . when he came in he was full of ideas . . . but a lot of the things he said . . . never happened . . . .
> Just little things like we were supposed to change from white to wine-colored scrubs. He gives us the OK for that, everybody goes out and buys them. And, he comes back and says we can't wear them, after everybody's spent a couple-hundred dollars on scrubs. And, then we had to switch back to white, and can't wear them for a month, and then [he] comes back and says we can wear them now because they got approved. (Tay Diggs)

The following narrative illustrates the outcome for institutions when leaders fail to manage symbolism well:

> Lately I've been so put out with our . . . manager. I like what I do here, but it's time to move on. I mean when the boss says right out in a meeting that eighty-four hours a pay period is not enough commitment to this place and says, "Either get with the program and get behind the Vision or get out, cause we got ten new grads coming in May," it's time for me to go. I don't know how he could think that me and all the others, with all this experience, can be replaced by ten new grads who don't have a clue yet. It took me two years to get comfortable in here. You can't lose as many as we're losing and have the needed collective knowledge necessary to effectively care for sick people like these. (Colt Cox)

Colt shared the above narrative with me when I shadowed him at work one night. Without any control over the hours he worked and little control over the kind of nursing practice he desired to deliver, he left the facility shortly after the participant observation to begin graduate studies in nurse anesthesia. He figured that nurse anesthesia would allow him more autonomy and distance from administrative rancor, yet allow him to continue to have direct patient care contact.

Interactions with W Nursing Faculty: Preparing for the Future

The majority (26) of participants recalled primarily positive emotions in regards to faculty interactions. Terms often used by participants to describe faculty included

committed, inspirational, or courageous. Many commented that faculty prepared them for the future rather than just to succeed in passing the state board licensing exam and said that faculty members treated them like family. Narratives regarding faculty commitment to students included the following:

> As nursing faculty, I think you create a different kind of bond . . . than faculty that taught you English Comp. It's more of a long term commitment . . . . You're kind of relying on these teachers to really help you out in your responsibility as a caregiver. . . They are assisting you to get to your goal of becoming a responsible person in taking care of sick persons. So, I think the level of responsibility there, and their responsibility to you and your responsibility to them, just naturally makes you more committed to each other. . . . I mean they're teaching you how to do stuff . . . . It might be the simple act of this instructor helping you give a shot by putting their hand on your hand, and helping you give the shot, physically give the shot . . . . I'm never going to forget this teacher because they did this and helped me give this shot. Even more the huge feeling that you have that you're going to be responsible for these patients; and this certain instructor is the person who has given you the confidence to do that sort of thing, as your career. (Brad Jones)

Brad's recounted interactions with faculty demonstrate a level of horizontal reciprocity versus use of hierarchal power to motivate commitment to caregiving as a career. By placing her hand on his and assisting him to give a shot, he was infused with the how-to necessary to perform the psychomotor skill on his own. His instructor's teaching-touch and demonstration of commitment to, and confidence in him, instilled him with confidence in himself.

Students felt inspired by their faculty as these narratives reveal:

> I did have an instructor I feel like did realize some potential in me and thought that I would do OK. And, she encouraged me . . . throughout the whole program. She's been an inspiration to me and she picked me up . . . and helped me get through the whole thing. (Fred Johnson)

> I was in [this instructor's] office stressed out about something. I was always in [somebody's] office stressed out about something. But, one thing [she] said to me was, "Now, you really want this degree," . . . [she] realized how bad I wanted that

> degree. It was affirming! . . .[She] showed me that I had proven something, my motivation level. The nursing program is designed to be all consuming. It is designed that way. Which, in hindsight now I understand why: I get it! It was inspiring because it made me feel like, "Hey, this faculty knows that I can do this." (Carson Hyde)

Just by having faculty recognize that Fred and Carson could succeed in their endeavor to become nurses boosted them to do just that. With the following narrative a participant describes how an interaction with a faculty member provided him with courage to take initiative in his current job setting.

> We had a 95-year-old patient pull out a Foley catheter. Everybody, there were a bunch who did not want to put it back in, because when they pull it out, still with the balloon blown up, there's a lot of trauma and a lot of bleeding. [The instructor] was looking for somebody to stick it back in and she looked at everybody and nobody would do it. So she looked at me and said, "Come on Spock, let's go put this Foley back in this gentleman." It was the first time I'd put a Foley in a patient besides practice. She was funny. It was kind of like two buddies going down the road, "We need to get this done," and she was fired up and ready to get it done! That encouraged me to go ahead and take the initiative, to take the first step when other people were shrinking away. One of the reasons I chose to go to the ER is because of that. "Don't be afraid, this needs to be done." So, what I got from [her] was to have some courage. (Spock Andrews)

Narratives recounting faculty interactions that motivated participants to prepare for the future were similar to the one that follows:

> One instructor . . . had a long talk [with me] one day about things. She thought I was just going through the motions on things, and [that] really kind of opened my eyes to where I might be just going through the motions. We talked about thirty minutes, and it kind of opened my eyes to make sure that I didn't need to just be going through the motions at that point in my career. And, I really appreciated that, that she cared enough to sit me down and talk to me about that . . . and tell me what she thought I needed to do to progress in my career. (Tay Diggs)

Tay appreciated the instructor having taken him aside and letting him know he was headed for failure unless he changed directions. Kimmel (2000) asserts that men are unsexed by failure. Tay really wanted to succeed (avoid unmanly failure), and become

successful as a nurse and this faculty member assisted him to reflect on his behaviors which provided him insight into how best to progress toward goal realization.

A number of participants recounted interactions with faculty as promoting a sense of family away from home while students at MUW. By being nurtured in this manner they were better prepared to nurture patients and co-workers once in the workplace setting:

> When my dad had passed away . . . you all told me if I ever needed to talk to you all, your door was always open and some times when I came in there and you sat down and you talked to me. You know, it gives you a good feeling. You feel like you at home. If I ain't never told you thank-you for that, you know, thank-you for that. When my dad died and I came in the office and talked to [the program director], she come over and hugged me and she told me, "It's OK if you ever need anything at all, don't be afraid to ask me." What I'm trying to say here, is you all did a little bit more than what you had to do. It was like, in a way, I had a whole department full of moms, that stayed on my butt about class work, about paper work (laughs). . . . I do remember whenever I come in you-alls offices that, with a problem, or you called me in or something like that, that I always left out feeling like if I needed somebody to talk to, somebody was going to help me. (Nick Wilson)

The meaning inherent in the interactions with faculty was poignantly and succinctly expressed by Kendi Alded: "They shaped me." Indeed, the identities of these men as nurses were molded through the interactions and experiences modeled by faculty. Likewise, identities continuously are being re-forged, re-made through interactions with others in the environments where these men work.

Among the thirty participants, twenty-four cited only positive interactions with MUW faculty while students and just as many have continued contact with former faculty members. Six participants, three each from the mid-career and seasoned groups recounted interactions with faculty members that resonated with negative emotions.

None of the participants in the novice group recounted negative interactions with former faculty.

In the methods section I stated I would point out when I noted bias on the part of participants' narratives. I do so here. Because I am a faculty member, I had expected a degree of social desirability bias which might result in a number of the men declining to share with me, faculty interactions they might have thought I did not want to hear about. Thus, I find it important to include a sampling of the negative comments about faculty that participants were willing to share.

Narratives from the mid-career participants who recounted negative interactions were similar to the following:

> [I was] scared to death of a couple of teachers! Well, one in particular. The only way to describe her would be "Butch," very intimidating! I remember in clinicals there was a PRN medication, and she made you memorize every side effect. And, all these side effects would run together on these drugs. You're talking about memorizing a hundred side effects per day for a different patient and she would make you recite them to her at clinicals. And, if you didn't get every one of them, she was like, "Well, go ahead and review your notes because you've got one more chance, and if you don't you leave." And, if you leave a couple of times you are out of the program. So that was kind of a hair-raising experience. I don't remember the drug. I was probably, probably wasn't remembering too much of anything, I was so scared. (Ram Jones)

The three men at mid-career who shared having had negative experiences with faculty members, recalled faculty intimidation of students verging on the point of academic terrorism. Certainly, the feeling of terror still remained with Ram even years after having graduated. As he recounted the experience with his clinical instructor and the medication he was to administer, his body changed: His head and shoulders drooped forward, and he raised his left arm and rubbed his head nervously from crown to neck, in a self-comforting motion, his voice was shaking.

Participants among the seasoned nurses who recalled negative interactions with faculty centered on experiences with relatively new faculty who were inexperienced in pedagogic matters with students as the following narrative illustrates:

> We were just starting clinicals. She was kind of new at the time. She was our clinical faculty at the time, and this lady just raked us over the coals about everything. Nothing we could do was right . . . . We went to the nursing administrator and complained about her. We just didn't feel like the grading was accurate or she was being fair. (Colin Monseur)

Male nurses who participated in this study found meaning and purpose in their lives by engaging in practiced, competent caregiving as a career. Caregiving skills learned in nursing school, afforded them confidence and courage in meeting challenges in their respective workplace settings. Interactions with clients, other nurses, physicians and managers in their respective workplace settings continue to produce tensions which promote, but likewise, may stifle their growth as caring men. They care. And, they care in ways not so different or far removed from the ways their female colleagues care for sick and vulnerable people.

Institutions: Processes of Socialization and Professionalization

I analyzed institutional data collected at three phases of the socialization process: (1) choosing the institution of nursing as a career; (2) choosing and attending a non-gender-balanced educational institution; and (3) practicing as a professional RN in a health care setting. Themes emerged for each institution examined: nursing, the W, and workplace.

Why Nursing?

Power issues including a sense of financial vulnerability and powerlessness emerged as the primary theme for motivating participants to choose a career in nursing. Among the participants all but five made primary references to securing personal power resources through a steady income and job security the nursing profession was perceived to afford. Most of the participants did have prior knowledge of nursing as a career option and among those several had worked in hospital settings in previous jobs. From their viewing point nursing offered a way to advance, provide a steady income and attain job security. Certainly, Fred Johnson's comment summarizes the advancement he perceived inherent in nursing as a career:

> I was working as a respiratory therapist. I had come to pretty much a dead end. I really had gone as far as I could go. So in order to make a bigger difference, I needed to go into nursing because I wanted to be a nurse-practitioner.

Steve Thompson, however, was motivated more by a need for job security:

> [I recall] . . . a specific set of conversations I had with my brother (a physician) [about nursing as] . . . a good field to go into, a secure job . . . something you can advance in and have a secure future for your family.

And, resounding in the comments of John Wright was both the desire for job security and a steady income:

> I was working for an ambulance company at the time in Texas and I realized that people in their mid-thirties and forties, their families were having a hard time making ends meet on a paramedic's salary. And, I kept on seeing other nurses who did what I saw as pretty much the same thing I was doing in the ambulance had a lot better hours, a lot better pay. So, I started looking into it.

Emotional desire to help others emerged as a secondary theme among the twenty-five participants who had identified the primary reason for entering nursing for them as

securing power resources through their career choice and was also the primary reason given for choosing nursing among the remaining five male nurse participants.

Jackson Jones shared that as a child he was often sick and frequently ended up in the hospital emergency room. Because the nurses had such a calming effect on him and made him feel better he wanted to be able to do that same kind of work. He was the one participant who came closest to stating that even as a child he wanted to be a nurse. Jackson expressed his emotional attachment for nursing as follows:

> I decided to become a nurse because I like to help people, I like to interact with people, I like being around people . . . . I like the simple fact that you have more interaction with patients. So, you get to develop a better relationship with them. You actually get to see them improve and help them participate in their own recovery. I always thought that was just the neatest thing. So, kind of at an early age, I think I probably already decided toward going into nursing but the way society is and stuff like that: "Men-are-supposed-to-be-doctors and women-are-supposed-to-be-nurses" (shrugs shoulders and pauses). I was young, so I'm not so sure I really had an understanding of what the nurse was. I really didn't know what their role was, but I knew that was the person that made me feel like everything was going to be OK. (Jackson Jones)

For two other participants, an emotionally laden decision to pursue nursing as a career came not due to encounters with personal illnesses but with having cared for dying family members during their adolescent years.

> I had an experience with my grandparents who were both ill. One had leukemia and another one had multiple health problems. And, for the last year, year-and-a-half of their life I was involved in their care a lot . . . . (Dan Owens)

> With my dad being kind of sick all through high school, he had been recently diagnosed with prostate cancer that had metastasized, and taking care of him a long time, I thought I wanted to go on . . . into nursing. [I] . . . wanted to do something that may . . . impact on people's lives . . . Like you never touch nobody in the way [you do], if you take care of them! (Nick Wilson)

These three men challenge traditional masculinity by holding fast to an ethic of caring. Their choice of nursing as a career was due, not to purely instrumental reasoning,

but was based more on having experienced satisfaction in providing comforting care for vulnerable others in deeply meaningful ways.

Two men who had followed traditionally masculine career trajectories in their young adult years entered nursing as a second career because it was something they had always been interested in, but for which they were denied access as younger men:

> It's just something I've always been interested in. As a child my dad had some old text books lying around and I'd look through them. My father was an industrial RN for Shell Oil Company, all his life. He retired when he was sixty-two. After I'd been in the military for thirty-six months, I attempted to cross-train into medical. They wouldn't let me do that. And, I attempted again at the seventy-two month point and was turned down again. So, that's why I stayed in the aircraft field for twenty years. And, the main reason why I retired from the Air Force was nursing. Because it's just something I've always been interested in doing. (Harley Weewak)

> Well, I had always, ever since I was a child, been interested in medicine. My parents never really pushed me in that direction [but] always hearing as a child my parents saying, "Oh, I hope he grows up to be a doctor," motivated me. We had a very lucrative construction business. I was thrown into the real-estate career and it was lucrative for me, so it wasn't really feasible to change careers. When I got to an age, and nursing, at the age I entered nursing just seemed to be the most logical choice. Striving to be a physician would be out of range for me. When I got to an age I said, "Well, if I really want to go after my passion, I need to do it now or it's going to be too late." So, I just started taking one class after another and it kept my interest. (Marion Jones)

Both Harley and Marion ascribed to a more traditional hegemonic ideal of masculinity in their respective first careers. Once secure of their place in the masculine hierarchy, having proven their manhood by having earned respectful paychecks, they were free to pursue their passion.

Decision Making: Choosing and Attending the W

Relations of power and securing personal resources again provided the motivation for all of the participants when asked why they decided to attend the W's nursing

program. However, variation surfaced as to the reasons given for having attended. Three strategies for explaining why subjects selected the W's nursing program did emerge: location, reputation, and scholarship.

Location

The primary reason discussed was location, as no other baccalaureate nursing program, exists in north Mississippi. These men were all keenly focused on attaining a BSN degree as opposed to an associate degree (ASN) not only because many planned to obtain advanced degrees and the BSN is the required entry degree for advanced practice programs, but also because many had already been exposed to the door-opening opportunities for nurses with a BSN degree. That the W had a BSN program, conveniently located near their homes or communities so that they could commute rather than live on campus was also a plus for many. Saving money and not burdening family resources, was of concern to many as so aptly expressed by the following participant:

> Purely location [was the reason for my choice of the W]. Home for me is [here], and I came back here [for] family support. We had . . . two small children. My wife could work here. She had a job offer here. We had the support of family with the children and I could go to school full-time and not have as much a burden of trying to juggle family life and school life. The W was just the closest place to my home. . . . It was closer and more convenient for me to go to the W. (Preston Jones)

Convenient location of the W was defined as the primary draw for ten of the twelve seasoned nurses and eight of the nine mid-career nurse participants. But, among the nine novice nurse participants, six defined the availability of scholarships as their primary reason for attending the W. Although still a power resource concern, this may also be indicative of more macro-structural social influences on individual decision-

making, such as the exorbitant rise in college tuition and fees as federal funding for nursing scholarships has concomitantly declined (HRSA 2004).

Reputation

Seventeen of the thirty nurses identified the W's "good reputation" for producing competent graduates, as an additional reason for choosing to attend the nursing program. One man named the reputation of the W as the primary reason for attending the W. Again, a pattern, though not surprising, arose among the three subgroups of participants. Only four of the seasoned nurses named the institution's reputation as a secondary reason for attending the W's program, while six and seven of the mid-career and novice groups, respectively, did so. The responses made by participants in relation to the W's reputation, really were not surprising because earlier MUW men graduates would have had limited access to a homosocial network to inform them of the texture and quality of the education available at the institution. As more men have matriculated and entered the workforce, the W's reputation for producing highly valued and skillful nurses has become better known in the region. The following participant from among the novice group, whose father is also a nurse illustrates the results of such networking:

> The W's nursing program was spoken of very highly . . . not just to pass boards but to be a good nurse, from speaking to prior graduates (men) before I went there. It's just a well known nursing program as far as having your skills and your training. Once you graduate you're ready to hit the door running. (George Wright)

Another participant, who had worked as an emergency medical technician (EMT) prior to nursing, concurs with the comments made by George while offering a comparison between W graduates and graduates from other schools and programs:

> I have always heard good things about the W, the nursing program. I know people that have gone to other programs . . . and listening to them, a lot of them didn't go through nearly [the clinical rotations] what we had to go through. Some people and certainly some of the new graduates I see come out now don't seem to be quite as prepared as they should be. (Barker Bush)

Barker's comments are reinforced, clarified, and made more specific by another participant, also a former EMT, but with a military, rather than a civilian emergency service:

> I had just heard people say you'd get to go to these certain facilities, "These are the facilities you get to do your clinicals in." And, I think it kind of gave you an idea of where you might want to work when you get out of school. Some schools in the state only do their clinicals at one location so you don't get to see a lot. (Jackson Jones)

Barker and Jackson both had foreknowledge about the variety of different facilities the W sends students to for educational experiences and interpreted this, through informal networking with former W-men graduates, as an opportune way to assess for future potential jobsites.

Although acting on their decision to attend the W's nursing program was made based on traditionally masculine power relations, through the securing of power resources, emotional concerns about attending a university with "for women" in the name undergirded the duress felt by less than half of participants (40%). Clearly, the specter of traditional masculine hegemony was not absent.

The positive, negative or ambivalent emotions attached to attending a university with a gender-opposite name stemmed from the perception of prestige loss, particularly in the eyes of other men. One participant expressed his concern in the following way:

> When . . . a male . . . [asks] . . . "Where did you go to school?" And, you say, Mississippi University for Women, that's an embarrassing thing. I'm not going to tell you it's not. The name was the only thing that I ever felt a little

uncomfortable with and it was strictly because it was a pride thing for a man. (Marion Jones)

Joseph Brown, another participant, whose wife is a W graduate, but in a major other than nursing, recounted the difficulty he had in deciding to attend the W's nursing program in this way: "There was quite a bit of stigma attached to the fact that it was MUW . . . . Yes, it was a huge stigma that almost talked me in to not coming."

Among the seasoned nurses, only 22% commented they were concerned about attending a nursing program at a university with "for women" in the name, while 33% and 56% of mid-career and novice nurses, respectively, did so. This pattern reflects perhaps a perceived need among the novice nurses to "prove" their manhood.[16] Indeed, the novice nurses who said they were concerned with "for women" in the name of the university were all in their twenties, and just beginning to establish careers and competencies. Additionally, the novice nurses who expressed no concern about the university's name included either mature men for whom nursing was a second career or younger men who had identified male nurse role models (fathers or friends) to guide them.

Scholarship: Socialization Experiences at the W

In order to capture the meaning of socialization experiences participants were asked if they would recall any memorable or unusual experiences encountered as a man on a mostly women's campus. The responses were mixed with fourteen recounting only

[16] Kimmel (1996) discusses traditional strategies used by American men to prove manhood as including (1) work / paycheck; (2) working out or muscle-building; (3) exclusion of women and lesser men; and (4) homosocial solitude or escape to the wilderness.

positive experiences, five recounting only negative ones and eleven recounting both positive and negative (ambivalent) experiences.

The positive experiences participants recounted, centered almost entirely on access to knowledge and development of skills in a serious and scholarly learning environment. Following are comments from one participant that are representative of the others' comments about positive experiences:

> I remember taking chemistry at Mississippi State and it was a huge auditorium, classes that were anywhere from 100 to 200 students in there at times. And, just the smaller classes [at the W] make, it creates a more, a better atmosphere as far as learning. The teachers were able to focus more of their time on each individual student. I felt like the W was an atmosphere more conducive to learning and there [weren't] as [many] peripheral student life activities to distract me. (Dan Owens)

Among participants' recounting of negative experiences, two camps emerged. One group recounted a lack of campus activities reflective of men's traditional social interests such as college ball games, intramural athletics, and fraternities. As the following participant explained, it was not nearly as much fun being a man-graduate of the W:

> At the time, I think I felt a little bit de-masculinized by it. It was a small school. It had no sports teams. It's not as much fun to be an alumnus of a school that does not have a bowl game. (Carson Hyde)

Another group having recounted negative memories while students at the W, focused on power struggles with faculty, revealing a host of negative emotions toward the institution:

> There were times I just felt picked on. There were times I was singled out. I just always attributed that to being a man. I had trouble with my advisor right off the bat. I had trouble getting some of my classes scheduled, and [an elective course] legal aspects of nursing, she wouldn't let me take. She said I didn't have any experience [even though I had] fourteen years of experience in the hospital [as a respiratory therapist]. (Fred Johnson)

Although Fred was no longer angry about having his work experiences discounted by a female authority, the experience was still vivid in his memory. However, another man's anger was still clearly visible and visceral. As he recounted his experiences, his neck veins were distended, neck and face reddened, jaw set, fists clenched, and voice raised:

> I did not have a good experience at MUW within the department of nursing. I do not advocate anybody going to the W, primarily because I know there are still professors there that were there when I was there. When they get that group of people cleaned out and gone, I might be a little more open-minded. But as it is, no! I don't advocate it. Since I've been graduated, I've been very forth-coming with anybody asking me about the W and the school of nursing. "The school of nursing, go somewhere else. I don't care how far you have to drive." And, that's the bitter taste that department put in my mouth when I left there. I refused to walk during graduation. I just wanted my degree and get the hell outta there! (Preston Jones)

When I asked him what changes he would like to see made in the W's nursing program, he provided a bit more insight into the origin of his anger toward the W:

> The only problems I had with that program were strictly academic related and the decidedly lack of adequate instruction within that program. . . . [F]rom a . . . practical standpoint there was far too much emphasis on research in that program. The time and effort spent . . . on research . . . could have far better been spent on . . . teaching . . . how to take care of patients. And, then I was a paramedic with ten years of experience . . . . It seemed as though the staff there thrived on intimidation . . . and it just didn't work. It didn't go over well with my group . . . . (Preston Jones)

Preston perceived his masculine identity to be threatened by the discounting of his paramedic experiences. The labor inherent in "doing" emergency paramedic care is visible, physical, tangible work whereas the "thinking" labor tied to research is non-visible, and thus, he does not view it as valid, valuable work for men. Although he displayed this initial burst of anger, the remainder of the interview was uneventful.

Workplace Practices: Muscle, Touch and Multiproblem Patient Assignments

Gendered work practices in the men's various places of employment were described in much the same manner as previously reported by both nursing and sociology scholars alike (Bernard Hodes Group 2005; Evans 2002). Three major themes for participants emerged in relation to workplace practices. The first theme related to work expectations, centered on the provision of muscle for lifting and moving patients or restraining violent, psychiatric, or difficult patients. Not unexpectedly, a second theme also emerged regarding stereotypical suspicion of male touch in relation to the performance of technical and therapeutic procedures involving the genitals of female patients to whom the men were assigned to provide care. However, a third theme emerged, which centered on an often lesser discussed workplace expectation for men nurses, and was underscored by the voices of participants in this study. The male nurses in this study perceived that they were often assigned multiproblem patients and the most complicated cases admitted to their particular units, and they perceived they were expected to respond with cool, stoic reserve in crisis situations when providing care to such patients. Male nurses' perceptions of being consistently assigned multiproblem and complex-needs patients, presented as an interesting excavated artifact that may have particular relevance in regards to why men nurses leave the profession at such a higher rate than women.

Muscle-Men

All thirty male nurse participants identified lifting, turning, moving and restraining patients as an every day job expectation. The majority of participants accepted

this expectation as what-male-nurses-do and assessed men as having greater physical strength than women, thus ascribing to an essentialist view of gender differentiation. The following demonstrates this taken-for-granted expectation:

> We are used a lot of times because we are male to lift patients . . . . That's just part of the male nurse's job. . . . It [has] mostly . . . to do with having the strength to lift a patient or do something a female nurse could not do to safely detain a psychiatric patient where the female nurse is physically overwhelmed by them. (Dan Jones)

The men made clear that women nurses do lift, turn, move and restrain patients as well, and seemed to do just fine with this task when no male nurses were on duty. However they hinted that women nurses seemed to defer to them for such activities when men nurses were at work:

> Female nurses. . . appreciate having a male nurse around to help with some of the lifting, tugging and pulling because so many of our patients are in bed, in traction and they really appreciate a little muscle being around. I don't feel misused, or overused doing it, but they appreciate there is extra muscle around. And, I'm glad they do. It makes me feel appreciated. It doesn't make me feel put upon. (Carson Hyde)

Although participants accepted the expectation for lifting as a duty for men nurses, many were not as exuberant nor did they feel as appreciated as Carson:

> I have no problem doing anything out there that a female does. It just goes back to heavy lifting, always: "Lift this patient, lift that one." I wonder what if I wasn't here, how would they do it. And, I understand that I have more muscle and things like that, but it just gets overwhelming some times when I'm the only male on my shift. (Bob Flowers)

> We're called to other floors and other places throughout the hospital to help with patients: lifting or if they've fallen on the floor. Of course we're always happy to go if they need help but . . . sometimes it puts us behind helping turn and roll and get the patients up. (Jackson Jones)

Not only did participants cite concern for completing their own patient care duties when consistently called upon to lift patients, but many were also concerned about their own physical well-being:

> The men do all the lifting work (laughs). So it's tough on our backs. I've got a bad back from pulling up 300-pounders on a daily basis. (Ram Jones)

> Lifting patients, turning patients; I have some gutter humor I've mentioned on some occasions: "My male member is not the handle on a Hoyer lift." I can lift. I'm 40 years old and in questionable health, and it needs to be a team effort. I'm not up there to lift all the patients. I'd be home with my back on a heating pad. (Owen Wellons)

Among the participants, even among those who held an essentialist view that men possess greater physical prowess than women, many questioned the utility and certainly the equity of the workplace expecting men nurses to do all the heavy lifting. As Owen expressed, a team effort is required for the demanding physical labor involved in providing care as well as consistent use of lift-assist devices.

Suspect Touch and Getting the Job Done

Male nurses' touch, often regarded as suspect, was viewed by participants as having originated in broader culture and not just an artifact of the health care industry. Yet, recognizing this did not reduce the anxiety these men nurses encountered when faced with an assignment requiring performance of intimate or genital related therapeutic treatments or procedures for a female client:

> I hated going in there and asking: "Ma'am, I'm fixing to put in a Foley." You feel a little funny cause that . . ., in public, that's taboo. You know, you just don't mess with private areas. (Dave Wayne)

Many of the participants expressed concern about being rejected by their female patients or that they might somehow damage the nurse-patient trust relationship by

performing intimate procedures and thus requested other female nurses perform such procedures for them or act as chaperone while they performed them. One home care nurse who had previously worked in an ICU did not have that same concern in the home setting caring for female patients. He made mention of the following which seemed to underscore patient vulnerability in the hospital setting as a possible reason for patients desiring same-gender nurses for intimate procedures:

> In home care I can't think of a time I've been asked that. People are more comfortable at home . . . . They're in a familiar environment and I think a lot of that, they're scared and in an unfamiliar environment [in the hospital]. And, I'm sure they want something they can have a little control over. Then why not just get a . . . female nurse to do it? (John Franks)

Certainly, any male or female patient in their own home would have a greater sense of control as well as a decreased sense of vulnerability. However, in the home setting another nurse is not readily available to call upon. Thus, strategies for overcoming social suspicion regarding men's touch must be developed as the following comments suggest:

> Occasionally [I would] get a patient that [was] really uncomfortable with a male putting a Foley in a female patient. But usually after you went in and spoke to them a little bit, they caught hold of the professionalism and knew you were there as a nurse, not as a man. (Dave Wayne)

> A lot of females . . . if they're having . . . pain they don't care if they need a Foley. It's like "Hey, get it done," to resolve the problem. A lot of it is if the nurse is professional. That's what people want is someone who is professional; that will come in and do the job and take care of them. (Spock Andrews)

Developing strategies for dealing with gendered touch issues that nurses often encounter in practice begin in nursing school. The sensitivity of faculty regarding men student's anxiety in caring for female patients can enhance development of positive strategies available for use in the workplace. One participant described an incident that

had occurred in the week prior to our interview with a current male nursing student who had come to him with his concerns about his upcoming maternal-child rotation in the spring semester:

> Every man in the maternal-child rotation is worried about being accepted or not. Most of those departments don't have men but you still have to get your rotation in. And, I just related to him my experience at the W. My professor picked the patient out for me. She went in ahead and talked to the patient and got permission and brought me in and introduced me. I got to do everything the other female nurses did: I massaged her fundus, I checked her lochia, I checked the episiotomy site, the whole nine yards. I attribute that experience to my instructor. She went with me for my first examinations only. I think that was primarily for my sake as well as the patient's sake. She took the professional route. She recognized the fact that I needed the experience, but she was sensitive to the patient's concerns and needs. And so, she ensured that I got the learning experiences I needed without interfering with patient care. My gender does not interfere with my patients' care. I can say in the years I've been a nurse, I've never been asked by a patient not to take care of them. (Joseph Brown)

Another participant concurred with Joseph's comments:

> The OB-GYN area has never been something I was comfortable with as a male nurse. I talked to the instructor of the clinicals and . . . she knew about my apprehension and so I think everything was real professional and it worked out real well. The only thing is that you got to keep the door open for that communication and I feel it was there with the faculty. At the W, I found that support. And, I hope they still have that because guys sometimes want to be macho and not talk about these things. (Rusty Shackleford)

Nursing education curricula are nationally standardized so every student male or female must complete a maternal-child clinical rotation in order to graduate. However, insuring positive experiences as described by the preceding participants depends on a host of willing actors beyond student, faculty and patient.

Depending on the worksite culture, participants were either advised not to catheterize female patients, either through verbal edict from the nursing manager or

through a loosely structured quid-pro-quo arrangement developed among men and women coworkers. Illustrative of the former are the comments shared as follows:

> Oh, there's one other thing I've been asked not to do in the hospital. Women can do private things to male, men patients throughout the spectrum; I can't on the other hand. The hospital does not want me to do anything that involves genitalia or below the belt on a female. It's alright if they are old or confused or I have a female with me. But, I was told that I could not cath a younger woman. You know, I always ask, "Would you feel more comfortable with a female nurse?" And, I always took somebody with me, a female witness. But that was the news the other day. That came down from the big boss; that men did not do that. (Owen Wellons)

The following comment is emblematic of an informal strategy developed among coworkers at participants' workplaces. It involves trading off tasks so that gender same nurse-for-patient can be achieved for implementing intimate procedures. Participants expressed satisfaction with this strategy because patients were less uncomfortable and unit cohesiveness was encouraged among members of the work group:

> We don't have any policy that addresses that at all. It's just kind of a nursing judgment call that you just try to involve the patients in the decision. Everybody that I've worked with has been willing to trade off with tasks like that, because it also happens the other way. There's times when a male patient may not want a Foley catheter put in by a woman. I just feel like it's just a kind of fair trade. I have had good people to work with; it just kind of works itself out. There's so few staff members we have to depend on each other. (Dan Owens)

One African American participant hinted that an intersection of race and gender influenced his care when I asked him if there were any procedures he was not permitted to do at work:

> [S]ome older [white] female patients that need a catheterization; they will ask a female do it, a female nurse. . . . But a lot of people from the . . . [19]60s on . . . I see a change in attitude in females. . . . So, there is a change in attitude toward that male-female type change. Just as long as you will take care of them that's what they look for. (Spock Andrews)

I found Spock's response interesting because the majority of white men nurses had opposite experiences with elderly white female patients. The white males had no problems catheterizing elderly women of any race; however, tensions for them arose when assigned adolescent or young adult women of any race who required urinary catheterizations.

Urban and rural differences were also noted in relation to institutional practices that permitted or disallowed intimate touch procedures by male nurses with female patients. When I asked another African American participant who worked in a large metropolitan medical center specifically about female catheterizations he responded as follows:

> They pretty much encourage us to do our own. They don't care if you're male or female; if we are capable of doing it, we're doing it. I do pelvic exams down here, rape kits, Foley catheter placements, if they need a rectal tube placed; pretty much any and every thing. (Nick Wilson)

In stark contrast to the experiences described by Nick are those that follow as described by a nurse manager of an emergency room in a small rural hospital:

> We don't go in and do pelvics and vaginal exams or set up ladies for pelvic exams without a female escort. . . . In fact, I ask the male nurses in my department: "Do not do that." They do not do female related procedures. They will have a female in there with them . . . to chaperone. (Preston Jones)

Perhaps the depersonalization common in large metropolitan centers allows Nick to practice without the traditional southern constraints imposed in smaller communities as in the rural community where Preston resides. Although Preston would most likely know many of the patients who seek care in his emergency room, it is less likely that Nick would meet his patients in social settings outside the hospital facility.

Multiproblem Patient Assignments

A third workplace expectation described by participants demonstrated a particularly dark and often insidious side of hegemonic masculinity. Dark because men are often asked to deny bodily cues indicative of stress which can result in personal poor health and insidious because men are taught that doing-a-good-job means taking on an ethos of iron-man capableness. Identities become so steeped in this image that men who do not endure and push physical limits perceive themselves as less than manly. Rusty Shackleford's comment is a reminder here: "Guys sometimes want to be macho and not talk about those things."

Participants described being consistently assigned the most complicated, multiproblem patients on their units. They were often assigned these types of patients when more experienced female nurses were available and when they were novice nurses, not yet ready to competently take on such responsibility. Additionally, participants often described expectations at their respective workplaces for them to deny their physical needs, work excessively long overtime hours, and to respond to crises with cool-headed, take charge attitudes. The workplace expectations as described carry many of the hallmarks of hegemonic masculinity such as: "Real men" know how to get the job done, are physically powerful and endure pain and bodily cues indicative of physically stressful insults, and lead in adverse situations as calm commanders. Typically, comments regarding concerns were scanty and could easily have been overlooked as the following comments made by participants illustrate:

> I worked in a level I hospital that was the biggest ICU in [that] state and we saw some really harried situations. The guys that . . . I worked with, we'd have to take charge in that type of situation . . . . (Ram Jones)

> I usually took care of patients like the post-bypass patients with a little more equipment on them. You sorta see more men in the ICU and ERs get drawn to the more technical gadgets. I don't know if it was because I'm male. Because taking care of more critical patients, I was asked to take care of some of those. (Dave Wayne)

> A lot of times they will, I don't know if it's they feel confident in a guy . . . . I think they are more comfortable talking to me if they have questions about a patient or about heart rhythms and stuff like that. (Tay Diggs)

At interview with the three participants above (Ram, Dave and Tay) I felt that my gender did suppress their responses. Intuition informed me they were reluctant because they did not want to sound as if they were complaining about their workplace practices. Other participants hinted they thought more was expected of men nurses:

> Sometimes down here [in the ER] and me being a guy, a little more is expected. It gets physical . . . . I don't mind doing some tasks but physically with the restraining of the patients and heavy lifting; on a bad day, it can get really bad. (Nick Wilson)

> I think sometimes men are looked to accomplish more. You're not only expected to carry your load but you're supposed to help with theirs also. (Mark Willis)

Other participants were very forthcoming and helped illuminate the more veiled concerns of other participants who were less so. The following participant shared a longer narration regarding his concerns:

> In my experience, as men we are sometimes given harder assignments because they think we can handle it a little bit better, like stress. I've asked them, "You think maybe we should let some of these other ones take 'em so they have the experience?" And generally, the response I get is, "Well, we know you can handle it." And, my response . . . to that is, "I can handle it, but maybe I don't want to handle it all the time. Maybe it would be nice to have a break and to share the work load a little bit more." I don't remember being allowed to say, "I don't feel comfortable with that assignment," or "I don't feel comfortable taking that yet." (Jackson Jones)

Later in the interview Jackson came back to this theme with a specific patient example:

> We had a patient in OR whose right ventricle was cut through during the operation. The [administrator] . . . came over and told my charge nurse that he needed a nurse to go back to surgery to take care of this particular patient because they could not bring him off the pump and safely transport him. I was elected to go. I wasn't given a choice. I was told I was going. So, I went over there and she asked me, "Who do you want to stay with you tonight?" This was around 5:30. I kinda looked at her like, "Are you serious? I've been here since 9:30." And basically the bottom line was, "You're not leaving." I chose another male nurse who I knew would be willing to come. At 9:30 the next morning we called my charge nurse who was back that [next] morning and I said, "Someone's got to come over here and relieve us, we are running on fumes." (Jackson Jones)

The other male nurse Jackson referred to was also another W graduate and participant in this study. He confirmed that he is also assigned the most complicated cases in the ICU where they both worked at the time, although on opposite shifts:

> They tend to put me with the heart patients . . . they just say I'm good with them. I'm not real sure. It's kind of funny that . . . guys that work in ICU . . . are better with the heart patients. But there's me and this other guy that graduated ahead of me and he's good with heart patients too: bypasses, balloon pumps, Swanzs, valves . . . . I think it's the mind set of how well you can handle yourself when something goes bad, because those patients tend to go bad real quick (snaps fingers). There was one situation where a young man had bypass surgery. They couldn't get him off the bypass machine . . . . So instead of moving him to the unit they moved . . . me and one other guy . . . in the OR. [We took care of him] the whole shift; me, him and the surgeon. (Colt Cox)

Colt also allowed me to observe him at work in the large ICU where he works, and I can attest to the grueling pace he encountered for what he called a "normal shift:"

> Twelve-hour shifts are hard and seven, twelve-hour shifts [84 hours in a pay period] is a lot of time! It's not safe to do any more than that, not with this kind of patient, and they call me for overtime all the time. (Colt Cox)

Colt has been at the work of nursing for less than five years, one of those among the novice group of participants. Jackson, although among the participants with five or

more years experience at the time of our interview, would have also been among the novice group at the time the patient scenario described above occurred. Not surprising is that both have retreated from the ICU and returned to school for advanced degrees. With little power over their labor practices as nurses they were dissatisfied with consistently being expected to push to their physical limits. Of major benefit to their careers were those prime experiences with multiproblem patients (experiences denied female nurses with more or at least equal experience) because they served to expedite entrance into graduate nursing education for them.

It is well established that men enter nursing with the same desire as their women cohorts: to care for vulnerable persons. The men who participated in this study were no different in that respect. They desired that their labor in the workplace exemplify the nursing values that serve to mark the "good nurse." Providing compassionate care, active listening, being a patient advocate, respecting confidentiality, keeping patients and their family members informed, comforting patients, applying the Golden Rule and even offering mothering nurturance were phrases most frequently used to describe experiences in the workplace recalled as best examples of nursing labor and the caring inherent in that labor. However, institutional gendered workplace practices too often were recounted as having worked to thwart the ability to be a good nurse, as the above narratives have hinted. With a sense of longing, one participant summed the dilemma he encountered in being restricted from delivering the caring labor required to be a "good nurse" and yet, meet the expectations of being a man who happens to work as a nurse:

> Caring, that's what makes you a nurse. And, even if you get tired of caring about some people you still have to care about them. Compassionate listening, that's how you build trust with patients. It's very hard . . . the way hospitals are run . . .

> you don't have time to build up nurse-patient relationships . . . there's so many . . . different things expected, you don't have time to spend listening to people. (Brad Jones)

The male nurses in this study touch lives, are motivated to make a difference in people's lives, feel emotions and share the same concerns about patient care as do female nurses. Yet, the men in this study also revealed that tensions do reside in the interactions and institutions that influence their identities as caring W-men nurses.

CHAPTER V

CONCLUSIONS

In this chapter, I will discuss conclusions drawn from the study findings about the processes a group of male nurses who attended a formerly all-female university used to negotiate masculine identities in a predominantly female profession. Conclusions drawn about the men's recounted experiences of performing masculinity in distinctly female-oriented educational and work environments will be discussed. Additionally, conclusions about the institutional labor practices and interactions these men described as problematic for them will be summarized. I will follow with limitations of this study, implications and recommendations for the future.

To reiterate, the overarching purpose of this study was to explore how men in nursing who graduated from a formerly female-only university negotiate masculinity in the predominantly female profession in which they work. To satisfy the purpose of the study, three objectives about men in nursing were accomplished. First, I explored the reasons male nurses recounted for having chosen nursing as a career as well as recounted reasons for studying at a university with a predominantly female student body for nursing school rather than at a university with a more gender balanced student body. Second, I explored socialization processes and experiences male nurses recounted while students

at Mississippi University for Women (MUW) as well as recounted professionalization concerns encountered in respective workplaces for the meaning they hold for them. Third, I explored recounted and observed labor practices and communications of male nurses as they cared for patients and interacted with others in the work environment. I utilized the gender theories of both Connell (1987; 1995; 2000; 2002b) and Kimmel (1987; 2000) as guides to collect and explore data in order to better understand the meaning inherent for male nurses whose masculine identities are negotiated in doing work deemed a feminine project by cultural dictates.

Summary

In the process of becoming a nurse, the men in this study revealed they encountered two major decision-making junctures. First, they had to choose nursing as a career, and once having made that decision they were faced with decisions about a college of nursing for attaining a degree in nursing.

Although motivated to choose nursing because of job security and a steady income the profession appeared to offer, the men in this study were confronted with stereotypes about male nurses early in the decision making process regarding career choice. Stereotypes about sexual preference and effeminate caring characteristics forced the realization for these men that male nurses, more often than not, are viewed as belonging to marginalized, subordinate, or at best complicit masculinities. Certainly, they encountered that the measure of manhood for them as working men was not going to be based entirely on income and family providership. A number of participants recalled

their male friends thought they were weird or bizarre for wanting to be a nurse. Therefore, many felt their identity as a man was attacked for desiring a career in nursing.

The images of male nurses portrayed in popular culture are scanty and not favorable for encouraging men to choose nursing as a career. Without a more favorable campaign to counter the existing images of male nurses as effeminate, marginalized men, it is unlikely that stereotypical images will be changed. To the eleven men who granted me participant observations of them at work, I presented the Oregon Center for Nursing, campaign poster card and asked them to comment about the message the card portrayed to them. The poster card depicts male nurses as tough men dressed in after-work leisure or recreational attire, and is used to aid recruitment of men into nursing. All but one participant thought it was "realistic" and depictive of various leisure activities that men engage in after work. However, they also thought a campaign depicting what they do at work, rather than after work, would be more effective for recruitment into nursing. The Oregon Center for Nursing is one center of nursing that is currently attempting to actively recruit men into the profession. The men in this study questioned the effectiveness of such current campaigns, especially if the campaign did not somehow depict the work men are engaged in as nurses.

Decisions to attend the W's nursing program were steeped with tension about potential prestige loss for not having attended a college with a more gender-balanced campus. Though the men said they based their reason for having attended the W on the utilitarian and instrumental motive that it was the only BSN program nearby, many ambivalent emotions about attending a university with "for women" in it's title remained attached to that decision. For many, the university's name, with "for women" in the title

presented so much stigma for them as men that they were given more than just slight pause regarding enrolling into the W's program. While some found it difficult to tell people that they had attained their nursing degree at a "for women's" university, others playfully introduced themselves as "W-girls" after having graduated.

During the time that they were students at the W, the men encountered a nursing curriculum nationally standardized by external accrediting bodies in a predominantly gender-opposite environment. One man in this study recalled the first semester he attended only eight men students were enrolled on the entire campus. Among graduating nursing classes, no more than nine men have ever matriculated within a single cohort. The experiences these men recalled revealed images of isolation, not because faculty and other students shunned them, which was certainly not the case, but rather they felt isolated because they were surrounded by an unfamiliar feminine terrain or habitus and did not have available to them the taken-for-granted masculine habitus with which they were familiar. Unavailable were fraternities, sports and bowl games, and male faculty role models. In retrospect however, they viewed having attended the W as having been a good learning environment devoid of many of the distractions that fraternities and sports present.

Interestingly, solidarity among male students on campus may have been enhanced by the experience of having fewer men in close proximity with which to compete. Participants described how male students on the W campus supported each other without having to say anything to each other. Verbal declaration of support was not necessary because the men shared a familiar male habitus that spoke to them without words.

Interactions and relationships with faculty were recounted primarily as positive ones. Nursing faculty members were viewed as having invested time in preparing them for a future in the nursing profession. Rather than just teach them how to do the skills necessary to care for sick persons, they viewed faculty as having vested them with how to be nurses by encouraging and inspiring them to be courageous and by modeling compassionate caregiving.

Kimmel (2000) contends that men who attend male-only learning institutions are taught that women cannot do what men do. On the other hand, he suggests that women educated in same-sex settings learn that they can do anything. However, he is mute regarding what men might learn by attending college on a predominantly female campus, with the express plans to enter a discipline traditionally deemed for women. It is not surprising that Kimmel overlooked this possibility because there are so few higher education institutions that do afford such an opportunity. This study, however, did consider such a "what-if."

The men in this study had attended Mississippi University for Women, a university formerly for females only. They entered the W's nursing program in order to prepare for work in a predominantly female profession. Participants revealed that while students at the W, they learned to communicate and order their lives in unanticipated ways that have benefited them, not only in their professional careers, but also in their personal lives. Specifically they learned about: (1) the synergy inherent in egalitarian, horizontal reciprocity; (2) the value of acknowledging feeling and emotions; (3) the satisfaction in caring compassionately and competently for vulnerable persons; (4) the

benefits of engaging in healthy lifestyles and avoidance of risk-taking behaviors; and (5) the satisfaction of relating to women in school and the workplace in unique ways.

Even though many of the men were initially concerned about the stigma attached to choosing nursing as a career and attending the W for nursing school, they did not encounter these types of barriers once in various healthcare workplace environments because men, nurses and other health care providers, were found in abundance in the institutions where they work. Choosing a workplace site that had more men in the unit to relate to, was a strategy used to reduce or deflect feelings of having their manliness attacked. Workplaces in the hospital such as the ICU, ER, and OR where technology reigns appealed to these men. However, for the men in this study, gravitation to specialty units had little to do with avoiding touching patients or demonstrating technical prowess as previous research has asserted (Evans 2002). Rather, in specialty units, these men could interact socially within the habitus of other men and relate to honor codes inherent in scientific men's communications (Nye 1997). The presence of a number of gender-like others' drew the men in this study to specialty areas, thus, resulting in significantly more men working in those areas than in other places in their respective healthcare institutions.

The professional work practices or actual labor practices of these male nurses were undergirded by an ethic of emotional caring, non-characteristic of hegemonic masculine power. Professionalization in the men's respective workplace settings meant for them maintaining practice competencies in caregiving skills and engaging in continuous learning about the latest advances in caregiving practices, not unlike the expectations for female nurses engaged in caring employment. However, these men

concurred with male nurses in previous studies that they are routinely expected to provide muscle for heavy lifting, and their touch is treated with suspicion because of deep-seated cultural and institutional practices (Bernard Hodes Group 2005; Evans 2002; Guiffre and Williams 2000).

Unlike the findings of previous studies (Bernard Hodes Group 2005; Evans 2002; Feldman 2005), these men revealed that they are routinely expected to respond with stoic reserve in crisis situations and are often assigned patients with multiple problems requiring complex care. Before they felt prepared or comfortable with providing care for patients with multiple needs the male nurses in this study were asked to care for complicated cases without experienced supervision and guidance. Though female nurses with more and/or at least equal experience were available on the units where these men worked, it was perceived by participants that female nurses were permitted to voice concerns about complex patient assignments, while as men they could not voice similar concern. A male nurse's reluctance to accept an assignment could signify vulnerability or incompetence resulting in attenuation of his identity as a man. Ascribing to an ideology of hegemonic masculinity carries with it the burden of an iron man ethos that disallows men from revealing vulnerabilities (Cassell 1986).

Study Implications

Unrealistic and non-validated expectations that stereotype male nurses as better equipped to handle complex patient needs and technical equipment just because of their gender can lead to nurse burn-out, as well as promote detrimental outcomes for patients. Additionally, consistent use of unexamined and non-valid assignment making practices,

such as assigning the most difficult patients to only a select few caregivers, limits the flexibility and skillfulness of the entire nursing staff. When a nurse exits a unit because of job dissatisfaction and burn-out, he (or she) takes with him (or her) stores of knowledge and technical competencies about patient-care specific for the unit. To restore the knowledge lost when a seasoned nurse exits a nursing unit requires significant amounts of time and energy to impart to a novice. The idea of spreading the knowledge around to all nurses working on the unit becomes a most salient management activity when assigning patients to nursing staff members.

An implication of grave importance for patient safety centers on the acceptance of patient assignments when the nurse knowingly is not prepared to do so because this positions the health outcomes for patients in jeopardy. Nurse managers should consider how taken-for-granted ideas regarding gender may influence patient assignment making. Until nurses at the bedside are fully comfortable with providing highly competent care for complex client needs, nurses, regardless of gender should be placed with a seasoned nurse-mentor to provide expert backup to the novice.

An equally important implication can also be surmised from the workplace labor practices as revealed by the male nurses in this study. Continued lifting of patients without consistent use of assistive devices or team effort can result in personal back strain and possibly preclude continued practice as a nurse. Additionally, violation of culturally ascribed touch norms with either gender can result in rejection of the nurse's care by a patient. Both of these workplace practices directly affect the individual nurse, and can result in job dissatisfaction, contribute to injury or burn-out, and subsequently result in exodus from the profession thereby deepening the shortage of nurses. Even though,

lifting and touching are two workplace labor practices long recognized as normative expectations that have been apprehended and discussed, only cursory strategies have been developed for resolving the tensions they create for male nurses. Health care managers would do well to insure the availability and usability of assistive lifting devices on every unit. Also, managers should insure all employees are trained through routine provision of inservice education programs regarding proper use of assistive lifting equipment.

Nursing, as a profession, and healthcare workplace institutions continue to engage in gender blindness as well as the pretense that gender does not matter in the delivery of patient care. But gender does matter and does influence, as these men revealed, whether patients are assigned the most competent and experienced caregivers available. Unexamined gender expectations of male nurses can and do result in nurse managers making inappropriate care assignments. A number of participants shared that they are routinely assigned the most complicated patients on the respective units where they work. They suspect their respective managers continue to assign them difficult patients simply because they are men, and "men can handle it."

An iron man ethos or mentality also encourages male nurses to deny personal needs which mean they may not be at their best for assessing, diagnosing, and responding appropriately to rapid deterioration in a patient's status when they work excessive overtime or ignore physiologic signals of pain and discomfort. Gendered hierarchies in health care institutions which position males (doctors and administrators) as authorities in control of females (nurses, secretaries and assistants) combine with an iron man ideology that results in male nurses being pressured to accept excessive overtime and to deny physical needs. The response male nurses make in regards to these pressures often means

that they will move up and away from direct patient care through job change or pursuit of graduate education, as William's "glass escalator" informs (1995a).

Not one of the men in this study felt powerful in the work setting. Even though they did acknowledge they were successful and competent at what they do, they did not posses the degree of autonomy and control over their respective practices they had anticipated at graduation. Indeed, the measure of manhood among U.S. males falsely informs men that power is a characteristic or trait to be possessed (Kimmel 2000). Power, however, does not reside in the individual but rather in groups and institutions. The men in this study find it difficult to respond to and are disoriented by gendered, institutional, top-down, silo-type communications. They recognize the disadvantages and inequities such interactions place on the shoulders of women colleagues, and they feel impotent in effecting change in the institutions where they work to remedy the situation.

For the male nurses in this study, their respective identities as successful professional nurses centered on providing competent, compassionate care to vulnerable patients. Interference with the provision of the kind of care they were trained to provide (what-they-do) provides fodder as to why men leave nursing at a far greater rate than women, because their identity as competent caring men is violated when they are consistently placed in situations where they are rendered incapable of performing as "the good nurse." For the men in this study, "the competent nurse" equals "the good nurse." Previous studies have concluded that improved workplace environments, which included reductions in both forced and elective overtime, reduced the likelihood that nurses, both men and women, will leave the field (Page 2004).

Through interactions with others in their respective places of work, these male nurses' identities as masculine men-who-care were forged and continue to be tempered. Interactions with patients were undergirded by altruistic caring and compassion as well as a dogged pursuit for rooting out, understanding, responding to and resolving potential and actual patient care problems. Job satisfaction as nursing caregivers came not only when the care the men provided was acknowledged by the patients and/or their families but also by seeing positive results in their patients' health status because of their therapeutic interventions. Positive patient outcomes signified for them that they were performing responsibly and competently.

Therapeutic procedures requiring touch, particularly procedures requiring intimate touching of female breasts or genitals required the men to strategize around culturally imposed limitations of men's touch. Some strategies included enlisting female chaperones or family member's assistance, using patient's clothing or draping as barriers, and employing loosely developed systems of task exchange with female coworkers so same-gender, nurse-to-patient care, could be enacted. When these primary strategies were not available, male nurses communicated a "professional nurse image" to gain female patients' acceptance for completion of tasks or procedures. Until male violence, images of masculine touch violating or raping women, can be eliminated in larger society and women are no longer seen as sex objects (which will not likely occur any time soon) men's touch will remain suspect. The male nurses in this study responded to this suspicion in ways that demonstrate cultural competence by performing intimate tasks in a manner acceptable to the patients for whom they provide care. Indeed, gender matters.

Violence, inherent in hegemonic masculinity, limits and binds the practices of men in nursing and can push them from continuing to engage in caregiving activities.

Interactions with fellow nursing coworkers, for the most part, did not involve hierarchal power displays characteristic of hegemonic masculinity. Rather, interactions with female nurse colleagues were marked by respectful horizontal reciprocity. Though the men did suggest they often desired the presence of other men with whom they felt greater comfort in communicating, they were pleased with the trusting work relationships developed with female colleagues. These men shared that being more aware of the concerns of their female coworkers helped them recognize areas for improvement when communicating with spouses and/or future partners, although tensions did remain in communications and relations with female coworkers when other males, particularly physicians, were involved.

Interactions with male physicians frequently served as sources for producing relational tension between male nurses and their female coworkers. Male nurses in this study were complicit with male physicians regarding what Nye (1997) described as male honor codes. The men in this study spoke of an "unwritten, unspoken respect" among the male nurses and physicians with whom they worked that was not present between male physicians and female nurses. Additionally, they acknowledged the taken-for-granted masculine respect and honor connections they had with male physicians placed their female colleagues at a greater disadvantage in communicating effectively with physicians.

A most damning implication about the interactional disadvantage female nurses encountered with male physicians was that patient safety could be jeopardized.

Additionally, physicians were reported to frequently ask male nurses to check on patients behind female nurses, thus discounting, disregarding and devaluing the female nurses' capableness. Being complicit with such requests made by male physicians undermines the trusting reciprocity developed among male and female nursing coworkers. Yet, if the male nurse does not comply with requests made by the "top-guy-in-the-hierarchy," he risks violating the codes surrounding male honor and may lose respect in the eyes of the (powerful) male physician. Thus, it is not surprising that male nurses do not refuse and subsequently check up on their female nurse colleagues' work. However, when male nurses comply with such requests made by male physicians, they create tense and difficult working relationships with their female coworkers, resulting in decreased synergy and efficiency, which may result in adverse patient events. Connell (2000) asserts that masculine performances are for the benefit and evaluation of other men. Therefore, it should not be surprising that male nurses most often comply with male physicians' requests rather than refrain from discrediting female nurses' labor.

Recommendations

Currently, a severe nursing shortage threatens the very foundations of the U.S. health care system. Enhanced recruitment of men into the profession has been suggested as one strategy to relieve the shortage (Sigma Theta Tau 2001). However, the utility of such a strategy has also been questioned because the numbers of male nurses in the U.S. workforce has never been significant, and men leave the profession sooner and at a higher rate than do women (Page 2004).

Recent studies confirm that adequate surveillance by experienced RNs safeguards patients, prevents patient injuries, and is associated with better patient outcomes (Page 2004). However, nursing staff experiential levels are threatened in American healthcare facilities, particularly hospitals, by high turnover rates (Page 2004).

The narratives of male nurses in this study suggest that taken-for-granted ideas about masculinity negatively influence the movement of men into nursing. For the few men who resist hegemonic masculine ideology and forge onward into the profession, negotiating masculine identities as competent compassionate caregivers is not a simple process. The W-men in this study struggle with images of the "real man" or the "ideal man," often complying but sometimes resisting these masculine images prevalent in contemporary culture. They do not recognize the hidden power inherent in gender, the power gender exerts in structuring and ordering everyday relationships, advantaging some men but disadvantaging other men and all women. But, they do realize with unease that gender inequities exist in the places where they learn and labor; this realization may offer hope, a starting point, for gender equity within the healthcare arena in the future.

It will not be an easy task to move toward gender equity in healthcare environments, but the results, for both men and women nurses, are worth the struggle necessary to hoist beyond existing obstacles. The following are some recommendations for moving toward more democratic gender relations in health care institutions.

Recommendations for Education and Workplace Institutions

A number of recommendations can be suggested to education and workplace settings based upon the conclusions of this study. Broadly, in educational and workplace

settings efforts to recognize and protest the formation of gender-apartheid arenas, or "islands of masculinity," should become a priority. Efforts should be placed on promotion of consistent and persistent interaction between men and women nurses beginning in centers of nursing education and continuing into the workplace.

A strategy for increasing interaction between male and female nursing students can be accomplished by consistently placing male and female students on the same clinical, research and project teams, rather than placing all male students in one group. The men in this study said they benefited in both their work and personal lives because of the persistent interactions with female colleagues they encountered.

Faculty should also assist nursing students to recognize the significance of gender in structuring relations of power, labor, emotions and communications so they may be better equipped to deal effectively with gendered, hierarchal communications with physicians and managers. This could be accomplished by offering a course on gender relations in health care or by tracking a gender-issues thread throughout the curriculum. Faculty should also assist students in recognizing that power is not a characteristic or trait which can be possessed; power does not reside in individuals but rather in institutions (like universities and hospitals) and aggregates (like physician or nursing organizations).

Finally, nursing faculty should also become more aware of the way gendered language influences students' images of what it means to be a "good nurse." Faculty members are advised to avoid referring to the nurse as "her" or "she" and to use more inclusive gender-neutral terms. Additionally, faculty members are encouraged to become more aware that a masculine habitus and male honor codes may render male nursing students less likely to ask female faculty for assistance and guidance when learning to

care for patients in clinical rotations. To ask for assistance or guidance is risky for them because they may fear they will perform inadequately, and ". . . men are unsexed by failure" (Kimmel 2000, 117). Thus, nursing faculty should make certain that both male and female nursing students receive equal observation, guidance, and direction in the clinical learning environment.

Among nursing administrators and managers in health care institutions, levels of awareness should be raised regarding how gender matters in regards to quality patient care. First, nurse-managers would do well to balance the number of men and women nurses in specialty units such as ICU, ER and OR and recruit men heavily on medical-surgical, women's and pediatric units, as well as into settings such as home care and hospice. These are areas traditionally thought not technical enough to hold men's interests, but higher acuity levels of patients and shorter hospital stays now mean all hospital units are specialty units with technical equipment that is patient population specific. Therefore, previous rhetoric used to explain why nursing specialties are segregated by sex are negated and new explanations for the formation and maintenance of gender-apartheid arenas in the nursing profession must be explored.

The men in this study demonstrated just how patients can be harmed when male nurses are complicit with a male-physician-ethos that exiles female nurses to the lowest level of the health care hierarchy. Therefore, nurse managers should recognize when male nurses comply with an ideology that declares male and female nurses are not on the same level in any way, patient care teamwork is undermined and patient care errors may rise. Additionally, nurse managers who increase the interaction between male and female

nurses by placing them on the same nursing teams and units should anticipate greater teamwork with resultant enhancement of patient care outcomes.

Another recommendation for nurse managers, centers on avoiding the gender pitfalls inherent in assuming male nurses can handle stressful situations with greater ease than female nurses. Certainly, both women and men nurses work long hours, often enduring beyond physical limits, engaging in both elective and forced overtime. And, both men and women nurses are assigned complicated, multiproblem cases before they may be ready to provide care with a high degree of competence. However, institutional culture may often permit novice female nurses to express reservation about taking on such assignments, while masculine honor codes inhibit novice male nurses from expressing like-same reservations. The consequences to be anticipated for patients cared for by lesser experienced caregivers include adverse patient outcomes due to medication errors, procedural mishaps, or scheduling delays. When nurses fail to deliver the degree of quality care for which they are trained to provide for all their patients, nurse-employee job satisfaction can be expected to diminish.

A major question this study has produced for the nursing profession (including education, management, research, and practice elements) is whether the profession should continue to engage in gender blindness. To do so ignores not only male habitus and honor codes which influence the development of an iron man ethos among men in health care, but also promotes an inhospitable environment for male participation. Additionally, the image of male nurses may be in the midst of a cultural transformation. Consider that in a very short time our culture has moved from depicting a male nurse as the bungling and adorably sweet protagonist in the movie “Meet the Parents” to the

current popular television show which depicts a male nurse as a smart, proficient and technically savvy member of a loosely knit group of "Heroes" who must save the world. The nursing profession cannot ignore such cultural shifts and must respond by acknowledging that gender influences health care decision making practices.

Limitations and Recommendations for Future Studies

A number of limitations of my study exist. However, these same limitations do provide avenues for future research. First, this study was limited to a rural, southern portion of the U.S. and thus cannot be generalized beyond the region. Second, participants were graduates of a gender-opposite university which would be non-consistent with the experiences of most men who have graduated form more gender diverse college environments. Third, for this study, I was not granted permission to observe male nurses at work in home care, hospice or occupational health settings. Most likely the experiences and practices of male nurses in settings beyond the hospital environment offer different challenges and meanings for the men who practice in those settings. Fourth, although I examined in retrospect the educational and socialization experiences of male nurses, experiences as divulged may have been perceived through a lens clouded by time and/or by having been on the graduate side of the educational experience. Finally, even though I explored the white experience of male nurses, I could only hint at the experiences of ethnic men's experiences as men-who-care. Intersections of social forces of gender, race, class, geographic region and religion were outlined primarily for white male nurses, making generalizability again a decided problem.

Males reared in the southern regions of the U.S. are reared in homes that generally endorse a traditional essentialist philosophy regarding male and female roles. Men are expected to engage in more instrumental activities and women are expected to pursue more expressive ones. Work outside the home proves an extension of these traditionally instrumental and expressive ideals regarding masculine and feminine roles. Comparative studies in regions outside the south, as well as cross-cultural studies in countries where females are well integrated (Europe and Scandinavia) and not so well integrated (Middle East and Latin America) into the workforce could provide insight regarding how social factors influence pull and push factors for men in the profession of nursing.

The men who participated in my study were W-men. Having graduated from a predominantly female university, their socialization experiences were most likely very different from those of male nurses who graduated from gender-diverse colleges. More field work exploring how nurses are educated needs to be conducted. Specifically, male and female nursing students could be followed through their program of study and determinations could be made regarding progression, retention and matriculation in the program. Additionally, surveys conducted at facilities where nursing students are placed for clinical experiences could be used to generate data regarding faculty and nursing staff perceptions about male students' performances. Such data could then be analyzed for differences across units and facilities regarding faculty and practicing nurses' perceptions of nursing students' performances in relation to lifting, touching, and other technical performance of skills based on gender. Such surveys could contain items constructed that would assess the degree of support and guidance nursing staff and faculty provide to male and female students respectively.

Socialization into the profession at educational and workplace institutions needs to be better understood in order to effectively recruit and retain caring women and men nurses. The processes of socialization and the formation of negotiated identities as nurses require gendered interaction with others. These processes continue to be poorly understood and most likely interfere and inhibit recruitment and retention of an adequate nursing workforce.

Although I did interview a man engaged in home care nursing, another in an occupational health setting, and men engaged as nurse practitioners in clinics, I was not provided an opportunity to observe the daily practices of these men in their respective work settings. Unfortunately, the picture of practice for male nurses in community health settings is far from complete. Therefore, I strongly encourage that additional qualitative studies such as this one be conducted in a variety of health care worksites, other than in hospitals alone, to better understand the meaning of work for male nurses in out-patient facilities. Additionally, qualitative studies should be conducted in school and campus health settings as well as in public and community health centers. To avert the problems of gaining facility entrance for participant observations in community settings, surveys could be conducted at such sites to collect data regarding nurse-employee, management and patient satisfaction with care provided by male and female nursing staff members. These data could be analyzed by gender for differences and similarities. Results from employee satisfaction surveys in community health settings could be compared with similarly conducted surveys of nurses in hospital settings.

The retrospective nature of my study of male nurses' perceived experiences while in nursing school raises concerns regarding issues of validity and reliability. Even though

triangulated methodologies were used herein to corroborate accounts, the perceived color and texture of recounted past experiences while students at the W could have been influenced by life events and changed over time. Longitudinal studies following male nursing students throughout their program of study and through the first decade of practice could be instituted. Such studies would provide greater accuracy as well as more richly textured data regarding men's socialization into nursing. Longitudinal studies could demonstrate changes in any practice due to early and mid-career professionalization policies or practices within a variety of institutional and occupational settings.

Although only three African-American men participated in my study the issue of race was not absent. In the south, the civil rights movement has not sufficiently removed racial tensions that continue to influence daily life experiences. This study does underscore the need for further investigation of differential experiences of white and non-white male nurses. Intersections of race, gender, class, age and region were hinted at by the responses of one black participant from a rural setting who perceived constraints in catheterizing older, white female patients but not the same constraints when providing younger female clients with the same care needs. Yet, white participants who worked in similarly small, rural community hospitals perceived more tension in providing intimate touching procedures centered in the care of young females (irrespective of race) and almost no tension when performing these tasks with elderly females. Additionally, a black male participant who worked in a very large urban facility encountered no resistance or reluctance when providing intimate touch procedures with any female patients for whom he delivered care. Thus, comparative studies conducted in large urban

and small rural facilities could determine and explain how the intersections of structural forces permit or place constraints on male nurses' touch.

The influence of gender, sexuality, race, class, geographic region and religion in motivating men and women to choose nursing as a career is understudied. We simply do not understand in what ways the intersections of these social factors influence the nursing profession. For decades, social factors have been ignored by the profession of nursing because the object of professional nursing care has been vulnerable persons, regardless of factors such as gender, race and class, as a means to ensure social justice for patients. Now that professional numbers have fallen to critically low levels, social factors in relation to the nursing workforce, including gender, race, class and religion must be examined in order to recognize ways to fill dwindling professional ranks at a time when nurses are most needed. Gender blindness and culturally sensitive and appropriate caregiving are not synonymous conceptual phrases.

Studies similar to this one regarding gender relations and gender negotiation among nurses should be conducted in large metropolitan areas, in different regions of the country, and among nurses who graduated from gender balanced university campuses. Studies conducted in the above suggested settings would better illuminate the meaning that adheres in providing care for vulnerable others.

This study provides theoretical direction for survey research related to job satisfaction among male nurses in inpatient hospital settings. Specifically, surveys of nursing employees could be conducted to determine if statistical differences exist in job satisfaction levels between male and female nurses on various inpatient nursing units. Nursing employees could be surveyed in relation to their perceptions about differential

assignments, patient lifting practices, and/or inservice training about safe lifting practices, and gender differences in nurse-to-physician communications to test the theoretical threads teased from this study. Information gathered through survey research can provide needed direction for retaining men and women in the profession.

Future Professional Directions and Closing Comments

This study provides insight regarding future directions for gender theory. First, Kimmel did not consider men choosing a predominately female educational center as an option for men while this study did so. Kimmel's masculine identities I-element can now be expanded to reflect such a possibility for men. Experiences of the W-men in this study demonstrate that egalitarian horizontal reciprocity was inherent in the confines of their predominately female educational arena. Second, men can and do form positive identities of self as caregivers, both in their professional work and personal lives. The men in this study demonstrate they used agency to overcome institutional constraints regarding the "ideal man" to become successful as caregivers. Perhaps as gender theorists begin to focus on the ways in which men care or demonstrate caring, expressive, emotional selves, ideas for attenuating male violence will emerge. Finally, results from this study encourage Connell and Kimmel to join ranks and combine their respective theories in order to form a more useable mid-range gender theory. Separately their theories may be difficult to operationalize. However, in combination I found Connell and Kimmel's respective theories formed a tight theoretical framework for examining issues of power, labor, emotion and symbolism within nursing institutions, interpersonal interactions, and in the formation of personal work identities among a group of male

nurses. My study offers a template for using both theories in tandem when applied to the sociological study of occupations and professions. Specifically, an expanded theory of gender based on Connell and Kimmel's works can offer sociologists who study occupations and professions insight regarding push and pull factors that influence the movement of men and women in the workforce.

Over the course of conducting this study, I have come to the realization that nursing researchers and social science researchers currently do not dialogue across professional boundaries. Such lack of interdisciplinary communication is more than just unfortunate; it is tragic. It is imperative that transdisciplinary dialogue between nursing researchers and social scientists begins as an earnest sharing of scholarly works. The lack of communication between nursing and the social sciences could very well contribute to the demise of the nation's largest health care workforce. Sociology's deeply rooted history of interest in studying vulnerable populations, aggregates and social institutions parallels many of nursing's historical interests in caring for vulnerable clients, however defined, as individuals, families, aggregates, communities or entire populations. The nursing profession needs the active input of social science research, and social scientists could benefit from opening dialogue with nursing about shared interests.

Our population is graying, requiring evermore health care services; and, we have tens of thousands of service men and women returning from the current wars in the Middle East requiring rehabilitative care. Consequently, our country has a looming structural need for an ever greater number of professional nursing caregivers. The shortage of nurses in the U.S. health care workforce is severe and deepening. Caring labor consists of a skills-set that can be and is being taught well. Men as well as women

can learn the caregiving skills of the nursing profession. Educational institutions, government and workplaces alike are needed to institute policies to protect nursing as a national health care resource and encourage entrants into nursing to remain in the profession. These institutions must now determine how to best recruit and retain both smart women and men into nursing.

REFERENCES

Aaron, G. (1981). Hogan files suit against 'W'. *The Spectator*, 76 (13), 1-7.

Addleston, J. and Stirratt, M. (1998). The last bastion of masculinity: Gender politics at The Citadel. In M. Kimmel, & M Messner, eds. *Men's Lives* (4th ed.) (pp. 205-220). Boston: Allyn & Bacon.

American Association of Colleges of Nursing. (1998). *The Essentials of Baccalaureate Education for Professional Nursing Practice*. Washington, DC: AACN.

American Nurses Association. (1999). *Code of Ethics for Nursing.* Chicago: Nurse's Books.

Bernard Hodes Group. (2005). *Men in Nursing Study*. New York: Hodes Research.

Boivin, J. (2005). Inside Iraq: Mission Critical. *Nursing Spectrum*. Retrieved 12/12/2005 from: http://www.nursingspectrum.com/iraq/part 2

Bourdieu, P. (2001). *Masculine Domination*, trans. Richard Nice. Stanford, California: Stanford University Press.

Bradby, M. and Soothill, K. (1992). Equal yet unequal. *Senior Nurse*, 12(6), 36-43.

Browne, B. (1997). Gender and belief about work force discrimination in the U.S. and Australia. *Journal of Social Psychology*, 137 (1), 107-116.

Bureau of Labor. (2002). *Household data annual averages: Employed persons by detailed occupation, sex, race, and Hispanic origin*. Retrieved from: http://www.bls.gov/cps/#charemp

Burns, C. (1998). A man is a clumsy thing who does not know how to handle a sick person. *Journal of Southern African Studies*, 23 (4), 695-718.

Campbell, M. (2000). Knowledge, gendered subjectivity, and the restructuring of health care: The case of the disappearing nurse. In S. Neysmith, ed. *Restructuring Caring Labour: Discourse, State Practice, and Everyday Life.* New York: Oxford University Press.

Cassell, J. (1986). Dismembering the image of God: Surgeons, heroes, wimps and miracles. *Anthropology Today*, 2 (2), 13-15.

_____. (1998). *The Woman in the Surgeon's Body*. Cambridge, Massachusetts: Harvard University Press.

Chodorow, N. (1980). Gender, relation, and difference in psychoanalytic perspective. In H. Eisenstein & A. Jardine, eds. *The Future of Difference* (pp. 3-19). Boston: G.K. Hall.

_____. (1989). *Feminism and Psychoanalytic Theory*. New Haven: Yale University Press.

Collier, R. (1998). Ma*sculinities, Crime and Criminology*. Thousand Oaks, CA: Sage.

Connell, R. W. (1987). *Gender and Power*. Stanford California: Stanford University Press.

_____. (1993). The big picture: Masculinities in recent world history, *Theory and Society* 22, 597-623.

_____. (1995). *Masculinities*. Berkeley: University of California Press.

_____. (2000). *The Men and the Boys*. Berkeley: University of California Press.

_____. (2002a). Long and winding road: An outsider's view of U.S. masculinity and feminism. In J. K. Gardiner ed. *Masculinity Studies and Feminist Theory: New Directions* (pp. 193-209). New York: Columbia University Press.

_____. (2002b). *Gender*. Malden, Massachusetts: Blackwell Publishing Inc.

Cushman, R. F . (1989). Mississippi University for Women v. Hogan. In *Cases in Civil Liberties* (5th ed.). Englewood Cliff, N.J.: Prentice Hall.

Cude`, G. and Winfrey, K. (2007). The hidden barrier: Gender bias: Fact or fiction. *Nursing For Women's Health*, 11 (3), 254-265.

Cummings, S. (1995). Attila the hun vs. Attila the hen: Gender socialization of the American nurse. *Nursing Administration Quarterly*, 19 (2), 19.

Dellinger, K. (Winter, 2002). Wearing gender and sexuality 'on your sleeve.' *Gender Issues*, 3-25.

Denzin, N. and Lincoln, Y., eds. (2000). *Handbook of Qualitative Research* (2nd ed.). Thousand Oaks: Sage

Diers, D. (2004). *Speaking of Nursing: Narratives of Practice, Research, Policy and the Profession*. Boston: Jones and Bartlett Publishers.

Ekstrom, D. (1999). Gender and perceived nurse caring in nurse-patient dyads. *Journal of Advanced Nursing*, 29 (6), 1393-1402.

Elliott, D. (2002). *The Angel out of the House: Philanthropy and Gender in Nineteenth-Century England.* Charlottesville: University Press of Virginia.

England, P; Herbert, M.; Kilbourne, B.; Reid, L.; and Megdal, L. (1994). The gendered valuation of occupations and skills: Earnings in 1980 census occupations. *Social Forces*, 73, 65-99.

Evans, J. (1997). Men in nursing: Issues of gender segregation and hidden advantage. *Journal of Advanced Nursing*, 26 (2), 26-29.

_____. (2002). Cautious caregivers: Gender stereotypes and the sexualization of men nurses' touch. *Journal of Advanced Nursing*, 40 (4), 441-449.

Farrell, W. (2005). *Why Men Earn More.* New York: American Management Association.

Feldman, H . (2005). *The Nursing Shortage: Strategies forRrecruitment and Retention in Clinical Practice and Education*. New York: Springer Publishing Company.

Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*, trans. A. Sheridan. New York: Pantheon.

Gardiner, J. K., ed. (2002). *Masculinity Studies and Feminist Theory: New Directions.* New York: Columbia University Press.

Gerth, H. H. and Mills, C. W., eds. and trans. (1958). *From Max Weber: Essays in Sociology*. Oxford University Press.

Giddens, A. (1976). *New Rules of Sociological Method.* London: Hutchinson.

Gilmore, D. (2001). *Misogyny: The Male Malady*. Philadelphia: University of Pennsylvania Press.

Guiffre, P. and Williams, C. (2000). Not just bodies: Strategies for desexualizing the physical examination of patients. *Gender and Society*, 14 (3), 457-482.

Glaser, B. and Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research.* Chicago: Aldine.

Gramsci, A. (1971; reprint, 2003). *Selections from the Prison Notebooks,* trans. and eds. Q. Hoare and G. N. Smith. New York: International Publishers.

Guggenbuhl, A. (1997). *Men, Power, and Myths: The Quest for Male Identity,* trans. G. V. Hartman. New York: Continuum.

Hartmann, H. (1981). The unhappy marriage of Marxism and feminism: Toward a more progressive union. In D. Grusky, ed. (2001). *Social Stratification* (2nd ed.) (pp. 673-680). Boulder, Colorado: Westview Press.

Hawke, C. (1998). Nursing a fine line: Patient privacy and sex discrimination. *Nursing Management,* 29 (10), 56-61.

Haywood, M. (1994). Male order. *Nursing Times*, 90 (20), 52.

Heikes, E. J. (1991). When men are the minority: The case of men in nursing. *Sociological Quarterly*, 32(3), 389-402.

Hochschild, A. R. (1983). *The Managed Heart: Commercialization of Human Feeling.* Berkeley: University of California Press.

HRSA. (2004). *The Registered Nurse Population: National Sample Survey of Registered Nurses, Preliminary Findings.* Washington, D. C.: Department of Health & Human Services.

Jesser, C. J. (1996). *Fierce and Tender Men: Sociological Aspects of the Men's Movement*. Westport, Connecticut: Praeger.

Kerston, J. (1996). Culture, masculinities and violence against women. *British Journal of Criminology*, 36 (3), 381-399.

Kimmel, M. (1996). *Manhood in America: A Cultural History*. New York: The Free Press.

_____. (2000). *The Gendered Society*. New York: The Oxford University Press.

Kimmel, M. and Messner, M. (1998). *Men's Lives (4th ed)*. Boston: Allyn and Bacon.

Kingma, M. (1999). Discrimination in nursing. *International Nursing Review*, 46 (3), 87-90.

Koff , S. A. (2004). *Nurse Educators and Politics.* Albany: State University of New York.

Lamont, M. (2000). *The Dignity of Working Men.* New York : Russell Sage Foundation.

Laroche, E. and Livneh, H. (1983). Regressional analysis of attitudes toward male nurses. *The Journal of Psychology,* 113, 67-71.

Lewis, J. D. and Snodgrass, M. (1990). Men in nursing: Some troubling data. *American Journal of Nursing,* 90 (8), 30.

Liddle, A. M. (1996). State, masculinities and law. *British Journal of Criminology,* 36 (3), 361-383.

MacKintosh, C. (1997). A historical study of men in nursing. *Journal of Advanced Nursing*, 26 (2), 232-236.

Marcellus, L. (2005). The grounded theory method and maternal-infant research and practice. *Journal of Obstetric, Gynecologic, and Neonatal Nursing,* 34 (3), 349-357.

Martens, T. and Emed, J. (2007) The experiences and challenges of pregnant women coping with thrombophilia. J*ournal of Obstetric, Gynecologic, and Neonatal Nursing, 36* (1), 55-62.

McElvaine, R. (2001). *Eve's Seed: Biology, the Sexes and the Course of History*. New York: McGraw-Hill.

Messerschmidt, J. (1993). *Masculinities and Crime: Critique and Reconceptualization of Theory.* Lantham, Maryland: Rowman and Littlefield.

Nevidjon, B. and Erickson, J. (January 31, 2001). The nursing shortage: Solutions for the short and long term. *Nursing World: The Online Journal of Issues in Nursing*, 6(1), 16 pp. Retrieved from: http://www.nursingworld.org/ojin/topic14_4.htm

Newberger, E. (1999). *The Men They will Become: The Nature and Nurture of Male Character*. Cambridge, Massachusetts: Perseus Books.

Newburn, T. and Stanko, E., eds. (1994). *Just Boys Doin Business?* New York: Routledge.

Nursing's Pulse: Bernard Hodes/*Nursing Spectrum* RN Survey, (New York: Bernard Hodes Group, 2003). Retrieved from: http://hodes.com/healthcarematters/index.html

Nye, R. A. (1997). Medicine and science as masculine 'Fields of Honor'. *OSIRIS*, 12 (2), 60-79.

Okrainec, G. (1994). Perceptions of nursing education held by male nursing students. *Western Journal of Nursing Research*, 16 (1), 94-107.

Oregon Center for Nursing. (2002). *Are You Man Enough . . . To Be A Nurse?* Portland, Oregon: Oregon Center for Nursing.

Padavic, I. and Reskin, B. (2002). *Women and Men at Work*, (2nd ed). Thousand Oaks: Pine Forge Press.

Page, A., ed. (2004). *Keeping patients safe: Transforming the Work Environment of Nurses.* Washington, D.C.: The Institutes of Medicine National Academies Press.

Painton, J. F. (1994). The outlook in male nursing. *Creative Nursing*, 1 (1), 22-24.

Poliafico, J. (1998). Nursing's gender gap. *RN*, 61(11) 39-42.

Porter-O'Grady, T. (1995). Reverse discrimination in nursing leadership: Hitting the concrete ceiling. *Nursing Administration Quarterly*, 19 (2), 56-62.

Porter, S. (1992). Women in a women's job: the gendered experience of nurses. *Sociology of Health & Illness*, 14 (4), 510-527.

Powell, G. N. and Graves, L. M. (2003). *Women and men in management*, (3rd ed.). Thousand Oaks, California: Sage Publications.

Roberts, S. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science*, 5 (4), 21-30.

Rogers, J. (Sunday, March 13, 1988). Joe Hogan: The man who broke the gender barrier. *The Clarion-Ledger*, 13E-14E.

Ryan, S. and Porter, S. (1993). Men in nursing: a cautionary comparative critique. *Nursing Outlook*, 41 (6), 262-267.

Sabo, D., Kupers, T., and London, W. W. (2001). *Prison Masculinities.* Philadelphia: Temple University Press.

Segal, L. (1990). *Slow Motion: Changing Masculinities, Changing Men*. New Brunswick, N.J.: Rutgers University Press.

Sellers, S., Poduska, M., Props, L., and White, S. (1999). The health care meanings, values, and practices of Anglo-American males in the Midwest. *Journal of Transcultural Nursing*, 10(4), 320-330.

Sigma Theta Tau International, Honor Society of Nursing. (July, 2001). *Nurses for a Healthier Tomorrow: Facts About the Nursing Shortage*. Retrieved from: http://www.nursesource.org/facts_shortage.html

Simpson, R. (2004). Masculinity at work: The experiences of men in female dominated occupations. *Work, Employment and Society*, 18 (2), 340-356.

Smith, S. (1981). Being first takes its toll. *The Spectator*, 77 (10), 3.

Snider, L. (1998). Towards safer societies. *British Journal of Criminology*, 38 (1), 1-39.

Spratley, E., Johnson, A., Sochalski, J., Fritz, M., and Spencer, W. (2001). *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses.* Washington, D.C.: U.S. Department of Health and Human Services Health Resources and Services Administration.

Squires, T. (1995). Men in nursing. *RN*, 58 (7), 26-28.

Stoltenberg, J. (2000). *The End of Manhood: Parables on Sex and Selfhood*, (rev. ed.). London: UCL Press.

Strauss, A. and Corbin, J. (1998). *Basics of Qualitative Research*, (2nd ed.). Thousand Oaks: Sage Publications.

Sullivan, E. (2002). In a woman's world. *Reflections on Nursing Leadership*, 3rd Quarter, 10-17.

Tomsen, S. (1997). A top night. *British Journal of Criminology*, 37 (1), 90-103.

Trentham, S. and Larwood, L. (1998). Gender discrimination and the workplace: An examination of rational bias theory. *Sex Roles*, 38 (12), 1-28.

Villeneuve, M. (1994). Recruiting and retaining men in nursing: A review of the literature. *Journal of Professional Nursing*, 10 (4), 217-228.

Walsh, A. and Borkowski, S. (1995). Gender differences in factors affecting health care administration career development. *Hospital and Health Services Administration*, 40 (2), 263-277.

West, C. and Zimmerman, D. (1987). Doing gender. *Gender and Society*, 1, 125-151.

Williams, C. L. (1989). *Gender Differences at Work: Women and Men in Nontraditional Occupations.* Berkeley: University of California Press.

_____. (1992). The glass escalator: Hidden advantages for men in the female professions. *Social Problems*, 39 (3), 253-268.

_____. ed. (1993). *Doing 'Women's Work': Men in Nontraditional Occupations.* Newbury Park, California: Sage Publications.

_____. (1995a). Hidden advantages for men in nursing. *Nursing Administration Quarterly*, 19 (2), 63-70.

_____. (1995b). *Still a Man's World*. Berkeley: University of California Press.

Winlow, S. (2001). *Badfellas: Crime, Tradition and New Masculinities.* New York: Berg.

APPENDIX A

IRB APPROVAL LETTER

Mississippi State University

November 30, 2006

Deborah Jane Yoder Miranda
2319 Twin Gum Road
Starkville, MS 39759

RE: IRB Study #06-288: "Male Nurses' Negotiation of Masculinity in a Predominately Female Profession"

Dear Ms. Miranda:

The above referenced project was reviewed and approved via expedited review for a period of 11/30/2006 through 11/15/2007 in accordance with 45 CFR 46.110 #7. Please note the expiration date for approval of this project is 11/15/2007. If additional time is needed to complete the project, you will need to submit a Continuing Review Request form 30 days prior to the date of expiration. Any modifications made to this project must be submitted for approval prior to implementation. Forms for both Continuing Review and Modifications are located on our website at http://www.msstate.edu/dept/compliance.

Any failure to adhere to the approved protocol could result in suspension or termination of your project. Please note that the IRB reserves the right, at anytime, to observe you and any associated researchers as they conduct the project and audit research records associated with this project.

Please refer to your docket number (#06-288) when contacting our office regarding this project.

We wish you the very best of luck in your research and look forward to working with you again. If you have questions or concerns, please contact me at cwilliams@research.msstate.edu or by phone at 662-325-5220.

Sincerely,

Christine Williams
IRB Administrator

cc: John Bartkowski

Office for Regulatory Compliance
P. O. Box 6223 • 8A Morgan Street • Mailstop 9563 • Mississippi State, MS 39762 • (662) 325-3294 • FAX (662) 325-8776

APPENDIX B

PRE-INTERVIEW SURVEY QUESTIONNAIRE

Pre-interview Survey Questionnaire

(Participant number_____)

1. Year entered Program:_____

2. Year graduated from program: _____

3. Did you know any nurses prior to entry into nursing school? (yes/no)____

4. If yes, how would you describe the nature of your relationship with this/these person(s) (check all that apply):
   ____Family member (specify)_____
   ____Family friend
   ____Nurse caregiver when I was young
   ____Worked with nurses in former job
   ____Other: (specify)_____

5. Age at graduation:_____

6. Current Age:_____

7. Highest educational degree earned:_____

8. List your work history as a nurse, beginning with your current job and progress backward to the first job you had after nursing school:

Position / Job Title	Time in Position	Reason for Job Change

9. Number of men in your class cohort (include yourself): _____

10. Marital status while in the nursing program:
    ___ Single
    ___ Never married
    ___ Married
    ___ Widower
    ___ Divorced
    ___Cohabitating (female partner)
    ___ Cohabitating (male partner)

11. Current marital status:

___ Single
___ Never married
___ Married
___ Widower
___ Divorced
___Cohabitating (female partner)
___ Cohabitating (male partner)

12. What was the marital status of your parents during your childhood through adolescence:

___ Single
___ Never married
___ Married
___ Widower
___ Divorced
___Cohabitating (female partner)
___ Cohabitating (male partner)

13. How many Brothers do you have?_____

14. How many Sisters do you have? _____

15. What is your birth order in your family (e.g. 1st of 3; 3rd of 4)_____

16. Do you have any children? (yes/no)____
If yes, list gender and ages of each child:

Gender of Child	**Age of Child**

Sections:
Prior to nursing school: 3, 4, 12, 13, 14, 15
Nursing school data: 1, 2, 5, 9, 10
Work history: 8
Current participant & family data: 6, 7, 11, 16

APPENDIX C

SEMI STRUCTURED IN-DEPTH INTERVIEW QUESTIONNAIRE

Semi-Structured, In-depth Interview Questionnaire

Institutions:

(Nursing)

1. **Tell me about why you decided to become a nurse**. [Prompts & Probes: Did you always want to be a nurse? What event(s) or person(s) influenced your decision? **Elaborate** on events/persons that strike you as having been the most profound or vivid in influencing you.]

(The 'W')

2. **Why did you decide to attend the W's nursing program?** [Prompts & Probes: What factors were primary motivators for you in making the decision to attend the W? Are there any other factors that may have accounted for your decision to attend MUW's nursing program?]

3. **Were you concerned about attending a nursing program at a university with 'for women' in its name?**

4. **Did you have any memorable or even unusual experiences there as a 'man' on a mostly 'women's' campus?** [Prompts & Probes: Describe in as much detail as possible.]

5. **Are there any changes for men students that you'd like to see made in the 'W's' nursing program?**

(The Work Place)

6. **At work have you been asked to do something just because you are a man? / Not permitted to do because you are a man?**

7. **What experiences in your workplace(s) exemplify for you the nursing values: caring, patient autonomy, dignity, social justice, and integrity?**

Identities:

8. **What meaning does nursing hold for you?** [Prompts & Probes: What does nursing mean to you?]

9. **How has the profession of nursing influenced you as a person / as a man?**

10. **What are some of the challenges you face as a male nurse?**

Interactions:

(The Work Place)

11. **Tell me about your interactions and relationships with other nurses you work with managers and physicians (positive, negative, ambivalent).** [Prompts &

Probes: Are there things about the different people with whom you work or even the requests they make of you at work that really irk you?]

12. **Have you ever felt pressure from any people at work to work in certain areas/positions of nursing and not others?**

13. **What do you find most meaningful about taking care of patients?**

14. **I know you've heard the phrase: "Patients with high-tech needs require high-touch nursing care." What does that phrase mean to you?**

(The W)

15. **One last thing: Are there any interactions with nursing faculty members that still resonate with you?**

APPENDIX D

MUW LETTER OF AGREEMENT

Mississippi University
for Women
A Tradition of Excellence for Women and Men

Provost and Vice President for Academic Affairs
1100 College St. MUW-1603
Columbus, MS 39701-5800
(662) 329-7142
(662) 329-7141 Fax

www.muw.edu

October 3, 2006

Institutional Review Board
Mississippi State University
Mississippi State, MS

Dear IRB Members:

I am writing to confirm that Mississippi University for Women will provide Ms. Deborah Miranda contact information on male graduates of MUW's BSN nursing program for the purpose of her conducting her research study, "Male Nurses' Negotiation of Masculinity in a Predominately Female Profession." This information will be provided upon approval of the study by the IRB and upon Ms. Miranda's agreement to comply with whatever conditions might be set forth by the IRB.

We are pleased to be able to support Ms. Miranda's study. Please do not hesitate to contact me if you have questions or need additional information.

Sincerely,

Thomas C. Richardson
Interim Provost and VPAA

Copy: Ms. Deborah Miranda
Ms. Jan Miller

APPENDIX E

FREQUENCIES OF MEN AND WOMEN AT ENTRY AND

GRADUATION FROM THE BACCALAUREATE

NURSING PROGRAM AT MUW

1982 TO 2006

Frequencies of Men and Women at Entry and Graduation from the Baccalaureate Nursing Program at MUW, 1982 to 2006

Year	Number Entered		Number Graduated	
	Male	Female	Male	Female
1982	2	31	0	29
1983	3	46	0	27
1984	5	49	2	26
1985	4	44	2	33
1986	4	26	3	41
1987	3	35	4	41
1988	0	26	2	29
1989	0	39	3	25
1990	2	42	0	13
1991	2	46	0	29
1992	12	41	3	32
1993	7	44	1	30
1994	10	41	9	35
1995	3	47	4	41
1996	4	46	9	34
1997	2	32	3	40
1998	2	48	3	39
1999	3	32	1	17
2000	2	43	1	28
2001	7	43	4	35
2002	2	45	2	36
2003	3	47	5	41
2004	5	55	3	43
2005	6	53	2	43
2006	5	55	2	44
Totals	98	1056	68	831

APPENDIX F

COVER LETTER TO POTENTIAL PARTICIPANT

Dear Former MUW BSN Nursing Student:

I am a nursing instructor at Mississippi University for Women and am working on my doctoral degree in sociology at Mississippi State University (MSU). I am studying the professional training and experiences of male nurses in order to gain insight into how best to recruit and retain men in nursing.

I am requesting your **voluntary** participation in this study. Voluntary participation may consist of all or part of the following activities:

(1) completion of a pre-interview survey for collecting demographic data which should take no more than 15 minutes to complete;
(2) an audio-taped and subsequently transcribed interview, lasting about one hour;
(3) a two hour observation of you performing nursing duties at your place of employment.

You may decline to participate in the study without consequence. Should you choose to participate in the study, you may refuse to answer any question without fear of reprisal. Your information will be kept strictly confidential and your name or other identifying data will not be released to anyone other than my major professor, Dr. John Bartkowski, who is directing my dissertation research.

I will contact you by phone or by e-mail correspondence within one week to verify your preference regarding time and place for obtaining informed consent, completing the pre-interview survey, and conducting the audio-taped interview. If you have questions or requests for clarification, you may contact me as follows: Ms. Deborah Miranda, at: MUW 1100 College Street, Columbus, MS 39701, or by phone at 662-329-7301. My email address is: dmiranda@muw.edu You may also contact my dissertation advisor, Dr. John Bartkowski, at: P.O. Box C (USPS) / 207 Bowen Hall (courier), Mississippi State University, Mississippi State, MS 39762, or by phone at 662-325-8621

Respectfully,

Deborah Y. Miranda, RNC, MSN, PhD(c)

APPENDIX G

PARTICIPANT INFORMED CONSENT LETTER

Participant Informed Consent Letter

I am a nursing instructor at Mississippi University for Women and am working on my doctoral degree in sociology at Mississippi State University (MSU). I am studying the professional training and experiences of male nurses in order to gain insight into how best to recruit and retain men in nursing.

I am requesting your **voluntary** participation in this study. Voluntary participation may consist of all or part of the following activities: (1) completion of a pre-interview survey for collecting demographic data; (2) an audio-taped and subsequently transcribed interview; (3) a two hours observation of you performing nursing duties at your place of employment. You may refuse to answer any specific question that may be asked of you without fear of reprisal. Your information will be kept strictly confidential and your name or other identifying data will not be released to anyone other than my major professor, Dr. John Bartkowski, who is directing my dissertation research. I cannot assure your anonymity. Because so few men have attended the "W's" generic BSN nursing program, should someone desire to determine who attended the program during a certain year they could certainly do so. However, they would not be able to determine who said what. You may choose to allow me to submit for future research the audio-tape of our interview along with the transcribed document of our interview to the nursing oral history section of Fant Library on the "W" campus and to the Oral History Collection at Mississippi State University Libraries. If you choose not to permit audio-taped interview placement in these libraries, the audio-tape will be destroyed and the transcribed document of our interview along with detailed notes I make about observations of you at work will be held by the researcher in a locked and secured cabinet in my home for five years, at which time they will also be destroyed.

You may ask questions at any time. No aspect of the research shall be concealed from you as a participant and you may request a summary of the research results after data analyses are completed. You have the right to withdraw from the study at any time. Participation in the study will require no more than fifteen minutes of your time to complete the pre-interview demographic survey. However, the interview will require a minimum of one hour of your time and the observation of you at work will necessitate two additional hours of your time. Participation in this study carries negligible potential risks for emotional and/or physical injury. Participation in this study will not impact your status at your place of employment or work environment. If you have any questions, you may contact me, Ms. Deborah Miranda, at: MUW 1100 College Street, Columbus, MS 39701, or by phone at 662-329-7301. My email address is: dmiranda@muw.edu You may also contact my dissertation advisor, Dr. John Bartkowski, at: P.O. Box C (USPS) / 207 Bowen Hall (courier), Mississippi State University, Mississippi State, MS 39762, or by phone at 662-325-8621. For additional information regarding your rights, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220.

Attached to this consent form is a pre-interview survey questionnaire that you may choose to complete. If you choose to participate in the study: (1) choose a name other than your own (no celebrity names shall be used) that I may use to call you during our interview and over the course of this research project; (2) fill out the pre-interview survey questionnaire; (3) allow me to proceed with our interview now or schedule another time and place more convenient for you for conducting the interview; and (4) provide me with information about the person(s) I should approach to secure consent to observe you at work, if you agree to allow me to observe you at work.

Thank you for your generous consideration of this research endeavor. Please keep this form for your records.

Respectfully,

Deborah Y. Miranda, RNC, MSN, PhD(c)

APPENDIX H

CONSENT FOR PLACEMENT OF AUDIOTAPED INTERVIEW

AND TRANSCRIPTION DOCUMENT IN THE

LIBRARIES OF MUW AND MSU

CONSENT FOR PLACEMENT OF AUDIOTAPED INTERVIEW AND TRANSCRIPTION DOCUMENT IN THE LIBRARIES OF MUW AND MSU

Please indicate with your signature below that you **DO** consent ____ or **DO NOT** consent _____ to allow the audio-taped interview and subsequent transcription document of our interview be placed in the nursing oral history section of the Fant Library on the campus of Mississippi University for Women and the Oral History Collection at Mississippi State University Libraries. Both the tape and the transcript will be made available in these University Libraries for purposes of research, for instructional use, for scholarly publication, or for other related purposes. ***"Also, please note that these records will be held by a state entity and therefore are subject to disclosure if required by law."***

Without your consent the audio-taped recording of our interview will be destroyed after transcription, all identifiers will be removed from the transcription document and the transcription document will be secured in a locked file in my home.

_____ _____

Participant Signature Date

_____ _____

Investigator's Signature Date

APPENDIX I

CONSENT FORM PERMITTING PARTICIPANT

OBSERVATION IN THE WORK SETTING

CONSENT FORM PERMITTING PARTICIPANT OBSERVATION IN THE WORK SETTING

Please indicate with your signature below that you consent to allow me to observe you in your work setting. Your signature shall indicate that you voluntarily choose to allow me to observe you at work for a two hour period.

_____	_____
Participant Signature	Date
_____	_____
Investigator's Signature	Date

APPENDIX J

LETTER OF REQUEST FORWORKSITE/INSTITUTION PARTICIPATION

Letter of Request for Worksite/Institution Participation

Dear Employer of Former MUW BSN Male Nursing Students:

I am a nursing instructor at Mississippi University for Women and am working on my doctoral degree in sociology at Mississippi State University (MSU). I am studying the professional training and experiences of male nurses, and am in the process of applying to MSU's Institutional Review Board (IRB). I must include permission letters from institutions willing to participate in the research project. To that end, I am requesting a letter from you indicating your willingness to participate in this research project. The results of this study may provide necessary insight into how best to recruit and retain men in nursing. I am requesting permission to observe employees at your facility. Observations would last for a two-hour period of time as the men perform daily nursing care activities.

Information gathered during participant observation will be kept strictly confidential and your facility as well as the name(s) of employee(s) including other identifying data will not be released to anyone other than my major professor, Dr. John Bartkowski, who is directing my dissertation research. You may ask questions at any time. Because employees constitute a vulnerable research group, I am not permitted to reveal to you individual actions or communications of employee participants. Once identifiers linking participants to specific institutions are removed and the data are analyzed you may request a summary of the research results.

As an observer, I will not interfere with, deter, or impede in the delivery of patient care provided by the employee(s) I observe. I will respect and abide by all Health Insurance Portability Act of America (HIPAA) confidentiality regulations as well as facility accreditation regulations. I understand that I am a guest and not an employee of your facility and therefore am not entitled to compensation of any kind. I attest that I carry my own health and professional insurance policies and that your facility shall not be responsible for any illness or injury I might incur during participant observation of the employee(s) at your facility. I am up-to-date on immunizations for communicable illnesses, have had a negative TB skin test during the current year, and hold current certification for CPR and basic life support from the American Heart Association. Documentation of these items is available upon request.

If you have any questions, you may contact me, Ms. Deborah Miranda, at: MUW 1100 College Street, Columbus, MS 39701, or by phone at 662-329-7301. My E-mail address is: dmiranda@muw.edu

You may also contact my dissertation advisor, Dr. John Bartkowski, at: P.O. Box C (USPS) / 207 Bowen Hall (courier), Mississippi State University, Mississippi State, MS 39762, or by phone at 662-325-8621. Thank you for your generous consideration of this research endeavor.

Respectfully,

Deborah Y. Miranda, RNC, MSN, PhD(c)

APPENDIX K

PARTICIPATING WORKSITE PERMISSION FORM

Participating Worksite Permission Form

INSTITUTION PERMISSION OF OBSERVATION OF EMPLOYEES

Please indicate with your signature below that you grant permission for me (Deborah Y. Miranda, RNC, MSN, PhDc) to observe former Mississippi University for Women nursing graduates in the performance of daily patient care activities in your facility for a two-hour period.

Please indicate if this research project does___ or does not___ need to go through IRB at your institution.

_____ _____

Participant Signature Facility

_____

Date

APPENDIX L

PARTICIPATING WORKSITE OBSERVATION CONSENT FORM

Participating Worksite Observation Consent Form

INSTITUTION CONSENT FOR OBSERVATION OF EMPLOYEES

Title of Study:
"Male Nurses' Negotiation of Masculinity in a Predominantly Female Profession"

Name of Researcher(s) & University affiliation:
My name is Deborah Jane Yoder Miranda. I am a PhD candidate in Sociology, Anthropology and Social Work at Mississippi State University and an instructor in nursing at Mississippi University for Women.

What is the purpose of this research project?
The purpose of this study is to examine the professional training and experiences of male nurses in order to gain insight into how best to recruit and retain men in nursing.

How will the research be conducted?
I have received informed consent from the nurse(s) on the enclosed list to observe the nurse(s) as he/they provide(s) nursing care for a two hour period at your facility. Additionally, I obtained permission from your facility on (date) to conduct this/these observations. Now, I am asking for your consent to actually observe this/these employees on the respective dates indicated on the enclosed list.

Are there any risks or discomforts to this institution because of participation in this study?
There are minimal, if any, risks associated with this study. All institutional identifiers will be de-linked from the data collected and your institution will not be identified in any way.

Does participation in this research provide any benefits to this institution or any other?
One possible benefit would be that themes from the findings may contribute to the body of knowledge in nursing by illuminating how nursing can better recruit and retain men in the profession.

What are alternative procedures or courses of treatment that might be advantageous to this institution?
You may choose not to participate in this study without concern for any consequences.

Will this information be kept confidential?
Yes, the information gained through participant observation(s) will be kept confidential and your institution or other identifying data will not be released to anyone other than my major professor, Dr. John Bartkowski, who is directing my dissertation research.

Who do I contact with research questions?

If you should have any questions about this research project, please feel free to contact me, Deborah Jane Yoder Miranda at 662- 329-7301. You may also contact my dissertation advisor, Dr. John Bartkowski, at 662-325-8621. For additional information regarding your rights, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220.

What if I do not want to participate?
Please understand that your **participation is voluntary**, your **refusal to participate will involve no penalty or loss** of benefits to which you are otherwise entitled, and you **may discontinue your participation** at any time without penalty or loss of benefits.

You will be given a copy of this form for your records.

_____ _____
Participant Signature Date

_____ _____
Investigator Signature Date

APPENDIX M

OREGON CENTER FOR NURSING COPYRIGHT PERMISSION

OCN
Oregon Center for
NURSING

Because Oregon's Health Depends On It.

Oregon State Board of Nursing

Oregon Nurses Association

Oregon Council of Deans

Oregon Council of Associate Degree Programs

Northwest Organization of Nurse Executives

March 2, 2007

Debbie Miranda
2309 Twin Gum Rd.
Starkville, MS 39759

Dear Ms. Miranda:

The Oregon Center for Nursing hereby grants you permission to use the poster "Are You Man Enough . . .To Be A Nurse?" (copyright 2002 Oregon Center for Nursing) for your doctoral dissertation. Please mail a copy of your completed dissertation to our office in Portland.

The Oregon Center for Nursing retains all other rights in the copyright work, including, without limitation, the right to copy and distribute the work.

I hereby represent that I have the authority to grant the permission granted herein.

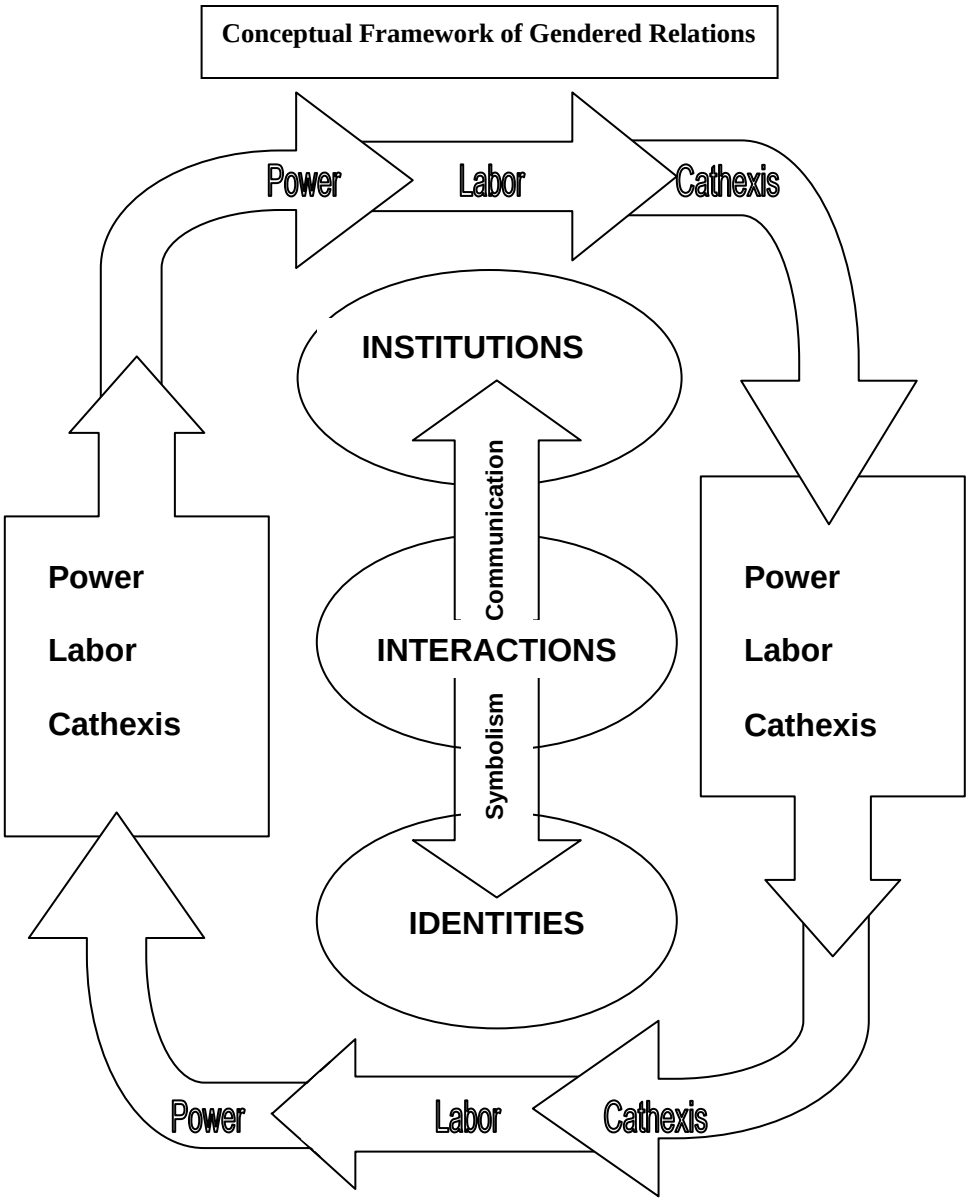
Sincerely,

Kristine Campbell

Kristine Campbell, RN, PhD
Executive Director
Oregon Center for Nursing
5000 N. Willamette Blvd.
Portland, OR 97203

APPENDIX N

CONCEPTUAL FRAMEWORK



APPENDIX O

DATA ANALYSIS TOOL FOR AIDING THEMATIC CODING

USING PRE DETERMINED SENSITIZING CONCEPTS

Data Analysis Tool for Aiding Thematic Coding

Using Pre-Determined Sensitizing Concepts

	Level of Analysis		
Gender Relations[1]	**Identities** ("I")	**Interactions** ("We")	**Institutions** ("We") (W, Nursing, Workplace)
Power ("I/we can"; "I/we will"; "I/we have")	Certification Career progression Leadership / Management Discipline	Teaching/Power-knowledge Coercion Intimidation Regulation	Why Nursing?[2] Why the W?[2] Physicality Advanced nursing degree
Labor ("I/we do")	Provider for self/family Notes clinical strengths Business vs. social	Consultations Assistance Specialty[3] vs. Bedside	Gender dichotomous duties Touch[3] (work =unwritten policy; Nsg = expectation)
Emotional Attachment / Cathexis ("I/we am/are"; "I/we want")	Man Nurse Male Nurse A Nurse Practitioner Health Care Provider "Calling" / spiritual Caring	Connects with clients with empathy Positive relations Negative relations Ambivalent relations	"Good Nurse" Nursing Values "W-Girl" "W Grad"
Symbolism / Communication (subjective; objective)	Facial hair Jewelry / make up Body art	Body comportment Voice tones Displays of muscle/bravado Masculine term usage	Differential attire

[1] Pay special attention to emerging themes regarding issues of power, labor, emotion and symbolic expressions made by participants in relation to professional nursing socialization and professionalization while at MUW and in the workplace setting. Code these themes as: (1) traditional hegemonic masculine displays; (2) alternative masculinity displays; (3) traditional feminine displays; or (4) non-determinant or ambivalent.

[2]Further code as: (1) traditionally masculine; (2) traditionally non-masculine or feminine; and (3) non-determinant or ambivalent. As sub-themes emerge in each category, note them.

[3]At second round analyses, themes emerging regarding gendered practice configuration code as: (1) distancing from feminine acts of caring behaviors; (2) non-distancing or feminine acts of caring behaviors; and (3) non-determinant or ambivalent. (Homosociality, honor codes, habitus may or may not show here). Address sub-themes related to male homosociality or male honor codes/ habitus that emerge through analysis of men nurses' practice in the profession.