The Dissertation Committee for Christopher R. Edwards certifies that this is the approved version of the following dissertation:

The Journey of Men in Nursing: A Critical Ethnography

Committee:

Elnora P. Mendias, PhD, RN
Supervisor

Carolyn A. Phillips, PhD, RN

Ernestine H. Cuellar, PhD, RN

Yolanda R. Davila, PhD, RN

Chad E. O'Lynn, PhD, RN

Dean Cary W. Cooper, PhD

The Journey of Men in Nursing: A Critical Ethnography

by

Christopher R. Edwards, PhD, RN

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas Medical Branch

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas Medical Branch

May, 2013

Dedication

I dedicate this dissertation to my family. Tu-Quynh, my dearest wife: I thank you for all your sacrifices and encouragement throughout my doctoral journey. I never would have been able to reach this point without you. My children, Ethan and Aria: thank you for being so understanding when daddy had to do his schoolwork. I promise to be as supportive of you should you decide to pursue your doctoral degree. Go Team Edwards!

Acknowledgements

I owe a debt of gratitude to my dissertation committee members, whose collegiality, mentorship, guidance, and support are greatly appreciated. This research was conducted under the guidance and tutelage of Dr. Elnora "Nonie" Mendias. I want to thank her for pushing me to my limits and for her wonderful editing skills. I would like to thank Dr. Carolyn Phillips for her willingness to work with us throughout the dissertation process, and for being a consistent source of support since I began my doctoral studies. I thank Dr. Davila for her open-door policy, and for always being willing to listen when I wanted to talk. Dr. Cuellar has been a source of encouragement since I enrolled in the undergraduate nursing program. Dr. O'Lynn authored the articles that first interested me in my research topic and has provided fruitful insight.

I would like to thank the nurturing faculty and staff at UTMB's School of Nursing: my doctoral education is second to none. Dr. Pamela Watson: thank you for your leadership. Dr. Alice Hill: you are always available to the students and are always so optimistic. Without the excellent faculty members in the Baccalaureate, Masters, and Doctoral programs, I would not have achieved this degree.

I would like to thank my fellow students in the doctoral program. Having been through so much together, I feel as though you are part of my extended family.

I would also like to thank Dr. Mark Kirschbaum and Kathy Emmite for their continued flexibility at work and support for my education. You have been instrumental in my growth and development, both personally and professionally.

I would like to acknowledge the funding sources that allowed me to complete my dissertation research. One such monetary form of assistance includes the Graduate Assistance in Areas of National Need grant. This funding mechanism is a U.S. Department of Education program that provides fellowships to academic programs and departments designated as areas of national need, such as this one which assists graduate students to pursue advanced degrees. As a recipient, I was able to concentrate more fully on my education. I would also like to thank those individuals who helped to establish the Arthur V. Simmang Academic Scholarship, the Salute to Nursing Scholarship, the Regina R. and Alfonso J. Mercante Memorial Scholarship, the Marie and Talbert Aulds Scholarship, the Edgar and Grace Gnitzinger Scholarship Fund for Geriatric Nursing, the Lois E. Nickerson, R. N. Endowed Scholarship, and the Jesse and Alicia Dunn Professorship.

The Journey of Men in Nursing: A Critical Ethnography

Publication No._____

Christopher Ray Edwards, PhD, RN

The University of Texas Medical Branch, 2013

Supervisor: Elnora ("Nonie") P. Mendias

Patient health outcomes are linked to the quality of nursing care, which in turn is linked to adequacy of nurse staffing. Changing population and nurse demographics are anticipated to exacerbate the current nursing shortage. Men are underrepresented in nursing, and enhanced recruitment of men has been identified as a possible solution to the shortage. Research has suggested that men face gender-specific challenges in nursing and other gender-atypical occupations, which may influence the low recruitment and high turnover of male nurses.

The study employed critical ethnography, as described by Thomas (1993), to explore and describe how others perceive men in nursing and how gender may influence men when choosing their career paths. For this study, nine male nurses who practiced at the bedside were interviewed. Data were obtained using a bio-demographic questionnaire, semi-structured interviews, and participant observation. Data were analyzed using a modified version of Carspecken's (1996) six-step coding method. Measures to ensure study rigor and trustworthiness included credibility, fittingness, and auditability (Beck, 1993; Lincoln & Guba, 1985).

Findings revealed that men in nursing experience gender-specific challenges during three timeframes: choosing to become a nurse, becoming a nurse, and being a

nurse. During the first timeframe, choosing to become a nurse, the men decided whether nursing was a fitting profession for them. Three factors positively affected men's decisions to become nurses: a) exposures to nurses, especially males; b) understanding the benefits of a career in nursing; and c) support from family and friends. Social influences, such as stereotypes about nursing and men in nursing, negatively impacted men's decisions to become a nurse. During the second timeframe, becoming a nurse, the participants' primary focus was to survive the often rigorous nursing program. Participants experienced both supportive and stereotypic responses to their career choice, and they began to learn ways in which to process stereotypic responses. Although the men continued to experience gender-specific challenges during the third timeframe, being a nurse, they felt confident and comfortable with themselves as men and as nurses. Study findings have implications for the recruitment and retention of men in nursing, nursing practice, nursing education, and theory development.

TABLE OF CONTENTS

List of Tables

Chapter One: Introduction

INTRODUCTION

Chapter One provides an overview of the study, beginning with an introduction to the problem and relevant definitions. The sensitizing orientation that served as the framework for this study is described. Next, the purpose of the study, significance of the study, and research design are explained. Finally, an overview of the remaining chapters is provided.

BACKGROUND

The Institute of Medicine (IOM) (2000) has suggested that as many as 98,000 patients in the United States (U.S.) die each year from human error. One factor contributing to patients' high mortality rates is quality of nursing care received (IOM, 2004); this factor, in turn, is affected by the number of nurses providing care (Aiken et al., 2002; IOM, 2004; Vahey et al., 2004).

The U.S. nursing shortage, estimated at 123,000 full-time equivalents (FTEs) in 2001, is expected to reach 260,000 FTEs by 2025 (Buerhaus et al., 2009). Such an increased demand for nurses is related to aging in both the population and nursing workforce (Buerhaus, 2008). The number of U.S. residents 65 years and over is expected to reach 71.5 million, or 20 percent of the population, by 2030 (Federal Interagency Forum on Aging-related Statistics, n.d.). The average age of the nursing workforce increased from a median age of 38 in 1988 to a median age of 46 in 2008 (Health Resources and Services Administration, 2010a). Another contributing factor to this shortage can be found in the proportion of new nurses who are not practicing in nursing. Sochalski (2002) stated that between 1996 and 2000, 4.1 percent of newly licensed female nurses and 7.5 percent of newly licensed male nurses were not practicing nursing.

Recruitment of foreign-born nurses has been one approach to solving the nursing shortage. Many prosperous countries, unable to produce enough nurses to meet their own needs, import foreign nurses (Abraham, 2007; Aiken et al., 2004; Chikanda, 2005; Parish, 2003). Indeed, the percentage of foreign-born nurses in the U.S. nursing workforce increased from 9 percent in 1994 to 16.3 percent in 2008. Between 2001 and 2008, the U.S. nursing workforce recruited 155,000 foreign-born nurses, and 48,000 in 2008 alone (Buerhaus et al., 2009). Although some countries have an excess number of nurses (Berg et al., 2004; Drevdahl & Dorcy, 2007; Parish, 2003), others face dire health outcomes due to shortages (Abraham, 2007; Chikanda, 2005; Drevdahl & Dorcy, 2007; Heath, 2008).

It is clear that increasing the number of nurses is critical to the health and safety of the citizenry. Studies examining nursing recruitment and retention and positing suggestions to mitigate nursing shortages are needed.

PROBLEM STATEMENT

Recruitment and retention of nurses has been studied for many years, but there is limited research about recruitment and retention of men in nursing. It is well-established that men remain underrepresented in nursing; according to the 2000 National Sample Survey of Registered Nurses (NSSRN), of the 2,694,540 licensed Registered Nurses (RNs) in the U.S, only 5.4 percent, or 146,902, were men (Health Resources and Services Administration, 2000). In 2011, 9.6 percent of nurses were men (U.S. Census Bureau, 2013).

Although women have successfully moved into traditionally male-dominated occupations, fewer men have crossed over into traditionally female occupations (e.g., nursing, teaching, office work) (Williams, 1992). Underrepresentation of men in nursing may be due to perceptions of nursing as a “feminine” profession (Chung, 2000; Ekstrom, 1999; Evans, 2004; O’Lynn, 2007a; Villenueve, 1994; Williams, 1989; Yang et al., 2004). Further, male nurses may be viewed as anomalies, and women may be seen as

better suited as nurses (Evans, 2002; Okrainec, 1990), even though male nurses are found throughout the world (Mackintosh, 1997; O'Lynn, 2007a; Yang et al., 2004). Regardless of need, effects of gender in the workplace typically focus on women in traditionally male professions (Simpson, 2004).

Men in gender-atypical professions have reported gender-specific challenges (Bernard Hodes Group, 2005; Edwards, 2008; Lou et al., 2007; O'Lynn, 2004, 2007a; Williams, 1989; Wilson, 1997), sometimes resulting in gender role strain, or feelings of being unable to conform to masculine gender role norms (Berry, 1997; O'Neil, n.d.; O'Neil et al., 1986, 1995; Pleck, 1981, 1995). Williams (1989) suggests that men in female-dominated professions experience prejudices that may cause gender identity strain or result in permanent departure from their career-track.

The gender role conflict (O'Neil, n.d.) and gender role strain (Pleck, 1981, 1995) paradigms propose that conflicting gender roles, which are created through stereotypes and norms, may be difficult to attain and can lead to psychological and emotional distress. The application of gender role strain theories to men in nursing may explain why men are more likely than women to leave the nursing profession (Sochalski, 2002).

The extant research regarding men in nursing has studied male nursing students and been quantitative in nature. There is a dearth of studies examining how gender affects the experiences of men in nursing from their early interests to being nurses.

DEFINITIONS

The following are definitions for concepts of interest to this study:

1. **Culture** is the "totality of all learned social behavior of a given group; it provides the 'systems of standards for perceiving, believing, evaluating, and acting' (Goodenough, 1981, p. 110) and the rules and symbols of interpretation and discourse" (Thomas, 1993, p. 12).

2. **Gender role** is "the set of behaviors and characteristics widely viewed as (1) typical of women or men ([*gender*] *role stereotypes*), and (2) desirable for women and men ([*gender*] *role norms*)" (Pleck, 1981, p. 10). Gender roles are influenced by individuals' "personality (traits, dispositions) and social roles (especially activities performed at the job and in the family)" (p. 10).
3. **Gender role stereotypes** are "widely shared beliefs about what the [genders] actually are like, that is, descriptive beliefs about the [gender]" (Pleck, 1981, p. 135). Gender role stereotypes are the characteristics people of a gender are compared to and/or to which they compare themselves.
4. **Gender role norms** are described by Pleck (1981) as "widely shared beliefs of what the [genders] should be like, that is, prescriptive beliefs about the [genders]" (p. 134). Male gender norms could be elicited by asking individuals to describe the prescriptive characteristics expected of the "ideal man." Gender role norms exist on a continuum of varying degrees of idealization. People often compare themselves to minimal standards rather than more idealized norms. Androgynous traits are found at the highest level of gender role idealization.
5. **Gender typing** "refers to the actual characteristics of a particular individual along the gender role related dimensions" (Pleck, 1981, p. 11). Whereas gender role stereotypes and norms are third-person characteristics (i.e., "Men are…."), gender typing is a first-person characteristic (i.e., "I am…."). Gender typing can be used to describe characteristics as differences *between* genders or *within* a particular gender.
6. **Gender role strain or conflict** refers to stress felt from a perceived violation of a gender role (O'Neil, n.d.; O'Neil et al., 1995; Pleck, 1981, 1995; St. Cloud University, 2009).

7. **Power** is defined as "the ability to get things done, to mobilize resources, and to get and use whatever it is that a person needs for the goals he or she is attempting to meet" (Kanter, 1977a, p. 166).
8. **Dominants** are described by Kanter (1977a, 1977b) as the group that comprises the majority of an umbrella group. The dominants also control the group and its culture.
9. **Tokens** are described by Kanter (1977a, 1977b) as a group representing 15 percent or less of a larger group.

SENSITIZING ORIENTATION

Pleck (1981) initially used the term sex role to describe individuals' sexual orientation and biological gender identity. The term gender role is more widely used in the literature to describe individuals' biological gender identity (Liu et al., 2005; O'Neil, n.d.). Pleck later adapted his Gender Role Strain (GRS) paradigm to reflect the use of the term "gender" rather than "sex" (Pleck, 1995). To be consistent with Pleck and avoid reader confusion, this study uses the term "gender."

Pleck's (1981, 1995) GRS paradigm served as the sensitizing orientation for the study. Pleck's Male Gender Role Identity (MGRI) laid the foundation for the GRS, so both will be explained. Pleck developed his seminal paradigms based on critical reviews of the literature and his own research. Pleck's paradigms have been tested and used extensively in psychology and sociology, but have not been applied to nursing. Extant literature suggests that men in nursing experience role strain between the conventional masculine gender role and traditionally feminine nursing role (Evans, 2004; Villenueve, 1994). Men in nursing may experience strain in society or within the nursing profession because society considers nursing a gender-atypical profession for males (Codier & MacNaughton, 2012; Williams, 1989). Thus, Pleck's paradigms are applicable to this study.

MGRI Paradigm

Pleck's (1981) MGRI paradigm contends that gender role identity is an early psychological developmental process influenced by the relationship with the same-gendered parent and social beliefs. This developmental process is "thwarted by such factors as paternal absence, maternal over-protectiveness, the feminizing influence of schools, and the general blurring of male and female roles that is now occurring in society" (Pleck, 1981, pp. 3-4). Gender roles are influenced by individual cultures that give masculinity "intellectual shape and scientific legitimacy" (Pleck, 1981, p. 7). Gender roles, in turn, give rise to gender role norms, gender role stereotypes, and gender typing. Failure to conform to and uphold gender roles can lead to gender role strain.

GRS Paradigm

According to Pleck's (1981, 1995) GRS paradigm, social norms shape inconsistent and contradictory roles, leading to role violations and consequent psychological distress, conflict, and stress. Individuals who violate gender roles may experience feelings of shame, anxiety, and depression; they may also experience social condemnation. Individuals who perceive themselves as violating their gender role may overcompensate by over-exaggerating gender characteristics.

Pleck's (1995) GRS paradigm has 10 assumptions:

1. "Gender roles are operationally defined by gender role stereotypes and norms" (p. 12).
2. "Gender role norms are contradictory and inconsistent" (p. 12).
3. "The proportion of individuals who violate gender role norms is high" (p. 12).
4. "Violating gender role norms leads to social condemnation" (p. 12).
5. "Violating gender role norms leads to negative psychological consequences" (p. 12).

6. "Actual or imagined violation of gender role norms leads individuals to overconform to them" (p. 12).
7. "Violating gender role norms has more severe consequences for males than females" (p. 12).
8. "Certain characteristics prescribed by gender role norms are psychologically dysfunctional" (p. 12).
9. "Each gender experiences gender role strain in its paid work and family roles" (p. 12).
10. "Historical change causes gender role strain" (p. 12).

Over time, most work has been labeled by society as man's work or woman's work (Simpson, 2004; Williams, 1989). Nursing, often considered as woman's work, has been associated with female gender role stereotypes – nurturing, caring, and passivity (Villenueve, 1984; Williams, 1989). Men in nursing may experience conflicting role norms and stereotypes related to the social masculine gender role and the traditionally feminine nursing role, which may contribute to development of stereotypes about men in nursing and to higher attrition rates (Evans, 2002; O'Lynn, 2007a; Sochalski, 2002). Application of Pleck's (1981, 1995) GRS paradigm to men in nursing suggests that conflicts between men's gender and profession lead to gender role strain. Application of the GRS paradigm to the study of the effects of gender upon the experiences of men contemplating, studying, or practice nursing may facilitate better recruitment and retention of men into nursing.

PURPOSE

The purpose of this study was to explore and describe the perceptions of men in nursing about gender influences on their career paths.

SPECIFIC AIMS

The specific aims of this study were to:

- Describe perceptions of men in nursing regarding influences on their decision to become a nurse and how their decisions were perceived.
- Describe perceptions of men in nursing related to whether their gender affected their nursing educational experience.
- Explore perceptions of men in nursing in regards to how their experiences as professional nurses have been affected by their gender.
- Explore and describe perceptions of men in nursing which could enhance men's participation in nursing.

Critical ethnographic methods will be employed to answer the following research questions:

- What influenced the decision of men in nursing to pursue nursing as a career?
- What are the perceptions of men in nursing regarding the effects of their gender on their nursing educational experience?
- What are the perceptions of men in nursing regarding the effects of their gender on their professional experiences?
- What do male nurses believe would increase male participation in nursing?

RESEARCH DESIGN

A critical ethnographic approach was used to answer the research questions posed in this study. Critical ethnography explores non-quantifiable features of social life and social inequalities in order to influence positive social change and anticipate possible outcomes (Carspecken, 1996; Thomas, 1993). The critical ethnographic approach analyzes ordinary events and offers a perspective that exposes social structure, power, culture, and human agency practices that might repress or constrain (Carspecken, 1996;

Thomas, 1993). Critical ethnographers have experienced and witnessed forms of oppression directly and want to change them (Carspecken, 1996).

Critical ethnographers utilize Hermeneutic approaches to ensure that a culture is not misunderstood; they believe reality and truth are created through the association of experience with thoughts and symbols. These associations, in turn, influence perceptions of objects and phenomena. People see an object or experience a phenomenon and contend that it exists. The feelings or perceptions people have of an object or phenomenon are actually present before people are aware it exists (Thomas, 1993), described as "existence before essence" (Carspecken, 1996, p. 12). Rather than being stagnant, perceptions change over time. These perceptions can result in subtle or overt biases or oppression such as racism, sexism, etc. Perceptions can be skewed, but often remain unchallenged. Critical ethnographers attempt to show alternative perceptions by oscillating between the moments at which a person is aware of an object or phenomenon and the awareness of being aware of the phenomenon (Carspecken, 1996). Therefore, critical ethnographers attempt to stimulate people's minds by challenging perceptions and offering different viewpoints from which to view an object or phenomenon (Carspecken, 1996).

Thomas's (1993) critical ethnographic approach was used in this study. Thomas purports that critical thinking can occur in the seven stages of a critical ethnography study: ontology, topic selection, method, data analysis, interpretation, discourse, and reflection. Descriptions of how these criteria were met in the current study will be discussed in Chapter Three.

Critical ethnographic research begins with ontology, or a view that there is something to be known, stemming "from uncritically accepted preconceived assumptions about the world" (Thomas, 1993, p. 34). These assumptions can be embodied in "bodies of ideas, norms, and ideologies [that] create meanings for constructing social subjects and concepts like 'gender,' 'race,' and 'student'" (Thomas, 1993, p. 34). Thomas posited that the next preliminary step is selecting a critical topic, i.e., the researcher identifies a

concrete problem using the extant literature. The conclusions made from the literature become guidelines rather than universal truths. This step requires flexibility because the topic of interest may not present itself clearly until data collection begins; therefore, the researcher should be open to new views about the topic.

Once the topic is determined, data collection begins during the methods stage. Unlike traditional ethnography, critical ethnography's methods are more flexible and can include a variety of approaches such as "political action, participatory research, applied policy research, community organizing, or one can observe by the sidelines by critiquing and challenging culture and its symbols" (Thomas, 1993, p. 23). Data can be obtained in interviews, observations, and group discussions. The current study utilized data derived from interviews and demographic questionnaires. Thomas stressed that the purpose of gathering data is to obtain rich, deep, accurate information, and suggested four considerations for the method section: data sources, accuracy of evidence, data collection, and conceptualization.

The first methodological consideration, determination of data sources, requires the researcher to contemplate what type of informants possess an "insider's knowledge" of the domain of interest (Thomas, 1993). The initial study participants should be people to whom the researcher can return later if more information is needed. Less accessible participants can be used at study's end, when research questions are presumably better defined.

The accuracy of evidence is the second consideration for data collection methods in critical ethnography. Ensuring accuracy of evidence is vital to make certain the most accurate information is published while also preventing the imposition of researcher bias (Thomas, 1993).

Data collection is the third consideration. Thomas (1993) contended that structured questions "written in stone" may constrict the researcher's ability to collect

data. Interviews should be conducted using a semi-structured interview guide and follow-up questions as appropriate.

The fourth consideration is conceptualization. The focus of the project should become clearer as the researcher gathers data (Thomas, 1993). Nuances, symbols, and meanings become more apparent to the researcher, prompting the researcher to reconceptualize the broad topic of interest into a more precise topic. As this occurs, the researcher may have to reconstruct research questions to address the specific topic.

The researcher must then interpret and analyze the data obtained from the interviews, which Thomas (1993) referred to as defamiliarization. The researcher then translates findings into something new by decoding:

> . . . the ways that the symbols of culture create asymmetrical power relations, constraining ideology, beliefs, norms, and other forces that unequally distribute social rewards, keep some people disadvantaged to the advantage of others, and block fuller participation in or understanding of our social environs (Thomas, 1993, p. 43).

Carspecken (1996) elucidated the coding approaches for a critical ethnographic study; these processes are described in the data analysis section of Chapter Three.

The use of discourse is imperative to a critical ethnography study (Thomas, 1993). Thomas purported that language "is a form of power, because symbolizing events isolates and communicates one set of meanings and excludes others" (p. 45). Data text from the interviews forms the foundation of the researcher's concepts. The language used by the study's participants and the researcher provides new insight about the topic of interest by providing alternative metaphors and meanings.

The last stage, reflection, is the act of examining how the researcher's involvement affects the research process. It also requires the researcher to consider how the research process changed the researcher's perspective about the topic of interest. The researcher must scrutinize how personal values or ideologies may have affected the

results. Additionally, the researcher should analyze the significance of the findings to determine the social impact.

Significance of the Study

Very little research has explored the challenges men face in a predominantly woman's occupation, and even fewer studies have examined how gender affects the experiences of men in nursing. Most research regarding men in nursing has studied male nursing students. The current study provides further understanding about the effects of gender on the experiences of men in nursing across time (from before they became nurses to their current practice). Study findings may contribute to theory development, facilitate understanding of the challenges faced by men in nursing, and provide insight for developing effective recruitment and retention strategies.

Plan of Remaining Chapters

A summary of pertinent literature regarding men in nursing is discussed in Chapter Two. Research methods are described in Chapter Three. In Chapter Four, study findings are presented. Chapter Five provides a summary of the major findings; compares findings to the extant literature; discusses the study limitation, strengths, weaknesses, and implications; and makes recommendations for future research.

Chapter Two: Review of the Literature

INTRODUCTION

Chapter Two provides an overview of the literature pertinent to the study of the experiences of men in nursing. The chapter reviews literature related to: 1) culture and gender roles; 2) historical changes that have affected men in nursing; 3) the challenge of recruiting men into nursing; 4) the challenge of retaining men in nursing; and, 5) conflicts between masculinity and nursing roles. Finally, Chapter Two presents the significance of the study and the plan for remaining chapters.

CULTURE AND GENDER ROLES

Men in nursing face the dilemma of trying to uphold cultural norms prescribed by their gender and professional cultures (Evans, 2004; Kanter, 1977a, 1977b; O'Lynn, 2007a). Culture influences gender roles; a basic understanding of the concepts of culture and gender roles is imperative to exploring the experiences of men in nursing.

Overview of Culture

Sir Edward B. Tylor defined culture as "that complex whole which includes knowledge, beliefs, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society" (Perusek, 2007, p. 824). Leininger and McFarland (2002) defined culture as the "learned, shared and transmitted knowledge of values, beliefs and lifeways of a particular group that are generally transmitted intergenerationally and influence thinking, decisions, and actions in patterned ways" (Gray & Thomas, 2005, p. 3251). These definitions of culture illustrate the reciprocal, interdependent influence between individuals and cultures.

Cultures, experiences, perceptions, social roles, and socioeconomic status shape people (Gray & Thomas, 2005; Shim & Schwartz, 2007). Although people typically make generalizations about individuals or groups based on culture, such generalizations may ignore other extraneous variables that can influence an individual's personal identity (Gray & Thomas, 2005; Park, 2005). People may appear to conform to a culture-based system, but their core values may actually be different (Shim & Schwartz, 2007). Individual core values are affected by differences in "personal characteristics [such] as socioeconomic status, age, gender, and education potentially affect the manner in which respondents interpret and respond to probes concerning their attitudes, beliefs, behavior, or health" (Angel, 2006, p. 31). Cultural values, beliefs, resources, experiences, knowledge, and attitudes influence decision-making (Fritzche & Oz, 2007; Myers et al., 2006; Santoso et al., 2006; Scott et al., 2006; Shim & Schwartz).

While culture is a common characteristic of a group of people, individual variances related to personal characteristics within a culture need to be understood in context. Contextual relativism contends "traits, beliefs, and practices are defined and distinguished by members of a particular community through the manipulation of symbols and meanings" that must be treated as "discrete phenomenon" in that context (Feinberg, 2007, p.779). A strength of contextual relativism is the acknowledgement of the dynamic state of culture, in which "cultural elements should be understood in terms of their relationships to one another" (Feinberg, 2007, p. 779).

Multiculturality: Fit or Conflict

Some scholars have suggested that individuals can belong to more than one culture (Breugelmans & Van de Vijver, 2004; De Bruyn & Van den Boom, 2005; Gray & Thomas, 2005; Helly, 2002; Kim et al., 2006; Levant & Richmond, 2007; Shim & Schwartz, 2007). Early approaches to cultural interactions viewed cultures as bipolar entities, but later approaches included multidimensional and orthogonal models (Choi,

2001). The multidimensional model, also referred to as cultural orientation, outlines the complexity of acculturation and supports the idea for selective or uneven acculturation through adaptation. The orthogonal model asserts a bicultural individual maintains two cultural identities simultaneously through integration (Choi, 2001).

Acculturation occurs when cultural patterns are changed as a result of the two cultures interacting (Berry, 1997). Berry proposed that multiple possible behaviors or strategies can transpire when cultures interact, depending on which culture is the dominant and which is non-dominant: *assimilation*, *separation*, *segregation*, *integration*, and *marginalization* (Berry, 1997). Assimilation is when an individual wishes to forego their personal cultural identity to identify with another culture. Separation occurs when an individual wishes to maintain their personal cultural identity and not identify with other cultures. Segregation is when a dominant culture forces the individual to maintain their personal cultural identity. Integration is when the person choses to maintain some of their personal cultural identity while also adopting some cultural characteristics of the larger social group; in this case, the dominant group has to be willing to let the individual participate. Lastly, marginalization occurs when the larger group forces the individual to assimilate while also excluding the individual.

Adaptation results when the two cultures change in response to the interaction between cultures; this adaptation can be quick or slow to evolve (Berry, 1997). When an individual attempts to assimilate or integrate and the dominant culture is accepting, *fit* is achieved and conflict is avoided between the dominant and non-dominant cultures (Berry, 1997).

When one's culture is perceived to be in conflict or incongruent with a dominant culture, cultural marginality/marginalization (Berry, 1997; Choi, 2001; Dysart-Gale, 2007), role strain (De Bruyn & Van den Boom, 2005; Kim et al., 2006; Levant & Richmond, 2007), segregation (Berry, 1997), isolation (Simpson, 2004), or acculturative stress (Berry, 1997) can occur. Park was the first to introduce the concept of *cultural*

marginality in his description of the *marginal man* (Choi, 2001). Cultural marginality describes the sociopolitical aspect of acculturation that results in a feeling of racial, gender, political, and economic oppression (Choi, 2001; Dysart-Gale, 2007). Cultural marginality results from an establishment of hierarchy between two cultures based on factors such as ethnicity, socioeconomic status, geographic location, or gender, which results in a feeling of disempowerment (Choi, 2001).

The language used to describe cultures can lead to social and political bias (Jones et al., 2004; Laitin & Weingast, 2006; Park, 2005; Wrede et al., 2006) as well as the valuing or stigmatizing of a culture (Gray & Thomas, 2005; Park, 2005). The language people use is associated with their belief systems and how they make sense of the world around them (Cameron, 2003). For example, although the feminist movement continues to challenge masculine-gender linkages in language that imply dominance of the male in the larger culture (Cameron, 2003), the larger social culture and the nursing professional culture continue to use language implying that nurses are female (Bernard Hodes Group, 2005; Evans, 1997; Kerfoot, 1992; O'Lynn, 2004).

Role strain (De Bruyn & Van den Boom, 2005; Kim et al., 2006; Levant & Richmond, 2007) and acculturative stress (Berry, 1997) are terms used to describe the conflict a person feels when there is incongruence between two or more roles or cultures. Gender role conflict and gender role strain theories postulate that deviation from social gender role norms causes negative effects such as stress, conflict, personal restrictions, devaluation, and physical and mental health problems (O'Neil, n.d.; O'Neil et al., 1995; Pleck, 1981, 1995; St. Cloud University, 2008). Ultimately, this may result in "the restriction of the person's ability to actualize their human potential or the restriction of someone else's potential" (O'Neil et al., 1986, p. 336).

O'Neil and colleagues (1986) suggested that there are six signs of gender-role conflict and strain:

1. Restrictive emotionality – having difficulty expressing one's feelings or denying others their rights to emotional expressiveness.
2. Homophobia – having fear of homosexuals or fear of being a homosexual including beliefs, myths, and stereotypes about gay people.
3. Control – to regulate, restrain, or to have others or situations under one's command. Power – to obtain authority, influence, or ascendancy over others. Competition – striving against others to win or gain something.
4. Restricted sexual and affectionate behavior – having limited ways of expressing one's sexuality and affection to others.
5. Obsession with achievement and success – having a disturbing and persistent preoccupation with work, accomplishment and eminence as a means of substantiating and demonstrating value.
6. Health care problems – having difficulties maintaining positive health care in terms of diet, exercise, relation, stress, and a healthy lifestyle.

According to Berry's (1997) framework for acculturation research, the level of stress a person experiences from the incongruence of different roles or groups is highly variable because of two main factors. The first factor is moderating effects such as demographical characteristics, personality characteristics, social support, social attitudes, and expectations. Second is the individual's interpretation and appraisal of the stress as difficult, benign, or as an opportunity. When the level of conflict between the cultural interactions is high and the issues are viewed as problematic but controllable, the individual experiences acculturative stress. Depending on the level of the issue, the person may or may not be able to cope with the issue and remain in a state of stress. If coping mechanisms are effective, adaptation is achieved.

Men in nursing belong to at least two cultures: male and nursing. Failure to uphold the norms for both may result in role strain or stress (Berry, 1997; O'Neil, n.d.,

O'Neil et al., 1995; Pleck, 1981, 1995; St. Cloud University, 2008). Conversely, perceptions of congruity between the roles result in perceptions of fit (Berry, 1997).

REVIEW OF RELEVANT NURSING LITERATURE

Historical Changes Affecting the Experiences of Men in Nursing

To understand the experiences of men in nursing, it is important to understand historical events that may have contributed to the underrepresentation of men in nursing. Moreover, it is necessary to understand relevant sociocultural factors because "men's participation in nursing has been shaped by social and political factors, as well as by prevailing notions of masculinity and femininity" (Evans, 2004, p. 327).

The history of nursing is closely intertwined with that of medicine, making it difficult to separate the two disciplines (Anthony, 2004; O'Lynn, 2007a). There has been difficulty in "defining who was and who was not a nurse, particularly prior to the registration and/or licensure of nurses in modern times," and "whether or not a nurse must work outside the home to be considered a nurse" (O'Lynn, 2007a, p. 6). Therefore, the exact beginning of nursing as a discipline is not clearly defined.

The provision of nursing care by men can be traced back to approximately 2000 B.C.E., when male servants bathed, comforted, and cared for sick people outside the home (Brown et al., 2000; Okrainec, 1990). Some authors have labeled these non-physician caregivers in ancient times as physicians or surgeon assistants (Anthony, 2006; O'Lynn, 2007a), although they performed tasks typically considered to be nursing care. The first hospitals were established around 300 B.C.E. (O'Lynn. 2007a; Wilson, 1997). Male attendants performed tasks such as bathing and comforting patients and practiced cleanliness and ventilation; they also possessed knowledge of medication preparation and administration (Okrainec, 1990; O'Lynn, 2007a).

The first formal school of nursing was created around 250 B.C. in India (Anthony, 2004; Okrainec, 1990; Wilson, 1997). It should be noted that only males were admitted, as females were not considered to be as "pure" as men (Wilson, 1997).

Men's participation in nursing continued during the Middle Ages, when religious orders of monks and nuns created hospitals to provide patient care to the sick (Brown et al., 2000). Some have questioned the "masculinity" of these early monks since "they had 'renounced' their heterosexual role" (Brown et al., 2000, p. 5).

Male military nursing orders, such as the Knights Hospitallers, Teutonic Knights, Knights of Lazarus, and the Order of St. John of Jerusalem, flourished during the Middle Ages and the Crusades (Anthony, 2004; Evans, 2004; Mackintosh, 1997; Okrainec, 1990; O'Lynn, 2007a; Wilson, 1997). These orders provided care to the sick and wounded on the battlefield and later provided lodging and care for pilgrims (Anthony, 2004; Evans, 2004; Okrainec, 1990; O'Lynn, 2007a) "based on the altruistic ideals of love, humility, and caring and brought increased status to nursing as a profession" (Anthony, 2004, p. 122). Some scholars have claimed these nurses were soldiers "providing care to the wounded out of necessity or boredom between military pursuits" (O'Lynn, 2007a, p. 7); nonetheless, experts also assert that failure to recognize these early military nurses contradicts the widely accepted current role of military nurses.

A decline of religious orders and in men's participation in nursing occurred between B.C.E. 1500 – 1800, as secular organizations began taking over hospitals (O'Lynn, 2007a). Hospitals "were the only places where medieval women could practice healing arts without the risk of being accused of witchcraft" (Brown et al., 2000, p. 6) by theologians and inquisitors. Many nurses were "social misfits, alcoholics, or ne'er-do-wells, or were prisoners or prostitutes pressed into service" (O'Lynn, 2007a, p. 24). Men who remained in nursing tended to work with confused or mentally ill patients where men's strength could be utilized (Evans, 2004) or on battlefields (O'Lynn, 2007a).

Florence Nightingale's attempts to strengthen nursing as a profession assisted in the establishment of nursing as a woman's occupation beginning in the late 1800s (Evans, 2004; Matthews, 2001; O'Lynn, 2007a). Nightingale's reforms were aimed at recruiting single, respectable, Caucasian, Victorian women into doing what were considered feminine activities (Anthony, 2004; Evans, 2004; Mackintosh, 1997; O'Lynn, 2007a; Villenueve, 1994). Nightingale's reforms stressed "deference, obedience, and self-sacrifice" (Kleinman, 2004, p. 79) and deemed "nurturance, gentleness, empathy, compassion, tenderness and unselfishness to be essentially feminine and essentially nurse-like" (Brown et al., 2000, p. 4), qualities that were incongruent with shifting male role characteristics (Ekstrom, 1999; Evans, 2002, 2004; Gilloran, 1995; Kleinman; Matthews, 2001; Porter-O'Grady, 1995). Although males were more "physically intimate" early in the 19th century, social gender roles were shifting "to emphasise [sic] the qualities we see in [masculinity] today" (Brown et al., 2000, p.6).

O'Lynn (2007a) suggested that other extraneous variables also influenced the decline of men in nursing during of the 19th century. For example, O'Lynn noted that the declining quality of care in secular hospitals negatively impacted respect for nurses and caused a decrease in their pay. O'Lynn suggested that the most influential change in the decline of men in nursing was the Industrial Revolution, which created work that required physical strength and extended periods away from home, which were contrary to the female social role. As men assumed these higher paying work roles, more women entered nursing as men's participation declined.

In line with Nightingale's reforms, several European religious sisterhoods also supported "the increasingly popular view of nursing as women's work" (Anthony, 2004, p. 121). These religious orders often brought their views into other countries. As the perception of nursing as a viable career for men decreased "because of its female role connotations" (Okrainec, 1990, p. 6), men increasingly were consigned to the role of orderlies, where their strength was needed to restrain patients (Evans, 2004; Matthews,

2001; O'Lynn, 2007a; Tranbarger, 2007). Even though males accounted for approximately 10% of U. S. nurses in 1890 (Washington University School of Medicine, 2009), the perception of nursing as women's work persisted.

At the conclusion of the Spanish American War in the early 20th century, the U.S. Surgeon General, Stuernberg, tried to rid the military of female nurses because he questioned the ability of corpsmen and female nurses to work together. Female nurses lobbied against Stuernberg's action, leading to the formation of the Army Nurse Corps in 1901 and the Navy Nurse Corps in 1908, from which men were temporarily banned until 1955 and 1965, respectively (Houser & Player, 2004; O'Lynn, 2007a; Pittman, 2005; Villenueve, 1994; Wilson, 1997).

Nursing leaders further diminished men's role in nursing through establishment of nursing education or training that excluded males. The New York nursing registry outlined a training program and curricula, approved by the Board of Regents in 1903, intended to strengthen the nursing profession by establishing criteria for proper training of nurses (O'Lynn, 2007a). However, the approved curricula included an obstetrical training, from which many men were barred. As New York's model was adopted by the other states and nursing schools adapted their programs and curricula to meet the New York requirements, men were often barred from admission (O'Lynn, 2007a). Similarly, the United Kingdom's nurse registries, established in 1919, also limited male nurses' participation through restrictions in male admissions to nursing programs (Mackintosh, 1997; Matthews, 2001).

Patient care also became segregated by gender during the early 1900s (Pittman, 2005). Trained female nurses and nursing students cared for female patients, while male orderlies and attendants cared for male patients because few nursing schools were open to males (Tranbarger, 2007). Complaints by physicians in the U.S. about the different standards of care between female and male patients prompted the opening of more male nursing schools (Tranbarger, 2007). However, the number of male nurses in the U.S. had

declined to 7 percent in 1919 (Evans, 2004; Okrainec, 1990; O'Lynn, 2007a) and further decreased to around 1 percent by 1940 (Okrainec, 1990; Washington University School of Medicine, 2004). The percentage of U.S. male nurses hovered at 1 percent into the 1980s (O'Lynn, 2007a; Wilson, 1997).

Influential and highly respected male nurse leaders, such as Luther Christman, actively advocated for equal treatment of men in nursing (LaRocco, 2004), but the exclusion of students by gender to higher education continued until challenged. In 1982, an associate degree-prepared nurse, Joe Hogan, filed a lawsuit contesting denial of his admission to the Mississippi University for Women Baccalaureate Program of Nursing. Hogan asserted the denial was based solely on his gender (Cornell University Law School, n.d.). The case went to the U.S. Supreme Court (*Mississippi University for Women v. Hogan)*, where the court ruled in favor of Hogan. Justice Sandra O'Connor's opinion stated, "MUW's admissions policy lends credibility to the old view that women, not men, should become nurses, and makes the assumption that nursing is a field for women a self-fulfilling prophecy" (Cornell University Law School, n.d., para. 18). As a result of the U.S. Supreme Court's ruling, nursing schools were no longer able to prohibit men from admission based solely on their gender (O'Lynn, 2007a).

Currently 9.6 percent of the nursing workforce is male (U.S. Census Bureau, 2013). The review of historical and sociocultural factors affecting nursing and men in nursing provides some insight into past male underrepresentation in nursing, but little is known about contemporary causes of male underrepresentation in the nursing workforce.

The Challenge of Recruiting Men into Nursing

There have been increased efforts to recruit and retain more men in nursing to offset the current nursing shortage (Eveloff, 2003; Nelson & Belcher, 2006; Smith, 2006) and to recruit nurses who represent more closely the U.S. population, which is 49.2 percent male, 50.8 percent female, and 74.8 percent Caucasian (U.S. Census Bureau,

2011). However, while minor progress has been made, the current U.S. nursing workforce remains 90.4 percent female and 83.2 percent Caucasian (Health Resources and Services Administration, 2010b; U.S. Census Bureau, 2013).

Much of the research regarding the recruitment and retention of men in nursing has focused on why men are attracted to the profession. Men and women are attracted to nursing for many of the same reasons: the desire to help others, job security, flexibility, and salary (Bernard Hodes Group, 2005; Ellis et al., 2006). However, men in nursing typically consider nursing as a career later and often as a second career (Nelson & Belcher, 2006). Forty-four percent of the participants in the Bernard Hodes Group's study entered nursing as a second career, and most began to consider nursing as a viable career between the ages of 19 and 30. Wilson (1997) suggests men's late entry into the profession is because men are searching for a profession that can offer emotional support and financial gain.

Some researchers have studied deterrents to men pursuing nursing as a career. The Bernard Hodes Group (2005) suggests that the most prevalent challenges that men experience before entering nursing school are, in descending order of importance: (1) stereotypes, (2) nursing being viewed as a female profession, and (3) other professions being seen as more appropriate for men. LaRocco's (2004, 2007) "Theory of Socialization of Men into Nursing" contended that male socialization affects men's entry into nursing. LaRocco also reported that nursing is not supported as a viable career for men by high school guidance counselors. Most of the participants in her study pursued college education in other fields or pursued different occupations prior to pursuing nursing.

Researchers also have studied recruitment strategies aimed at increasing men in nursing. The Bernard Hodes Group (2005) suggested that recruitment materials maintain an inclusive, non-gender-specific message focusing on nursing career strengths, such as stable employment, multiple areas of practice, and demand for high levels of skill.

Additionally, the Bernard Hodes Group recommended use of images of actual nurses, not actors, as well as images depicting nurses as action or military figures, the diversity of the nursing workforce, the nurse as a heroic figure, and emphasizing teamwork and high-tech environments. Evans (1997) suggested stressing the financial and emotional rewards as well as the career opportunities. Kleinman (2004) recommended focusing recruitment materials on the advantages men may experience in nursing, such as preferential treatment in hiring and promotion.

The Oregon Center for Nursing's (OCN) (n.d) campaign "Are you man enough to be a nurse?" received mixed reviews from men in nursing. Although some men liked the OCN campaign, others perceive it as a challenge to their masculinity (Bernard Hodes Group, 2005; Nelson & Belcher, 2006). While some authors believe that campaigns, such as the Johnson and Johnson "Discover Nursing," the OCN campaign, or the "Men in Nursing" calendars supported by the Oklahoma Nurse Association, have helped to increase the enrollment of male nursing students, the impact of such campaigns is unknown (Nelson & Belcher, 2006; Romano, 2006).

The Challenge of Retaining Men in Nursing

Stimulation of men's interest in nursing is only the first hurdle to increasing male representation in nursing. The second hurdle, retention, begins when the men enter nursing school and continues as they practice nursing. Only about 15% of nursing students are male (National League for Nursing, 2011). However, the attrition rate for male nursing students ranges from 26.4 percent (Jefferies, 2007) to 37.5 percent (Stickney, 2008), which is slightly higher than reported female nursing student attrition rates (24.8 percent to 36.6 percent, respectively). Currently, men comprise less than 10 percent of the nursing workforce (U.S. Census Bureau, 2013), and men are twice as likely as women to leave the nursing profession (Egeland & Brown, 1989; Sochalski, 2002).

The majority of men in nursing schools and in the nursing workforce have encountered gender-specific challenges (Bernard Hodes Group, 2005). Researchers have suggested that the challenges men face may be related to the traditional view of nursing as a feminine profession (Bernard Hodes Group, 2005; Edwards, 2008; O'Lynn 2007a; Williams, 1989; Wilson, 1997). Men in nursing are challenged with integrating social expectations for men with nursing's feminine culture (Evans, 2004; O'Lynn, 2007a), a process which has the potential to cause additional strain (Berry, 1997; De Bruyn & Van den Boom, 2005; Kim et al., 2006; Levant & Richmond, 2007; O'Neil, n.d.; O'Neil et al., 1986, 1995; Pleck, 1981, 1995; St. Cloud University, 2009). Additionally, it is not uncommon for men to experience discriminatory practices as a result of gender stereotypes (Williams, 1995).

Several studies have linked retention of men in nursing to the gender-specific challenges men face after entering nursing school. O'Lynn (2004) surveyed 111 male nurses from Montana as well as members of the American Assembly for Men in Nursing to describe the prevalence and magnitude of the barriers they faced in nursing school. The four most prevalent barriers, in descending order, were: (1) no mentorship program for male students, (2) no history of men in nursing presented, (3) textbooks referring to the nurse as a female, and (4) the exclusive use of lecture format in class. The four barriers most important to participants, in descending order, were: (1) feeling welcomed in the clinical setting, (2) being concerned that female patients would accuse them of sexual inappropriateness, (3) lack of support by important people in their lives, and (4) anti-male remarks by faculty (O'Lynn, 2004). A study conducted by the Bernard Hodes Group (2005) surveyed 498 men in nursing and nursing schools. The researchers found the four most common challenges encountered by men during nursing school and their careers to be: (1) difficulty being a minority gender, (2) being viewed as muscle, (3) being perceived as not caring, and (4) communication issues with their female counterparts. Others have suggested that the low number of male nurse role models, lack

of acknowledgement of males in nursing's history, and gender bias negatively affect male nursing students' experiences (Egeland & Brown, 1989; O'Lynn, 2007a). Male nursing students' fear of being accused of sexual inappropriateness when touching female patients has been reported in Ireland (Keogh & O'Lynn, 2007).

Researchers also have identified gender differences in language as a retention issue for men once they have entered nursing school (Anthony, 2004; Egeland & Brown, 1989; Ellis et al., 2006; Kerfoot, 1992; Villenueve, 1994). Kleinman (2004) suggests that "language and images are often the most dominant and influential forces in our culture" (p. 81), but men "largely have been excluded from the language and image, and therefore, the history of nursing" (Villenueve, 1994, p. 222). Some men in nursing have suggested that the term "nursing" carries with it feminine qualities, as it can be used synonymously with breastfeeding (Bernard Hodes Group, 2005). Moreover, the use of the term, male nurse, or referring to nurses as she, can isolate men from the nursing profession as a whole (Bernard Hodes Group, 2005; Egeland & Brown, 1989; Inoue et al., 2006; LaRocco, 2004).

Being a gender minority in a predominantly female profession has been identified as another retention challenge for men in nursing. Kanter (1977a) suggested that gender and ethnic minorities in corporations are more scrutinized or noticed by others in the organization. Racial/ethnic or gender minority groups may look or behave differently from the larger majority group and may be considered tokens within the larger group. Kanter's seminal ethnographic study of women and minorities in the workplace defined "tokens" as a group representing 15 percent or less of a larger group, which is applicable to the approximately 10 percent of men in nursing. Kanter (1977a, 1977b) explained that tokens are viewed first as representative of their minority group rather than as members of the larger group. Applying Kanter's premise about tokenism to men in nursing suggests that men in nursing may be viewed first as men and secondarily as nurses.

Kanter (1977b) noted that if the minority group has physical characteristics that are different from the dominant group, such as in the case of gender, a heightened awareness of the token results. Tokens also have difficulty forming alliances within the larger group, which may add to feelings of isolation from the larger group. Moreover, being a token results in (1) increased performance pressure related to heightened visibility, (2) polarization or exaggeration of differences as the dominant group tries to keep the tokens slightly outside the dominant group, and (3) perceptual tendency or stereotyping by distorting characteristics of the tokens. Thus, men in nursing may feel pressure to over perform, feel isolated or marginalized, and experience stereotypes about men in nursing.

Others authors have suggested that the isolation felt by men in nursing is deliberate and self-created (Kleinman, 2004; Simpson, 2004; Williams, 1989, 1995). Williams proposed that men in nursing may maintain gender segregation by socializing with physicians as a way to maintain power. Heikes (1992) contended that male nurses who do not socialize with females may be disadvantaged bureaucratically. The end result of feeling isolated or marginalized for men in nursing, however, is likely to be dissatisfaction with their profession.

Interestingly, being a token or minority may lead to more success for men in nursing (Kanter, 1977b). Some authors have suggested that men in nursing receive preferential treatment due to their underrepresentation or tokenism in the nursing profession (Evans, 1997; Kleinman, 2004; Simpson, 2004; Williams, 1992, 1995). Kleinman suggested that men's gender can help them gain a higher status within nursing. Williams (1992, 1995) stated that men in female-dominated professions experience a *glass elevator* as opposed to the *glass ceiling* women in male-dominated professions encounter; the glass elevator refers to faster promotions for men. On the other hand, male nurses' professional success in itself can be stressful (Whittock & Leonard, 2003),

because their success is attributed to their gender rather than to their abilities (Edwards, 2008).

Conflicts between Masculine and Nursing Roles

Existing literature has identified the potential conflict for men and nursing between their masculine social roles and feminine nursing roles (Evans, 2004; O'Lynn, 2007a; Williams, 1989, 1995). Incongruence of roles can lead to stress (Berry, 1997; O'Neil, n.d.; O'Neil et al., 1986, 1995; Pleck, 1981, 1995), which can affect a person's satisfaction with their chosen profession (Fogarty et al., 1999; Jayaratne & Chess, 1984, Kanter, 1977).

Men who join a predominantly female workforce or gender-atypical occupation may be viewed by society as abnormal (Hayes, 1989). Evans (2002) has linked underrepresentation or tokenism of men in nursing to the development of social stereotypes about these men. For instance, sexual inappropriateness by one man in nursing could lead to men in nursing being seen as "sexual deviants and sexual predators" (Evans, 2002, p. 447). These and other pervasive stereotypes may cause male nurses to be more careful when touching patients while providing care (Evans, 2002) and influence how male nurses perform nursing care involving touch (Evans, 2004). Lewis et al. (1990) have questioned whether bias against men in nursing leads to disproportionate complaints against male nurses to Boards of Nursing, many of which have been found to be invalid. Male nurses, who minimize touching their patients, may be viewed as uncaring by patients and colleagues (O'Lynn, 2007b), yet male nursing students and new practicing male nurses are not taught to touch patients (Inoue et al., 2006) in a manner that will not be misconstrued.

Studies about gender effects on male nursing student's ability to care for patients are scant. Okrainec (1994) reports that male nursing students believe characteristics such as a caring attitude, cooperativeness, and empathy are similar for both male and female

nurses. Grady and colleagues (2008) conducted an interpretive phenomenological study to describe faculty perceptions of and responses to male nursing student's methods of caring. The study's participants consisted of six faculty (five female, one male) at a southwestern United States nursing school that had a higher than normal percentage of male nursing students in the program. Participants believed men and women in nursing schools may demonstrate caring in different ways and may have different levels of comfort in expressing caring behaviors such as touch. Most participants felt that men in nursing schools entered with some caring characteristics that could be developed further. However, only the male faculty participant identified the need to recognize and support the unique caring styles of male nursing students.

Some authors have explored the effects of gender on nurses' ability to provide nursing care (Ekstrom, 1999; Evans, 2002; Gilloran, 1995; Greenhalgh et al., 1998; Hart, 2005; MacDougall, 1997; Okrainec, 1994; Whittock & Leonard, 2003). In one study, female nurses perceived themselves as better than male nurses at basic nursing tasks and as more approachable to staff and patients (Gilloran, 1995). However, masculine and feminine elements can be found in many models of caring (Ekstrom, 1999). Male and female nurses are motivated by altruism and care for their patients equally, although males may express it differently (Ekstrom, 1999; Whittock & Leonard, 2003). Male nurses in Evans' study also felt that male and female nurses may demonstrate caring behaviors in a different manner.

Men's tendency to practice predominantly in specialty areas such as critical care, anesthesiology, administration, psychiatry, the emergency room, and industry (Egeland & Brown, 1989) has also been scrutinized. This tendency may occur because these specialties focus on technical skill may be perceived as more congruent with masculine roles (Egeland & Brown; Evans, 2004; Williams, 1989, 1995). Whereas Evans (2002) suggested that males move into administrative roles because administration is "more congruent with prevailing notions of masculinity" (p. 445), Egeland and Brown (2004)

suggested that males may go into management for many reasons, such as a desire to change the work environment, financial security, or pressures from others. Since some men do not desire to pursue administration (Simpson, 2004), the expectation to take on a leadership role could cause stress. Regardless of their specialty, men in nursing continue to experience gender role strain as a result of the way they are treated by colleagues, patients, and community members (Egeland & Brown, 2004).

A number of studies have explored real or potential conflicts between masculine gender roles and the feminine nursing roles and the suitability of men to practice effectively as nurses. However, there is limited research about how men in nursing perceive the fit between masculine and nursing cultures, as well as how they resolve conflicts between masculine and feminine gender roles.

STUDY SIGNIFICANCE

Men in nursing belong to the at least two cultures: male and nursing. Current theories and research suggest that failure to uphold the norms for both may result in role strain or stress (Berry, 1997; O'Neil, n.d.; O'Neil et al., 1995, n.d.; Pleck, 1981, 1995; St. Cloud University, 2009), and congruity between the roles result in perceptions of fit (Berry, 1997). Some nursing researchers have found men in nursing face challenges because of their gender (Bernard Hodes Group, 2005; Edwards, 2008; Evans, 2002, 2004; O'Lynn 2007a; Williams, 1989, 1995; Wilson, 1997), but the research has been largely quantitative in nature and has not facilitated full disclosure of their stories. Some researchers have suggested that men in nursing experience role strain due to their gender (Egeland & Brown, 1989; Evans, 2004; O'Lynn, 2007a; Villenueve, 1994), but research applying gender role strain theory to men in nursing is lacking. Most research on men in nursing has focused on male nursing students, and only one study (LaRocco, 2004, 2007) was identified that explored the effect of gender on the socialization of men into nursing. The current study addresses these knowledge gaps through applying relevant role theories

to men in nursing across a time span from before they selected nursing as a career, to their experiences as nursing students, and to their experiences as practicing nurses.

PLAN OF REMAINING CHAPTERS

Chapter Three explains the research method used to explore the perceptions of men in nursing about gender influences on their career paths. It also provides the strategies used to ensure scientific rigor and human subject protection. Chapter Four describes research findings. Chapter Five presents a summary of the entire study, including a discussion of the findings, implications of the findings, the strengths and weaknesses of the study, recommendations for future research, and the conclusion.

Chapter Three: Research Design

INTRODUCTION

Chapter Three describes the research methods used to explore the perceptions of men in nursing about gender influences on their career paths. As described in Chapter One, the Gender Role Strain paradigm served as the sensitizing orientation of this study (Pleck, 1981, 1995). Critical ethnography (Carspecken, 1996; Thomas, 1993) was the method used to answer the research questions proposed in the study. Chapter Three also provides the strategies used to ensure scientific rigor and human subject protection.

METHODS

A critical ethnographic approach was used to answer the research questions posed in this study. Critical ethnography is a "response to current society, in which the systems of power, prestige, privilege, and authority serve to marginalize individuals who are from different classes, races, and genders" (Creswell, 2007, p.70). The techniques of discourse and analysis used in critical ethnography are embedded in ethnography, a qualitative research method used to understand a culture from the native viewpoint (Carspecken, 1996; Spradley, 1979). Culture in ethnography is described as "the acquired knowledge that people use to interpret experience and generate social behavior" (Spradley, 1979, p. 5). Ethnographic researchers try to gain a better understanding of symbols, beliefs, and traditions through the language of people in the studied culture. Ethnographic researchers use participant observation, interviews, life history, or a mixture of these methods, focusing on the language of the participant(s), in order to uncover the attributes or meanings of cultural symbols (Carspecken, 1996).

Ethnography and critical ethnography are similar in that each relies on qualitative interpretation methods, adheres to the same methods and analysis, and tries to uncover

the meanings of symbols (Thomas, 1993). Thomas notes one difference in the two methods is that ethnographers attempt to describe the culture or "what is," while critical ethnographers describe a culture's current constraining state and advocate for social change by describing "what could be" (Thomas, 1993, p. 4) for the culture. According to Thomas, the purpose of ethnography is to provide an understanding of a culture, while critical ethnography tries to prevent a misunderstanding of the culture.

Critical ethnography was chosen for this study because it is a holistic approach that can be used to explore beliefs and meanings within a culture. Critical ethnography can be used to explore non-quantifiable features of social life and social inequalities in order to influence positive social change (Carspecken, 1996; Thomas, 1993). The critical ethnographic approach examines ordinary events and offers a perspective that exposes social structure, power, culture, and human agency practices that might repress or constrain members of a culture (Carspecken, 1996; Thomas, 1993). Critical ethnographers have experienced or witnessed forms of oppression directly and want to change them (Carspecken, 1996).

Critical ethnographers utilize Hermeneutic approaches to ensure a culture is not misunderstood; they believe reality and truth are created through the association of experience with thoughts and symbols which, in turn, influence perceptions of objects and phenomena (Carspecken, 1996). People see an object or experience a phenomenon and contend it exists. The feelings or perceptions people have of an object or phenomenon are actually present before people are aware the phenomenon exists (Carspecken, 1996; Thomas, 1993), often referred to as "existence before essence" (Carspecken, 1996, p. 12). Perceptions are not stagnant but change over time and may result in subtle or overt biases or oppression (Carspecken, 1996; Thomas, 1993), such as racism or sexism. Perceptions can be skewed, but often remain unchallenged by those who hold them. Critical ethnographers attempt to show alternative perspectives by oscillating between the moments when a person is aware of an object or phenomenon and

the awareness of being aware of the phenomenon (Carspecken, 1996). Therefore, critical ethnographers attempt to open people's minds by challenging perceptions and offering different viewpoints from which to view an object or phenomenon (Carspecken, 1996).

Carspecken (1996) notes that critical ethnography methods are appropriate for the exploration of social and professional structures that may cause inequalities for a segment of society. Thus, critical ethnography is appropriate for the study of perspectives of men in nursing about gender influences on their career paths because men in nursing are a minority, representing less than ten percent of the nursing workforce (U.S. Census Bureau, 2013). Men in nursing encounter specific historically-rooted and socio-culturally-influenced gender-related challenges (Evans, 2004; O'Lynn, 2007a; Williams, 1989, 1995) that are not experienced by women in nursing. The critical ethnography design of the current study and use of Pleck's (1981, 1995) GRS paradigm as a sensitizing framework facilitated examination of structures in the social and nursing cultures that give rise to the challenges to men in nursing. Specifically, the design and framework allowed exploration of elements that influence men's selection of nursing as a career or that impede the ability of men in nursing to reach their personal and professional goals. Study finding may create awareness of gender-related inequities in nursing and suggest ways to eliminate them.

Thomas's (1993) approach to critical ethnography guided this study. Thomas purported that critical thinking can occur during seven points in a critical ethnography study: ontology, topic selection, method, data analysis, interpretation, discourse, and reflection.

Ontology is a conceptualization or "abstract, simplified view of the world that we wish to represent for some purpose" (Gruber, 1996, p. 908). Ontology is a type of philosophical inquiry, synonymous with metaphysics, which explores whether an object or phenomena exists in reality. These objects or phenomena can be embodied in "bodies of ideas, norms, and ideologies [that] create meanings for constructing social subjects and

concepts like ‘gender,’ ‘race,’ and ‘student’” (Thomas, 1993, p. 34). The present study arose from the researcher’s interest in recruiting more men and women into nursing. Reading the extant literature led to the researcher’s awareness of and curiosity about social and professional structures that constrain nurses, particularly men in nursing.

Selection of a topic for a critical ethnography study is guided by researcher interest and desire to investigate a perceived injustice or disparity such as racism and cultural, social, or economic inequality (Thomas, 1993). Conclusions drawn from the literature become guidelines rather than truths to be proven, and the researcher should be open to new views about the topic based upon data. Exposure to O’Lynn’s (2004) Male Friendliness Tool, a review of the history of men in nursing, and an investigation of theories about gender role strain led to the researcher’s decision to explore the experiences of men in nursing using critical ethnography.

Sample/Sampling Plan/Procedures

Thomas (1993) suggested that informants should possess an “insider’s knowledge” of the domain of interest. The initial participants used for the study also should be people to whom the researcher can return later if more information is needed. Less accessible participants can be used as research questions become better defined.

This study focused on the perception of men in nursing practicing who were at the bedside in U.S. hospitals. Therefore, the researcher recruited participants who would possess in-depth insiders’ knowledge of the experiences of men in nursing. Criteria for participants in the study included: 1) males licensed as RNs, 2) at least 12 months of experience as an RN, 3) currently providing direct patient care, 4) willingness to share experiences in face-to-face interviews, 5) willingness to have the interviews tape recorded, 6) proficiency in speaking English, and 7) between the ages of 21 and 65 of age. Participants were excluded from the study if they 1) were female nurses, 2) had less than 12 months of experience as an RN, 3) were not providing direct patient care, 4) were

unwilling to share their experiences in face-to-face interviews, 5) were unwilling to have the interview tape recorded, 6) were non-English speaking, and 7) were younger than 21 or older than 65 years of age.

Participants were limited to English-speaking, as that is the researcher's primary language, and being able to understand the language of the participant is critical to data collection and interpretation in qualitative studies (Spradley, 1979). Nevertheless, since participants were practicing in clinical patient care settings where English is spoken, it is doubtful that any potential participant was omitted. The study was also limited to persons 21 to 65 years of age, but because of education and experience requirements and the requirement for currently providing direct patient care, it is doubtful that any potential younger or older participants were excluded. Moreover, the researcher made efforts to maximize participant variability as described below.

Sampling is a method of selecting a small group that is part of a larger group in order to make generalizations about the larger group (Gliner et al., 2000). The researcher initially employed convenience sampling by recruiting participants who were easily accessible (Gliner et al., 2000). As the study progressed, snowball sampling also was employed when a participant recommended other men in nursing for the study (Gliner et al., 2000). Finally, purposive sampling was employed to ensure maximum variability in selected participant characteristics, such as age, ethnicity, education, years in practice, and practice settings. Purposive sampling was used to recruit a sample more representative of the larger population (Creswell, 2007; Gliner et al., 2000).

Ethnographic studies typically use a small number of key informants (Spradley, 1979). Sample size in qualitative studies is determined by data saturation (Brod et al., 2009). Although the study was designed to recruit up to 30 participants if needed for data saturation, the actual number of participants recruited to the study was nine. Saturation of data occurred when interviews provided no new "or valuable information" (Brod et al., 2009, p. 1268). At the conclusion of the seventh interview, the researcher and two

members of his dissertation committee concluded that saturation of data possibly had been achieved; two additional interviews were conducted to confirm saturation.

Data Collection

The purpose of gathering data for studies using critical ethnography methodology is to obtain rich, deep, accurate information (Thomas, 1993). Critical ethnography data can be obtained in interviews, observations, and/or group discussions and may include a variety of approaches such as "political action, participatory research, applied policy research, community organizing, or one can observe by the sidelines by critiquing and challenging culture and its symbols" (Thomas, 1993, p. 23).

Participant recruitment materials (see Appendix A) were posted in the nursing lounges at several hospitals after permission had been obtained from the managers of units in which the flyers were to be posted. The recruitment brochure summarized the purpose of the study and provided the researcher's contact information in case more information was desired or a potential participant wanted to contact the researcher. Prior to scheduling an interview, the researcher confirmed that potential participants met study criteria and answered questions about the study. Participants were assured that every effort would be made to protect their confidentiality.

The researcher collected several types of data. Demographic information was collected at the beginning of a participant's initial interview, using a researcher-developed questionnaire. Demographic information included age, ethnicity, area of practice, and years of experience (see Appendix B), which was used to describe the sample population (see Chapter Four) and to ensure maximum variability in sampling.

Structured questions that lack flexibility to respond to participants may constrict researchers' ability to collect data (Thomas, 1993). Thus, the researcher used a researcher-developed semi-structured interview guide (see Appendix C), based on the literature, discussion with colleagues, and self-reflection. The semi-structured interview

guide encouraged participants to describe their perspectives and allowed the researcher to explore developing themes in greater depth. Examples of items on the interview guide were, "Tell me about what events, individuals, or situations influenced your decision to become a nurse," and "Tell me what it has been like being a man in nursing." Follow-up probes included such things, as "Tell me more about . . . ."

The initial interviews were face-to-face and conducted at a time and place convenient to participants and the researcher. Every participant chose his home. The researcher arrived at interviews dressed in casual attire, jeans and a t-shirt, in order to create a more relaxed atmosphere. The researcher spent 15 to 30 minutes casually talking with the participant in an attempt to help the participant feel more at ease. The researcher explained the study then asked participant if he had questions. After the participant's questions had been answered and the participant had provided signed consent to participate in the study (see Appendix D), the participant completed the study demographic form. Once the demographic form was completed, the researcher began the audiotaped interview, using the semi-structured interview guide. The interviews ranged from 45 to 90 minutes and averaged about 60 minutes. All nine participants were interviewed at least once, five were interviewed twice, and three were interviewed three times, a total of 17 interviews.

Follow-up interviews were scheduled based on participants' accessibility and the quality of information provided in the initial interviews. The follow-up interviews occurred face-to-face or by telephone, as convenient for participants, to clarify early themes that emerged from the initial interviews and to ensure the accuracy of interview data. Additional interviews were conducted for member checks, which allowed the researcher and participants an opportunity to discuss emerging themes and ensured the researcher's interpretation of the data was representative of the participants' experiences.

The researcher maintained two journals throughout the interview process (Carspecken, 1996). The first journal, or primary record, was used to record thick

(detailed) descriptions of observations in the field, such as the setting, time, and observations of nonverbal behavior or distractions occurring during the interview. The second journal, or field journal, was used to record the researcher's feelings or thoughts before and after conducting the interviews, as well about the direction of the research. The journals also included observations of nurses in public settings, casual conversations with health professionals, reviews of media, and the researcher's reflections on personal experiences.

Data Management

All interviews were audio-taped and transcribed verbatim by the researcher. The researcher reviewed transcriptions for accuracy by listening to the tape recorded interviews while simultaneously reading the transcriptions and correcting any discrepancies. Transcriptions were de-identified (i.e., all personal data which could identify the participant, such as name or institution, was removed) then saved on the researcher's hard-drive and a back-up jump drive. No names were used in the de-identified transcripts; documents were identified sequentially as Participant 1, Participant 2, etc., in the order interviewed, and using a "b" or "c" to indicate the second or third interview respectively. Access to the computer and jump drive was protected with a password known only to the researcher.

The transcriptions initially were imported into NVivo7 for coding. NVivo7 is a qualitative research software program that helps researchers to classify, sort, and arrange narrative information (QSR International, 2012); the software assists the researcher to discover patterns, identify themes, and develop meaningful conclusions from the interviews. NVivo7 allowed the researcher to integrate observations from the primary record and field journal with the transcriptions, thus creating a clearer audit trail.

After analyzing the first three participants' data, the researcher decided not to use NVivo7 for a number of reasons. The research mentors did not have access to the

program, so the data had to be printed, making the sharing of the data difficult and time consuming. Additionally, training for the research mentors and the cost of additional licenses for the software were prohibitive. Therefore, de-identified interview transcripts were shared with the two research mentors, and the researcher numbered the lines in each transcription for easy reference. Word documents were used for coding and analysis.

Data Analysis

Data interpretation and analysis are achieved through what Thomas (1993) referred to as *defamiliarization.* The researcher reframes observations, reflections and impressions, and narrative data into something new by decoding:

> . . . the ways that the symbols of culture create asymmetrical power relations, constraining ideology, beliefs, norms, and other forces that unequally distribute social rewards, keep some people disadvantaged to the advantage of others, and block fuller participation in or understanding of our social environs (p. 43).

The use of discourse is imperative to a critical ethnography study (Thomas, 1993). Thomas purported that language "is a form of power, because symbolizing events isolates and communicates one set of meanings and excludes others" (Thomas, 1993, p. 45). Data text from the interviews formed the foundation of the researcher's concepts. The language used by the study's participants and the researcher provided new insight about the topic of interest by providing alternative metaphors and meanings.

This study used descriptive statistics (i.e., frequencies, percentages, means) to analyze the participants' demographic information. Narrative data were analyzed using a modified version of Carspecken's (1996) six-step coding method. Guided by Carspecken's method, the researcher performed preliminary reconstructive analysis by exploring normative and subjective reference factors such as "interaction patterns, their meanings, power relations, roles, interactive sequences, evidence of embodied meaning, intersubjective structures, and other items" (Carspecken, 1996, p. 42). Carspecken described normative references as the unspoken factors people think are right, good, and

appropriate. Carspecken described subjective references as the feelings or state of mind of a person, which may or may not be similar to a normative reference. The researcher "'reconstructs,' into explicit discourse, cultural and subjective factors that are largely tacit in nature" (Carspecken, 1996, p. 93). Although Carspecken's coding process is described in a linear fashion, in actuality data analysis is a dynamic process that involves continuous revisiting of the data and ongoing search for interpretations of possible meanings (Carspecken, 1996; Thomas, 1993).

In keeping with Carspecken's (1996) method of coding, the researcher transcribed the first interview then reviewed the transcript, highlighting segments that seemed relevant to the phenomenon of interest. The researcher noticed recurring key words, patterns, or themes and exceptional or revealing events (Carspecken, 1996) and to identify meaning fields (possible underlying meanings). The researcher began to construct low-level codes, which organized the data in a meaningful way, using words similar to those voiced by the participant. An example of developing meaning fields and low-level coding is provided in Table 3.1. The underlining of certain words or phrases in the example in the table indicates recurring word, patterns, or themes noted in transcripts.

After analyzing the second transcript in the same manner as the first, the researcher reviewed both transcripts to compare, define, refine, or add meaning fields and codes. Subsequently, each additional transcript was analyzed in the same manner. As the coding continued, subcodes were constructed and defined to indicate important distinctions within codes. The construction of codes and subcodes began to give the data a hierarchal structure (Carspecken, 1996).

Table 3.1. Example of Developing Meaning Fields and Low-level Codes.

Data Sample	Meaning Field	Low-level Code
Okay, uh, when I was in high school, I wanted to be a chemical engineer, and uh, I had an extra elective, uh, my senior, my junior, my junior and senior year, so I took a class called HOSA, Health Occupation Students of America, just to see what the medical field was like. And uh, I ended up, um, really enjoying the medical field. Uh, our first year we got our CNA license and in our second year, we, uh, visited hospitals, uh, four days a week and followed people that we, you know, might want to be in the profession one day. And I knew I wanted to be in the medical field. I didn't know where. So, I knew nursing was a good platform to go anywhere. So, I decided to, um, start out as a nurse and um, use that as a platform uh, to go to, you know, I knew I would enjoy that and if I wanted to stay there I could or I could, if I, you know, it would be a good platform to go anywhere else in the medical field. (P1 L6-16)	Helped him learn about the profession to see if it was a good fit or decision for him	Experiences when choosing nursing as a profession
	Found he liked healthcare and nursing was a good platform if he wanted to move on	Experiences when choosing nursing as a profession
	Validated his decision and pursued nursing	Experiences when choosing nursing as a profession

An example of an early code with subcodes and distinctions is presented below:

1. Experiences when choosing nursing as a profession – exposures to people or situations when deciding to become a nurse.

a. Gender neutral experiences when choosing nursing as a profession – the participants' experiences were the same as anyone choosing nursing as a profession might have.
b. Male specific experiences when choosing nursing as a profession – the participants' experiences were specific to a male choosing nursing as a profession.

See Appendix E for a complete list of low-level codes.

As coding continued, the researcher refined the more concrete low-level coding into more abstract higher-level codes (Thomas, 1993). Compared to lower-level codes, which begin the process of meaning reconstruction, higher level codes are based on explicit reconstruction and are necessary for generalizing findings emerging from qualitative data (Carspecken, 1996). Higher-level codes were developed to describe, organize, and interpret themes in the data (Carspecken, 1996). Table 3.2 provides an example of coding evolution from lower to higher levels. The complete list of higher-level codes is provided in Appendix F. The abstracting process continued with the higher-level codes and led to the final themes and subthemes that are presented in Chapter Four.

Provisions for Trustworthiness

Ensuring accuracy of evidence is vital to make certain the most accurate information is published while also preventing the imposition of researcher bias (Thomas, 1993). While quantitative research utilizes methods to ensure reliability and validity in a study (Burns & Grove, 2005), qualitative research adheres to criteria to establish trustworthiness or truth value in a study (Lincoln & Guba, 1985); these criteria are "associated with openness, scrupulous adherence to philosophical perspective, thoroughness in collecting data, and consideration of all the data in the subjective theory development phase" (Burns & Grove, 2005, p. 55). Thomas briefly addressed the importance of ensuring accuracy in critical ethnographic research and Carspecken (1996)

Table 3.2. Evolution of a Low-level Code to a High-level Code.

Data Sample	Low-level Code	Higher Code	High-Level Code
. . . the field was just so vast, the medical field. And I thought well shit, you can get into nursing. You can go into pharmacy you know. I mean there was just so many, the medical equipment side. (P3 L37-39)	What he liked about nursing	Variety	Attractions to becoming a nurse
I was definitely expecting getting a hard time about going and doing, women's work. That, that's something that, girls do, kinda thing, you know. (P5 L348-350)	Nursing is for women	Stereotypic responses	Other's responses to him considering nursing
. . . [male nurses] help with the *pay*, we bring more *clout*, to nursing. Uh, I think it's made it easier for the women to get more respect in the field now, since there's a lot more *men* in it. (P3 L182-186)	Increase pay and respect	Helping the status of nursing	Contributing to nursing

deferred to Lincoln and Guba's criteria when discussing methods of ensuring trustworthiness of a critical ethnographic study. This study utilized Beck's (1993) modifications of Lincoln and Guba's criteria to assure trustworthiness of the study processes. Beck's criteria are credibility, fittingness, and auditability.

Credibility, the criterion against which truth value should be judged, "measures how vivid and faithful the description of the phenomenon is" (Beck, 1993, p. 264). Participants in the study as well as readers who have had the same experience should recognize the researcher's description of the experience as their own. Thomas (1993) and Lincoln and Guba (1985) referred to triangulation (Denzin & Lincoln, 2003) as a strategy to achieve credibility. Triangulation is a method of obtaining data redundancy as well as providing multiple perceptions (Janesick, 2003). Triangulation occurs when multiple sources such as multiple participants, multiple methods (i.e., interviews, focus groups), multiple investigators, and/or multiple theories, are used to develop themes in a qualitative research study (Creswell & Miller, 2000; Janesick, 2003). Triangulation was achieved in this study by reviewing data sources, conducting interviews with multiple participants, performing field observations, and having several informal conversations with different colleagues.

Member checks are used in many qualitative studies to establish credibility (Lincoln & Guba, 1985). This study used member checks at two different points. Member checks occurred during the data analysis process when the researcher asked three participants to review their interview transcripts to ensure accuracy. Member checking also occurred when the researcher discussed the research findings with five participants to ensure the researcher had accurately captured their experiences. The final thematic analysis also was presented to the five participants who each agreed the overall theme of the data was representative of their experiences. Participants' critiques were considered and their meaningfulness weighed before the researcher drew the final conclusions of the study.

Additionally, Carspecken (1996) advocated the use of peer debriefers to enhance credibility and to prevent introduction of researcher bias. Two female peer debriefers, who were members of the researcher's dissertation committee, reviewed every step of data collection and analysis in this study (Carspecken, 1996; Lincoln & Guba, 1985;

Thomas, 1993). Peer debriefing ensured that all low and high level codes were supported by the data and the categories were exclusive; the female gender of the peer debriefers provided a perspective that helped to identify potential areas of researcher bias. Differing perspectives were discussed until a consensus was reached.

Fittingness, the criterion against which applicability of the study findings should be judged, "measures how well the working hypothesis or propositions fit into a context other than the one from which they were generated" (Beck, 1993, p. 264). Carspecken (1996) suggested that using the same subjects repeatedly in order "to produce richer and more-disclosing information" (p. 166), or to produce thick descriptions of the sample and context. Follow-up interviews and member checks were performed via telephone with five of the participants to ensure the study findings reflected their experiences. Preliminary findings were presented to male nurses at a national conference; the male nurses in the audience agreed that the study reflected their personal experiences. Replication of the study by other researchers also will help to validate or challenge the study's findings (Thomas, 1993).

Auditability is "when another researcher can clearly follow the 'decision trail' used by the investigator in the study" (Beck, 1993, p. 264). A decision, or audit, trail describes the researcher's data, perspective, and situation to ensure another researcher could arrive at the same or comparable conclusion (Lincoln & Guba, 1985). This researcher maintained a clear audit trail of the study's aims, participant recruitment, data collection, and data analysis, documented in two separate journals, a primary record and a field journal. The first journal, or primary record, was used to record thick detailed descriptions of observations in the field. Items included in the primary record were the setting, time, nonverbal behavior, and distractions occurring during interviews as well as other observations that seemed relevant. The second journal, or field journal, was used to record the researcher's feelings or thoughts before and after conducting the interviews, observations, and thoughts about the direction of the research.

Chapter Three has described the research design of this study. Pleck's (1981, 1995) MGRI and GRS paradigms were used as the sensitizing orientation of the study. The methods for sampling, data collection, data management, data analysis, and trustworthiness have been described in detail, as well as the steps the steps the researcher took to ensure these criteria were met.

PLAN OF REMAINING CHAPTERS

The emerging themes from this study are discussed in Chapter Four. Chapter Five provides a summary of the entire study, discussion of the findings, implications of the findings, recommendations for future research, and conclusions.

Chapter Four: Findings

INTRODUCTION

Chapter Four presents the findings, what Thomas (1993) refers to as interpretation, of the critical ethnographic study exploring the perceptions of men in nursing about how gender influenced their career paths. Chapter Four begins by describing the demographic data gathered for the study, followed by presentation of the data. The findings then are linked to the following research questions posed in this study:

1. What influenced the decision of men in nursing to pursue nursing as a career?
2. What are the perceptions of men in nursing regarding the effects of their gender on their nursing educational experiences?
3. What are the perceptions of men in nursing regarding the effects of their gender on their professional experiences?
4. What do male nurses believe would increase male participation in nursing?

PARTICIPANT DEMOGRAPHICS

Lincoln and Guba (1985) dictated that demographic data can aid in determining the applicability of a study's result to other similar settings. The demographic data in critical ethnographic studies is important to help define the boundaries of a given culture. Table 4.1 presents the demographic data of the nine men who participated in this study.

Table 4.1. Demographics of the Participants.

Variable	N	Years	Mean
Age in Years	9	25-53	39.3
Experience in Years	9	3-24	10.9
Highest Education Achieved			
Associates	3		
Bachelors	5		
Masters (Non-Nursing)	1		
Highest Education in Nursing Achieved			
Associates	4		
Bachelors	5*		
Nursing Was First Career			
Yes	3		
No	6		

*1 individual enrolled in an MSN program

The nine men ranged from 25 to 53 years of age (mean age of 39.3). Six were Caucasian, one was African American, one was Hispanic, and one was Asian. Seven of the participants were married. One participant was single. One participant was openly gay and in a long-term relationship.

The participants' educational level ranged from an associate degree to a non-nursing master's degree. Four participants had obtained an Associate's Degree in Nursing (ADN); 5 had earned Bachelor of Science in Nursing (BSN) degrees, and another participant was enrolled in a Master of Science in Nursing (MSN) program. Nursing was the first occupation for three participants, while the remainder had worked in another field unrelated to healthcare prior to becoming a nurse. The men had been registered nurses from 3 to 24 years (mean 10.9). The oldest participant (53 years of age) had the fewest years of experience (3 years) as a registered nurse. Participants reported having worked in medical-surgical, adult emergency room (ER), pediatric ER, dialysis, cardiovascular recovery, intensive care units (ICU), and cardiac units. At the time of this study, seven participants were working in ICUs, one worked in the ER, and one worked in both the ER and ICU.

INTERPRETATION OF THE DATA

The study findings arranged themselves naturally into three timeframes: choosing to become a nurse, becoming a nurse, and being a nurse. Some themes and subthemes recurred across timeframes. Table 4.2 provides an overview of the timeframes, themes, and subthemes identified in the participants' narratives.

Table 4.2. Overview of the Timeframes, Themes, and Subthemes

Timeframe	Themes and Subthemes
Choosing to Become a Nurse	A. Exposure to the role B. Attractions to becoming a nurse 1. Stability 2. Helping people 3. Belonging C. Responses to his considering becoming a nurse 1. Supportive responses 2. Stereotypic responses a. Nursing is for women b. Men in nursing are gay c. Men should aspire to do more than bedside nursing D. Reframing a barrier
Becoming a Nurse	A. Surviving nursing school 1. Enduring the challenge 2. Feeling different B. Sustaining his desire to be a nurse 1. Helping people 2. Enjoying the challenge C. Responses to his being in nursing school 1. Supportive responses 2. Stereotypic responses a. Nursing is for women b. Men in nursing are gay c. Higher expectations for men in nursing D. Creating a niche 1. Contributing to nursing 2. Enhancing resolve a. Reframing a barrier b. Protecting self

Being a Nurse	A. Choosing to stay in nursing 1. Stability 2. Helping people 3. Camaraderie 4. Enjoying the challenge B. Responses to his being a nurse 1. Respectful reactions 2. Stereotypic reactions a. Nursing is for women b. Men in nursing are gay c. Nursing is menial work d. Higher expectations for men in nursing e. Men are viewed as muscles C. Creating a niche 1. Enhancing resolve a. Reframing a barrier b. Evolving norms c. Protecting self 2. Contributing to nursing a. Being an example b. Bringing different characteristics c. Helping the status of nursing D. Changing the image of nursing

The following sections present the study findings according to the three timeframes, choosing to become a nurse, becoming a nurse, and being a nurse. Excerpts of data are provided to support themes and subthemes.

The sources of data excerpts are identified within parentheses. The capital letter, "P," will be followed by a number (1 through 9) to designate which participant made the statement. For example, P1 designates the first participant recruited to the study. A lowercase "b" or "c" designates the second or third interview with a given participant. The capital letter, "L," designates the line numbers where the quote was located in the transcript. For example, the notation (P1c L5-10) means the statement was extracted from participant 1's third interview, lines 5 through 10. The presentation of the data begins in the following section with the first timeframe, choosing to become a nurse.

CHOOSING TO BECOME A NURSE

The first timeframe to emerge in the data was *choosing to become a nurse*. This timeframe was when the men were exploring whether they were suited for nursing and whether nursing was a fitting profession for them. Four themes, *exposure to the role, attractions to becoming a nurse*, *responses to his considering being a nurse*, and *reframing a barrier*, influenced their decision making.

Exposure to the Role

Participants described how their experiences with healthcare professionals, nurses, or male nurses gave them *exposure to the role*. Some participants became interested in healthcare or nursing because of personal experiences or family illnesses:

> To become a nurse. . . . Actually this started when I was about eleven years old. I had. . . [a family member] that was sick. He had diabetes real bad, and he had just become debilitated, and so we didn't want to put him in any nursing home or something like that. So we just took him home and we took care of him. And both of my parents were older, so basically, they showed me how to do it. . . . I got that love just from taking care of people and just taking care of him (P7 L11-17).

Another participant had several life experiences that exposed him to nursing roles: "I had had a knee surgery, and, actually, that's the point, I really started first seriously looking at nursing school and kinda checkin' it. . . but I still didn't do anything with it for several years" (P5 L12-15). He also had a child who required eye surgeries. Caring for the child influenced his decision to pursue nursing:

> I basically did her nursing. . . I'd lose three days of work every time we had a surgery, because I'd stay up all night, doing the drops in her eyes, tryin' to, trying to get stuff going. And so that. . . laid a ground work for [me wanting to be a nurse] (P5 L189-192).

An additional exposure that affected his interest in nursing occurred when a family member required hospice care. He developed a close, admiring relationship with the hospice nurse, "So that's what a hospice nurse does? I could see me doing that" (P5 L261-262).

Two participants had taken classes in high school or college that led them to see themselves in healthcare or nursing. One said:

> [In high school] I took a class called HOSA, Health Occupation Students of America, just to see what the medical field was like. . . I ended up really enjoying the medical field. Our first year we got our CNA license, and, in our second year, we visited hospitals four days a week and followed people that we might want to be in the profession one day. And I knew I wanted to be in the medical field. I didn't know where (P1 L6-12).

Another participant began studying pre-med but changed his major after experience with nursing:

> I was going to [college]. . . and we had to volunteer in a hospital as part of a psych course, and I was pre-med at the time. . . . I ended up going to [a hospital] downtown. . . in the ER and then also the ICU. And I realized at that point that the nurses had a lot more contact with the patients, and that the doctors just sat in the nurses' station and told the nurses, you know, instructed them about what needed to be done with the patient, . . saw the patient for about five minutes and went back and sat down back at the nurses' station and did like thirty minutes of dictation. And I thought, "Well, this is not really what I wanna do," and I just wanted to have more patient contact than what the doctors did (P4 L7-16).

Two other participants described how being around nurses led to their consideration of nursing as a career. One said:

> My mom was a nurse since before I was alive, and I'd always hear stories from work, and her telling me about what she does, so I kinda got the inside story about what a nurse actually does. I kept hearing from my mom about the things she would do [as a nurse]. . . so I said, "I'd like to try that out" (P2 L6-12).

Another participant described how his experiences with military nurses influenced his decision to become a nurse: "One of the nurses used to be my roommate, and, so, that's how I knew a lot of the nurses, and, I'd hear all their stories and everything. That's sort of how I got into [nursing]" (P3 L13-15).

The media also played an influential positive role in one participant's decision to become a nurse. "I always had this thing for the medical field because I was watching [television] shows, and you always see the excitement, and you know they're saving people's lives and doing all that stuff" (P2 L53-54).

Three participants reported little or no exposure to nurses. One said: "I didn't know any nurses. I'd never been in the hospital. . . . Never been around sick people or anything. First sick person I saw was when I went to my first patient in nursing school" (P8 L10-20).

Three participants described how exposure to men in nursing positively influenced their decisions to become nurses, although the exposures did not occur until they were young men. One's first exposure occurred in a college course that required hospital rotations, during which he first encountered a male nurse: "in my generation, when I was growing up, I never heard of male nurse, males being nurses" (P4 L256-7). Another said:

> Being from [state] and a small town, . . . male nurses weren't prevalent. Like, as a matter of fact, I didn't know any male nurses coming up, so it just wasn't something that was prevalent. . . . I didn't know that there were that many male nurses (P7 L50-54).

One participant explained that the exposure to men in nursing helped change his perception that men could not be nurses:

> The only thing that changed me is, when I was in the Air Force and I had a roommate that was a nurse, and then [I was] hanging out with her friends. She had a couple of guy friends. Oh, they're nurses, you know. And then I went up on the unit a couple of times, and got more exposure, and was like, "Huh," seeing the way people treated them and stuff (P3 L211-215).

He added, "I. . . found out there were more men in [nursing]. That's when I got interested in it" (P3b L148-150).

The participants' exposures to nursing through family and friends proved influential to their decisions to pursue nursing as a profession. The participants used these experiences to visualize themselves in the nursing role and determine if nursing was a good fit for them, as well as to gauge how they fit into the nursing profession. Positive exposures inspired the participants to become nurses and gave them firsthand knowledge about nursing roles. Men in nursing were role models for participants, aiding participants

to envision themselves as a nurse despite social stereotypes. Participants with limited or no exposure to men in nursing were more likely to hold social stereotypes about nurses, which at least initially, negatively impacted decisions to pursue nursing as a profession.

Attractions to Becoming a Nurse

The participants were attracted to nursing because of the advantages nursing offered them. *Attractions to becoming a nurse* were things the participants had observed about the profession that they saw as important for themselves and their futures. These included financial and career *stability*, opportunities for *helping people*, and a sense of *belonging*.

STABILITY

Some participants believed nursing was a good career that could offer financial stability. One explained:

> I had a family at the time, job security. And, of course, the money part of [nursing] was good too. I needed to do something that I liked, and something that I could do for a long time. I saw [nursing] as something I could do for a long time and enjoy doing, so that's what I did (P2 L67-70).

Another participant said:

> I was still in the military, and in the newspapers the job market [for nurses] looked good, and so that's why I decided to go to nursing school. Well, because the job market looked really good. . . . It always has [been good] for nurses (P8 L8-10).

Others perceived that various specialty areas and work schedules in nursing would offer them flexibility as the participants' interests or life situations changed:

> Nursing has so many options. You go into nursing, and you're not tied to just one thing. You can do critical care. You can work inside a hospital, outside a hospital in a clinic, and do research. You can do so much with a nursing degree that you couldn't do with others. I think that was part of the appeal (P2 L63-67).

Another was attracted to the career opportunities in nursing: "Nursing is a great background for any different area, a nurse practitioner, physician's assistant, administration" (P1 L23-25).

Participants used knowledge about themselves and about the nursing profession to visualize different possible scenarios in their future, such as changes in their interests or lifestyle. Their perceptions of nursing as offering stability, flexibility, and adaptability helped them determine if being a nurse was a good long-term fit.

HELPING PEOPLE

Five participants described the opportunities in nursing for *helping people* that attracted them to nursing. One explained: "I liked the fact that . . . [as a nurse, I would be] providing a service. . . that I felt like I could actually be of service. . . that I could give a hand" (P6 L67-71). He added, "I might be able to help out. . . . That's what drove me to [nursing]" (P6 L88-100). Another stated, "I always knew I was going to do something to help. I like working with people, but I never really knew what exactly what I wanted to do that" (P8 L82-83). Yet another was attracted because, "I like working with people. I like helping people" (P3 L7).

Some participants felt a calling to nursing. One described nursing as:

> Something that I felt like for a long time that I was supposed to do, and, back when I first got out . . .[of the military], that was actually one of the first times that I felt like this was something I was supposed to do" (P5 L7-9).

Nursing allowed this participant to help people and included opportunities to use personal qualities he had admired in other nurses: "The care that [the nurse] gave [my family member], the compassion that she had was, was one of the things that, tuned me in to [nursing as] something that I was supposed to do" (P5c L82-84).

Participants were attracted to nursing because nursing provided opportunities for helping others. They anticipated being able to work with others and to demonstrate qualities that they admired in other nurses.

BELONGING

Two participants were attracted to nursing because they wanted to be part of a group with similar beliefs or goals. They felt a sense of *belonging* in nursing:

> I liked the. . . close grouped-ness on the unit and seeing how they worked together and everything. . . . It seemed like, in nursing, it was more working together, you know, like as a team (P3 L32-36).

Another admired the close teamwork of emergency room nursing staff: "They worked really well together. They were a very cohesive group" (P4 L28-30).

The men in this study described several factors that attracted them to nursing and influenced their decisions to pursue nursing as a career. They viewed nursing as a career that offered them stability, good pay, flexibility, variety, and career choices as they progressed through their careers and personal lives. Nursing was a profession where they could see themselves for a long time. They were attracted to nursing because it offered opportunities for helping people, working as a team, and belonging to a group with shared beliefs or values.

Responses to His Considering Becoming a Nurse

The participants' decisions about becoming a nurse also were influenced by others' reactions. *Responses to his considering becoming a nurse* included reactions by family, friends, and others, which participants considered before making decisions about choosing nursing. Some people's responses were supportive or positive, and others reflected stereotypes about nursing and men in nursing.

SUPPORTIVE RESPONSES

Participants viewed reactions by others who indicated acceptance or reinforcement of participants' deliberations about nursing *as supportive* r*esponses*. Eight participants described receiving such support, most of which primarily came from family members or members of the nursing profession. One said, "My parents supported me, so

that's nice" (P1 L46-47). Another participant stated: "My family was, it was still, very supportive. My dad, his words were, 'Go for it man. If that's what you want to do, go for it'" (P5 L149-150). He added that family members had commented: "'You will do good at that, you've got compassion that they need. You need to do that'" (P5 L165-166). Yet another said his family was encouraging because:

> They knew it was a secure job, that no matter what would happen . . . there was always going to be sick people and they were always going to need nurses. And no matter what city I went to, no matter where I would go, or no matter what age I was at, I would always have a job. . . they also liked the fact that there were also so many opportunities in nursing (P6 L26-29).

Three participants had family members who were nurses. One participant described the reactions of his mother, a nurse, and his father:

> Of course she [mother] was very supportive of it. My dad I, I think he was supportive of it as well. . . . He was okay with it because he knew that what I was going for and that I had a young family at the time: the fact that I was just supporting my family made him proud (P2 L76-84).

Another participant reported support from his sister, a nurse, who told him: "'You know, I think you would do really good in [nursing]. . . . I think. . . it would suit you really well'" (P6 L13-14).

Although the participants held their family members' opinions in high regard, the responses of friends and coworkers also affected their decision making about nursing. One participant explained how he "got really encouraging words from [the nurses with whom he worked as a technician] to pursue a nursing degree" (P2 L15-16). Another participant described his friends' support: "Most of the people I hung with, they said, 'Great, go for it.' That's all they would say" (P8 L37-38). Hearing others' supportive responses reinforced participants' conclusions that nursing would be a good choice.

STEREOTYPIC RESPONSES

The second type of reaction encountered by the men as they considered nursing was *stereotypic responses,* which typically reflected prejudgments about men in nursing

and were viewed as unsupportive of nursing as a career choice for men. Participants encountered three stereotypical reactions: (1) nursing is for women, (2) men in nursing are gay, and (3) men should aspire to do more than bedside nursing.

Nursing Is for Women

Three participants described encountering perceptions that *nursing is for women*. One participant explained how his friend would call him "a *murse* or make several jokes about it being a woman's career" (P1 L53-55). He clarified that the term "*murse*" is "slang, like a joke for a male nurse. . . . It's a male nurse all slanged into one word. It's used to describe a nurse, a male nurse" (P1 L67-70). The term "murse" proved familiar to at least five participants who had heard similar comments.

The participants also encountered perceptions about nursing as menial and women's work. One explained such comments as, "like you're going to be changing bedpans" (P1 L89). Another commented, "I was definitely expecting getting a hard time about going and doing women's work. 'That's something that girls do' kinda thing" (P5 L348-350). Yet another described the relationship between traditional gender role norms and professions:

> Being a guy and an ex-athlete, . . . people just weren't open to [my wanting to be a nurse]. . . . There's always the old-school class of person that's like, "Man? Nurse?" . . . They just didn't understand how things have changed. It was just kind of that old-school mentality . . . for the most part, [nursing] was considered, "soft," you know (P7 L40-56).

Participants regarded such comments or jokes about nursing as a profession for women as suggesting that men in nursing would violate masculine role norms.

Men in Nursing Are Gay

A second stereotype that the participants faced while contemplating a career in nursing was about the sexuality of men in nursing. All participants encountered beliefs that men who enter nursing are gay. One said his friends believed: "Most of the guys I

would be [working] with would be homosexual" (P1 L52-53). Although this comment was not directed at the participant, it made him mindful of the stereotype. Another participant noted, "I got some of the things about 'the gay thing,' being a guy going into nursing. 'That's not what a straight guy does.' But that was *not* from anybody that really knew me" (P5 L357-360). Participants differentiated between people who knew them well and those who did not, and opinions of people who did not know them well had less influence on participants' decisions to become a nurse.

Nonetheless, three participants noted stereotypes about *men in nursing as gay* as inhibiting or delaying their decision to choose nursing. One participant said:

> Back [in the 70s], a guy going into nursing was thought to be a little funny, so, I did not go after [nursing] at that time. You can say I succumbed to peer pressure or whatever, or a perceived peer pressure, that I did not [pursue nursing] at that time (P5 L9-12).

It was not until later in his life that this participant decided to pursue nursing. Another reported, "If you would've asked me when I, like, first graduated high school, it's like 'nah,' because that was stereotypical. 'No, I'm not gay.' I'm not going to [become a nurse]'" (P3 L8-10). He added, "You know, at that time, there were more stereotypes, you know, of men being gay that were going into nursing, and, at that time, I wasn't even interested" (P3b L146-148).

A third participant reported being initially hesitant about nursing as a career because he was "already gay, and they [would] find out I'm gay" (P9 L124). His statement reveals that the stereotype that *men in nursing are gay* impacts both heterosexual men considering nursing as a profession and homosexual men who may not want people to know they are gay.

All participants noted having heard comments that men in nursing are gay. For some, at least initially, this pervasive stereotype delayed entry into the nursing profession.

Men Should Aspire to Do More than Bedside Nursing

A third stereotype encountered by participants as they were deciding whether to become a nurse was that *men should aspire to do more than bedside nursing* or that nursing could be a stepping stone to achieve a higher position, such as an advanced practice nurse, administrator, or physician. One participant described his health occupation teacher in high school: "She definitely pushed us [male students] towards CRNA [Certified Registered Nurse Anesthetists] school [rather than remaining a bedside nurse]" (P1 L33-35). The comment indicates how this participant's view changed from seeing the teacher as supportive to seeing the teacher as "pushy." The participant also felt pressured to become more than a bedside nurse when people asked him if he "wanted to go to med school one day" (P1 L58). He interpreted questions about his future plans to be a bedside nurse as pressure to decide what he might next become, as if being a man in bedside nursing violated masculine role expectations.

Nursing has traditionally been a female profession. All the men in this study encountered gender-related stereotypes about nursing that had potential to divert their attention away from nursing as a viable career choice. These stereotypes diminished the man who chose a traditional bedside nursing role and characterized the profession of nursing as a less suitable profession for men in our society.

Reframing a Barrier

The third theme in the *choosing to become a nurse* timeframe was *reframing a barrier*. This theme represented the ways participants dealt with the challenges they faced when choosing to become a nurse as a profession. The participants reframed people's stereotypic comments as being "teasing," "ribbing," or "joking" to lessen the impact of unsupportive responses to their interest in nursing.

A participant described a response shared by half of the participants; "you get a lot of flak. . . . You get a lot of joking" (P2 L93-94). Another participant perceived his co-workers' comments as "just teasin' me" (P3 L53).

One participant described how he interpreted his brother's teasing:

> Of course my brother was gonna give me a hard time. That's to be expected, right?. . . We give each other a hard time about things. . . but it's all meant in love. . . . There's no condemnation, there's no nailin' each other to the tree or anything (P5 L166- 301).

The same participant talked about how he also did not interpret stereotypic responses by his friends at work as being negative:

> And if [a comment] was ever said to me, it was all said with a smile. Of course I was going to get a little ribbing out of it, but it wasn't any kind of serious, anything, because the same people that was saying something like that, was the same people that were saying, "Go for it, you can do it." . . . It was all in jest (P5 L348-366).

The closer the relationship between participants and the people who made unsupportive remarks, the more likely the participant would be to perceive the comment as a joke or teasing. However, participants' tolerance had limits: "You can put up with it sometimes, but it does get *kinda old after a while"* (P1 L91-192).

Summary of Choosing to Become a Nurse

The participants' focus during the period when they were choosing to become a nurse was deciding whether they fit into nursing and whether nursing was a fitting profession for them. Most participants became interested in nursing through exposure to the nursing role via personal or family illness, acquaintances who were nurses, classes, or the media. Only one participant had no exposure to healthcare or healthcare providers prior to entering nursing school. Participants used the exposures as a way to explore whether or not nursing was a viable career option. Being exposed to healthcare or nursing allowed the men to gain insider's knowledge about the profession – what it took to be a nurse, what nursing had to offer, and especially the compatibility of their personal

characteristics with the profession. Participants' attractions to becoming a nurse included the financial or job stability nursing has to offer, the idea of helping people, and/or the sense of belonging.

Nursing was a second career for six of the participants. They understood that nursing had a lot to offer, but at the same time they also used people's responses to their considering being a nurse to gauge whether nursing would be viable for them. Additionally, they had to consider if men belonged to, or fit into, the female-dominant field of nursing in order to feel comfortable with social stereotypes about men in nursing. Other peoples' supportive responses enhanced the participants' perceptions that nursing could be a viable career. Others' stereotypic responses, often based on society's traditional beliefs about gender roles, were viewed as unsupportive, although such responses were interpreted as joking or teasing, especially if coming from a friend or family member.

BECOMING A NURSE

Once the participants in this study decided to pursue nursing as a career, they went through a transition period to become nurses. This transition is described in the second timeframe, *becoming a nurse*, which reflected the years the participants were enrolled in nursing school. Four themes characterized this timeframe: *surviving nursing school, sustaining his desire to be a nurse, responses to him being in nursing school, and creating a niche*.

Surviving Nursing School

Participants' descriptions during the timeframe of becoming a nurse primarily focused on *surviving nursing school,* or overcoming the difficulties they faced in nursing school. Two difficulties experienced during nursing school were *enduring the rigorous nursing program* and *feeling different*.

ENDURING THE RIGOROUS NURSING PROGRAM

Several participants described the rigors, or demands, they encountered while studying nursing. Three participants described how nursing school required so much of their time; they had to "juggle the work schedule with the school schedule" (P3b L28). One participant stated, "I didn't have a life back then. . . . Nursing school in itself is a sacrifice" (P7 L119-309). Another participant explained, "[Nursing school] is a really intense program. . . lots of busy work, sometimes a hectic schedule, a lot of material to learn" (P1b L25-6). Other challenges included working as part of a team and completing clinical experiences.

These men were not unlike female nursing students with limited or no knowledge about nursing when they entered nursing school. Nursing school placed intense demands on their lives.

FEELING DIFFERENT

The participants also explained that nursing school was challenging for them because they felt out of place. Three participants described *feeling different* from other nursing students *because of* their male gender:

> I felt that nursing school was a lot more "touchy feely"- type classes than I wanted. I prefer, I really enjoyed the anatomy and physiology, the patho, the advanced pharmacology, health assessment, even OB and pedi, you know, the critical care classes and stuff. I really liked those. Some of the other ones, they were really fluffy and wanted a lot of. . . [trails off]. I felt that a lot of the courses were like that in nursing school . . . [they] wanted a lot of feelings and emotions, and "what I felt," and things like that, which I didn't particularly like (P1b L14-19).

A pervasive lack of male role models in nursing also contributed to feeling out of place. One commented on the lack of nurses when the participant's father was hospitalized while the participant was a nursing student:

> When my dad was in this hospital over here, even in the ER, I don't remember one single male nurse over here. It was all female, all the way through, in the

> ICU, in the ER. I cannot think of a male nurse over here, . . . I was just fixin' to start A and P [anatomy and physiology], so I'm, you know, I woulda been payin' attention, and I don't remember seeing one. And that was a at least six bed MICU. So over here, in this part of the world, a male nurse is going to be a rarity (P5 L751-758).

Another participant described his experience as the only man in his nursing class:

> I was the only male in my class when I, when we first started. I was the only male. . . I knew I was in some trouble as far as the male - female thing, you know. . . I was just like, "This is going to be a little bit more of a challenge," as far as that part goes. . . .I just think it was going to be the fact that you're a male coming into a female dominated business, basically. That's what you're doing, you know. You're putting yourself into this environment, and I learned a lesson there. . . [He felt like] If you had a piece of paper, and had a bunch of squares, small squares on this piece of paper, and you were the only circle on that piece of paper (P8 L46-110).

Being a man in the female-dominated nursing profession made several participants feel out of place in nursing and in nursing school. They felt the content of some of their courses was incongruent with how they, as men, thought or expressed themselves emotionally. There were limited role models who were male nurses. And, finally they found themselves as the only man in their cohort.

Sustaining His Desire to Be a Nurse

Participants also described how nursing school allowed them to experience some of the same attractions that initially had made nursing seem appealing. Two aspects of nursing or nursing school that *sustained his desire to be a nurse* were *helping people* and *enjoying the challenge.*

HELPING PEOPLE

Two participants described how opportunities to help people sustained them during nursing school:

> The most rewarding about nursing school was first day and last day of clinical, when I did my first rotation in a nursing home. My first day there, I remember when we left. Man, I was almost to tears because I thought about how bad a shape these individuals were in, with horrible care. . . . and it broke my heart because I

> thought, "Okay, when I leave, none of us are going to be here next week. Nobody's gonna be here until the next class, which is God only knows when that'll be (P6 L154-176).

Another participant found the opportunity to help fellow students in the lab:

> I'd . . . go help people with skills and practice stuff. And so, through that, I developed a lot of relationships with a lot of people, that I think gave me, that might have been part of, why I felt like that maybe I got treated a little special, was 'cause I put myself out there to help people (P5 L436-439).

Helping others gave the participants a sense of worth or meaning. They felt able to make a difference in other peoples' lives.

ENJOYING THE CHALLENGE

Participants reported *enjoying the challenge* of nursing school. One participant enjoyed having "so much information to learn" (P9 L639). Another stated, "that's why I went to nursing school, was to learn the. . .information" (P1b L52). A third reported that nursing school "let me know that anything I put my mind to I could do. It was fun. I learned a lot" (P7 L119-120). These three participants found nursing school provided stimulating challenges and opportunities for growth.

Responses to His Being in Nursing School

Participants recalled faculty members' and other students' responses to them as males in nursing school. *Responses to his being in nursing school* were of two types: they were *supportive responses* or they were *stereotypic responses*.

SUPPORTIVE RESPONSES

Three participants described other peoples' reactions that showed acceptance or support of them as men in nursing school. One said he felt the faculty was:

> . . . glad to see you there. . . . They were glad to see everyone there, but it was. . . almost like there was extra. . . extra effort . . . like an extra support . . . maybe encouragement. . . . because I was a guy. . . .That was an impression I got from

> faculty there, that there was a need, and they were trying to help fill that need (P5 L399-460).

Another participant felt encouraged when the faculty "gave me a lot of confidence" (P9 L624). A third participant enjoyed the extra attention of being a man in nursing school: "I got more attention because I was easier to pick out in the crowd" (P2b L36-37). One participant reported support from faculty and students, who were "glad to see that it wasn't all women, going in there" (P5 L403).

Being a man in nursing school had its positive aspects. Some faculty and students were more welcoming because participants were men. Participants also got more attention because they were men.

Stereotypic Responses

All the participants described experiencing responses that reflected stereotypical beliefs or prejudgments about men in nursing school. The participants perceived these responses as challenging men's place in nursing. Participants reported experiencing three stereotypes when they were in nursing school: (1) nursing is for women, (2) men in nursing are gay, and (3) men should aspire to do more than bedside nursing.

Nursing Is for Women

The most common stereotypic response mentioned was that *nursing is for women*. One participant encountered staff nurses who were not accepting of male nursing students:

> In the clinicals, on some of the floors, the older nurses, were not so accepting. . . I remember the feeling, almost like I had been set up to fail. . . . It was mostly attitude, kinda, it was almost a, "Oh, what is he doing here?" kinda thing. You know, it seems like there was some of the night nurses, didn't really want to give report 'cause it was, like, "Well, a guy can't be a good nurse," so they didn't want to give me their patient. . . That was like the attitude that they were giving me. Yeah, and that could've been a misinterpretation of it, that they didn't want to do it 'cause I was a student. But I felt like it went further than that. It was more about the guy thing than a student thing. . . . [I felt] prejudiced against (P5 L497-534).

Another participant had a similar experience during his obstetrics rotation:

> Typically it's not acceptable for a male to be watching a stranger. . . delivering a baby. So a lot of times in obstetrics, males are maybe not allowed into the room or asked to go to another area because the females don't feel comfortable with a male in the room. And that can make you feel kinda like you're not really welcome. But, like, with doctors, the males have been obstetricians forever. They were the original obstetricians. They didn't even used to have female obstetricians. Now there still are a lot of male, you know, OBs. But it seems like, with nursing, it's just not as accepted for some reason for a male to learn from the child birth process from actually watching it, which is something a male needs to know. Like, in the ER, we get women delivering babies, and it's good to have that knowledge, but if you're not able to learn from, from actually watching that happen because of society's norms, and then it can be frustrating (P1 L437-453).

A third participant felt unwelcome on a post-partum unit:

> I was there for, like, two days, and nobody said a word to me the whole time. So that's where I kind of knew, "Hey, you know, no men here" . . . . It just kind of made me feel like it was a place where men didn't have a real strong, they just made me feel like it wasn't something for me – that it wasn't something I wanted to do . . . just because of the reaction to me (P7 L96-104).

Some participants believed nursing faculty were not accepting of men in nursing school. One participant explained:

> I think I've experienced more discrimination in nursing school than I did when I became a nurse. . . especially from instructors. I think that there were some instructors who felt like males coming into nursing was a threat to them, and so they treated us a little bit, uh, harsher, especially in clinical. I think there were some that were harder on the male nursing students. . . . in check offs, in clinical. Their attitude towards us seemed to be a little more negative. . . . The sentiment among all the male nursing students in that class was . . . , '*Oh*, you have her. She can be harder on you because you're a guy.' I think they graded us a little harder. They just didn't treat us as nicely as they did the females. It might just have been our perception as guys (P4 L136-155).

Another participant believed his faculty indirectly conveyed that nursing was a profession for females:

> I knew when I walked in, who was going to be the first one to be up there doing demonstrations. Yeah, the only male in the class, and that was, uh, I knew I was. You know I think they were trying to tell me something . . . . It was kinda like, "This is a female business," you know. "We dominate the business, and just make sure you understand that" (P8 L50-74).

A third participant recounted how male nursing students' educational needs were not addressed during lectures:

> My instructor would do stuff, like, if we were talking--and it wasn't just one instructor, it was a majority of them--but they were talking about something to do with women's health, like referring to OB/GYNs, menstruation, their cycles, the way things would work. They would ignore all the guys in the class and just say, "Well, you women know about this." . . . They would just genderize everything female. Okay ladies. I was like, "Well, uh hello." It was like, "Please don't emasculate me that much. All right. Come on. It's like I know I'm going into a female-driven field, but, hey, it's, I'm not neutered" (P6 L117-137).

These examples illustrate participants' perceptions that some nurses, including their faculty, subtly or overtly communicated to them that nursing and nursing school is for women and, thus, not for the male students. When this occurred, participants felt unwelcomed, uncomfortable, left out, and deprived of the full benefit of their educational experiences.

The stereotype that nursing is for women extended beyond nursing school to society in general. Several participants referred to the movie series that began with *Meet the Fockers*. The movies depicted a male nurse, Gaylord Focker, whose masculinity and career choice were constantly being challenged. A participant in nursing school at the time of the movie's release said he was teased about, "What that movie portrayed, you know, about male nursing. . . [and] of course [we got] a lot of flack about. . . wiping butt and. . . wearing the little white hats, and the dress" (P2 L90-96).

Participants in nursing school experienced subtle and overt messages from nursing faculty, nursing staff, and social media that nursing is for women. They encountered prejudice and discrimination as nursing students, and movies deriding men in nursing made participants feel they were being held up to societal ridicule.

MEN IN NURSING ARE GAY

Only one participant recalled facing the stereotype that *men in nursing are gay* while he was in nursing school:

> I'm *sure,* if I wasn't seen with a woman, [female classmates] might assume I was gay. In fact, my roommate--they used to think we were a couple. . . When we started dating different women . . . that's when they [female classmates] confessed. They said, "I thought you guys were dating" (P3 L57-62).

HIGHER EXPECTATIONS FOR MEN IN NURSING

One participant reported experiencing the stereotype during nursing school that men should do more than bedside nursing. He compared himself to the male nurse character, Ben Stiller, in the movie *Meet the Fockers*:

> He gets a lot of grief about being a nurse. They ask him, make comments like, "It's great that you volunteer, . . . Have you ever thought about going back to school and becoming a doctor?" and that kind of thing. They always make jokes (P2 L124-127).

He also perceived higher expectations from nursing faculty:

> I believe that the standards for me,I don't know, it just felt this way sometimes, were a little higher, that I had to meet, going to nursing school. And you know there was very few of us [men] in there (P2B L67-69).

He discussed hearing similar comments from his male friends.

The men in this study, while in nursing school, experienced both supportive and stereotypic responses. The supportive responses reinforced that nursing was an acceptable career for men and helped the participants feel that they had made a good decision in choosing nursing. The stereotypic responses, on the other hand, challenged the appropriateness of nursing for men or questioned the masculinity of men in nursing. Despite these challenges, the men remained committed to their decision to complete nursing school.

Creating a Niche

Participants negotiated the challenges they faced in nursing school by identifying their place as men in nursing. *Creating a niche* represents the participants' growing awareness of their unique contributions and confidence in their own abilities. Two subthemes emerged: *contributing to nursing* and *enhancing resolve*.

CONTRIBUTING TO NURSING

Participants could identify their contributions as men in nursing school. One participant reported he could provide a unique viewpoint: "I was the minority in the group. I think bringing my perspective to the group was kind of fresh and new to the group, so I was always seen as someone contributing to the class" (P2b L23-25). Another participant had skills that were helpful to his classmates: "I did help with tutoring and stuff so, you know, that part kinda set me apart also, because people would come to me with stuff, especially math stuff, because I'd made a living with math" (P5 L419-421).

Another participant reported that some of his nursing instructors helped him see his contribution as a man to nursing:

> [One instructor] was just overly excited that. . . she had a larger population of male nurses coming in, and she explained that one of the things was. . . because they knew that we were going to. . . have the possibility of getting paid more, thus their pay would also have to increase because of the equal labor laws. So it would eventually kick back to them. . . . [A] few instructors. . . were actually very excited about having more male nurses, . . . They saw us more as an asset. . . [and] as a way to leverage themselves into a better status (P6 L633-641).

Nursing school allowed the participants to identify ways males could contribute to the profession of nursing. Male nursing students brought a different viewpoint and skills; their gender brought the potential to enhance nursing salaries and status.

ENHANCING RESOLVE

Participants reported several methods they used to cope with the challenges they faced as men in nursing school. *Enhancing resolve* was an internal process accomplished by *reframing a barrier* and *protecting self.*

REFRAMING A BARRIER

Participants described transforming a challenge by *reframing a barrier,* or viewing it differently. One way they reframed barriers was with humor. For example,

they found humor, as well as some reality, in the media's portrayal of men in nursing in the movie, *Meet the Fockers*: "[It] is a comedy movie, but that's what makes it funny, because it has some realistic value to it" (P2 L154-155). Another participant described perceived a nursing faculty's behavior indicating that nursing is for women as humorous: "That's funny" (P8 L131).

Two participants described how they reframed other barriers by responding to them as a challenge. For example, one participant recalled his response to instructors' treating male nursing students differently: "It just made me more determined to finish. I don't like people telling me I can't do things or I can or can't do things" (P6 L148-149). Similarly, another participant described turning faculty's higher expectations for male students into a challenge:

> It's just a personality thing. I think in a way you can either handle it or you can't, you know, and I believe that if you push me, I'm gonna push back harder, and I'm going to meet or exceed those expectations. . . . Some [men] in our class. . . couldn't handle . . . those expectations; those were the ones that did poorly or who you didn't see the next semester (P2B L79-82).

Using strategies of humor or finding challenges was how the participants reframed barriers and coped with being men in nursing school. They recognized that men who were unable to develop similar strategies were not successful in nursing school.

PROTECTING SELF

One participant discovered during nursing school that he needed to practice with extra caution because he was male. He described the laboratory classes in which he had to practice physical assessments with female nursing students:

> You have to be careful while you were assessing the female nursing students, that you didn't say anything inappropriate, or you were very professional while you were doing that. You kind of worry about that because, you were assessing all areas of their body, so you had to be really careful in the way you handled those situations (P1B L72-76).

This participant felt that he had to be more cautious when practicing assessments with female students so that he would not be wrongly accused of sexual inappropriateness.

Summary of Becoming a Nurse

The participants' focus during nursing school primarily centered on surviving the rigorous nursing program and dealing with being a male gender minority in the predominantly female nursing school. Nursing school was consuming and difficult; it required sustained effort and changes in how they prioritized their use of time.

Being a man in nursing school entailed additional stress. As gender minorities, participants felt different, they felt constrained by others' expectations, their masculinity was questioned, and at times they felt unwelcomed and appreciated not for who they were but only for what they might offer to female nurses. Nevertheless, these participants all survived nursing school. Nursing school met their needs to help people and to be intellectually challenged. They learned to adapt to the rigors and challenges of being a man in nursing school. They were finding their niche as men in nursing.

BEING A NURSE

Being a nurse encompassed the time in participants' lives after they had graduated from nursing school and were practicing as nurses at the bedside. Four themes comprise being a nurse: *choosing to stay in nursing*, *responses to his being a nurse*, *creating a niche*, and *changing the image of nursing*.

Choosing to Stay in Nursing

The men chose to stay in nursing because nursing met their needs. Nursing offered them *stability,* opportunities for *helping people,* and *camaraderie*, and they *enjoyed the challenge*.

STABILITY

One reason all nine participants chose to stay in the nursing profession was because they saw the potential for growth, flexibility, and *stability*. Nursing provided "good job security" (P8 L532) and was "a steady job" (P5 L317). Several participants explained that the various specialties within nursing allow opportunities for people with diverse interests:

> There are so many opportunities in nursing. . . nurse practitioners, CRNAs [Certified Registered Nurse Anesthetists], critical care, medicine-surgery, psych nursing, L&D [Labor and Delivery], pedi [pediatrics], specials [special procedures], OR [operating room], teaching, research, industrial nursing, management, home health, hmm, what else, case management, those sort of things. There is so much to do in nursing (P2 L398-402).

Another participant explained:

> There are so many different areas. . . [where] you can be a nurse. There's. . . all kinds of different hours, days, nights, eight hours, twelve hours, plenty of overtime. . . . There's a nursing shortage. I mean, pay is good. You know, you can move up as far as you wanna go. I mean, there's anesthesia nursing, or if you just wanna build on, go for another job, be a physician, get your PhD, sell equipment. . . teaching. . . it's just so vast. I think it's just job security, especially with the way the economy is nowadays (P3 L281-290).

The demand for nurses in the U.S. allowed one participant to immigrate to the U.S. Three of the participants anticipated continuing their education in order to move into nursing management.

All of the participants described how nursing had flexibility and stability, regardless of their life circumstances or interests. The job security and diversity of opportunities in nursing were powerful draws to the profession.

HELPING PEOPLE

Participants chose to remain in nursing because nursing offered the opportunity to fulfill their desire or calling to *help people*. Helping people gave them a sense of self-fulfillment: "What else can you do for mankind? As part of being mankind, I get to put

something back" (P8 L579-580). One participant believed the desire to help people should be a fundamental value of nurses: "You just have to have that, that *want* to help people. You know, that has to be your number one goal" (P7 L322-323). Another participant stated:

> Sometimes you don't see the good that we [nurses] do or the outcomes, but there are times. . . you're doing good for the people around you. But, you know, it makes you feel good that you're doing something good in this world beyond going to work, having fun, and being challenged, and that sort of thing, and enjoying your job, not knowing what to expect every day, and doing good for your community at the same time. You can't beat that anywhere else (P2 L242-251).

Similarly, another participant recounted how he could help people on a daily basis through his own actions and teaching others:

> When I reflect on my nursing care, . . . every shift, when I go home, I know I've made a difference for my patients. I can almost always say that I've made a difference, and then, if I didn't make a difference that day, then maybe my nursing care was not as good as it could have been. I'm always telling my orientees that. "Ask yourself that at the end of the day. Did you make a difference for your patients" (P4 L87-94)?

The sense of making a difference was further explained by another:

> It is very rewarding, just to know that you're taking care of people and enhancing their life in some way and actually making a difference. I just love the bedside and just taking care of my patients. . . . You know, the way I look at it, especially being in the ICU, is that usually when I walk into a room and see a patient, sometimes, or most of the time, this is usually the absolute worst day of the patient's life, and I get to make a difference. . . . I just try to do whatever I can to make them comfortable. . . and it feels good to be able to make a difference that day, even if it's just something as simple as lettin' them, allowing them to have a good night's sleep. I value that (P7 L138-155).

Another participant described being a source of comfort to his patients:

> You're in a hospital, and it might be my third day there and my fifth year as a nurse, but it might be your first day, your first time in a hospital, or the first time that you've ever been this sick. And you, you're tired and you wanna go home. And for me, I get to stay there all day. I mean I get to go home at the end of my day and put in my twelve hours and I'm off, and I do my three days and I'm done. You're still here. They're still stuck there, so I try and give 'em a little sense of, I

> don't know, a little piece of home, a little normal, normal sense, a little sense of humor, a little something, to brighten up their day, other than a long, long day that they get of no sleep (P6 L89-96).

The ability to make a difference extended beyond what nurses could do for patients directly, as they felt they also influenced other nurses: "The other day, there were, not including myself, six nurses on the unit, and I had precepted all but one of them. So, I know I can make a difference" (P4 L338-339).

The participants found fulfillment through helping others: "It's very satisfying when you have people that are really sick and you can go in there, you know, and seeing them get better. It feels good for the accomplishment" (P3c L304-305).

Participants could directly and indirectly through teaching others help patients, which they found intensely rewarding. Helping people enhanced participants' sense of contributing to others.

CAMARADERIE

Five participants described a sense of *camaraderie* in nursing, the feeling that they were part of a group with something in common; a group bound by mutual respect and cohesion. One participant felt connected with other professionals in his organization because they shared the same professional goals: "The people you hang around with are mostly professionals trying to do something with their lives" (P3 L81-82). He described a sense of camaraderie in his ICU because the people working there were a cohesive group working toward the same goal:

> We all work really well together, so I usually don't have to ask for help because it's there before you ask for it. . . . We're all in the same field, and we all know what needs to be done, and [we] anticipate each other's needs (P3b L166-169).

Four of the participants described the camaraderie they felt with other men in nursing. One man stated, "Dealing with the female nurses can be difficult sometimes. . . . It is nice having other males, nurses, around to try and balance the workplace out a bit" (P1 L586-591). Another stated: "It's just always good to see more people like you in

anything that you do. . . the camaraderie [with other male nurses]. You have a lot in common" (P7 L184-193). A third commented: "In general, I'm more comfortable [now that] there's more males in the profession" (P3b L143-144). The fourth explained: "They hired two more male nurses in our unit. I feel good. Now I have someone to relate. You don't want to be a man alone, surrounded by women" (P9 L482-484).

Participants enjoyed belonging to a mutually supportive and dedicated team of professionals with a sense of shared purpose that contributed to the social good. Additionally, having other men in nursing working as a part of that team enhanced their sense of connection, camaraderie, and belonging.

ENJOYING THE CHALLENGE

Nursing was mentally stimulating to the participants; they *enjoyed the challenge* of practicing nursing at the bedside. Seven participants described how they enjoyed a profession that challenged their abilities. One explained:

> [Nursing] is definitely a lot harder than I thought it was going to be. I'm glad though. [I] like things that challenge me, that catch me off my guard. . . . [Nursing]'s very stressful, but that's what I like to do. I like to be challenged. I like to be stressed. . . . It's just so many things that you have to think about and juggle them at the same time, which makes it really challenging. You're always learning (P2 L240-247).

Another participant explained why he has continued to practice direct patient care, even as he plans for the future: "I'm still enjoying the bedside right now. I'm still learning a lot, so I'm going to stay there for a little bit longer and probably stay there while I'm getting my masters" (P1 L388-390).

One participant enjoyed the challenges of high-tech nursing: "The processes that you deal with require a lot more training. . . . There are a lot of toys and things and devices that require a lot more skill to operate" (P4 L308-312). Another explained learning to handle interpersonal aspects of nursing: "It's challenging at times, but most of

the challenge is just navigating through, you know, dealing with the doctors and the family dynamics of it" (P7 L141-143).

The participants could see themselves in nursing for the long term. A career in nursing provided participants with security, variety, and a platform to advance if they so choose. A career in nursing also offered personal benefits. The participants felt they touched others' lives and made a difference in the world. They also enjoyed the sense of belonging and stimulation of being a nurse.

Responses to His Being a Nurse

The participants in this study described how other people's reaction to their being a nurse influenced their satisfaction with their career choice. The theme *responses to his being a nurse* describes participants' perceptions of how others reacted to participants' career choices. Participants experiences two types of reactions to their being men in nursing: *respectful reactions* or *stereotypic reactions*.

Respectful Responses

Respectful reactions were other people's responses that showed acceptance or support for nurses or for men in nursing. Eight of the participants described respectful, accepting responses related to their being nurses. One participant said:

> [Responses have] been respectful. You know, it's like, "How long? What do you do?" Uh, you know sometimes they may ask some kind of question, something medical, you know. "What does this mean?" kind of thing, you know. Uh, it's been really good (P5 L718-720).

Another participant perceived other peoples' responses as respectful because of people's trust for nurses in general:

> You find that patients will open up to you as a nurse. . . . So it's rewarding knowing that they trust you and that. . . patients have this inherent trust already [for] nursing. I think it's voted one of the number one careers, trusted careers every year" (P4 L100-104).

Yet another participant shared perceptions of why some people became supportive once the participant became a nurse:

> Maybe they see that [nursing] has become a career for me, and they see it as a respectable career. And that I am succeeding in it, and. . . the sky's kind of the limit in it. . . . They've begun to. . . respect [my decision] a little more (P1 L361-379).

Men in nursing reported sometimes getting different or better treatment by others because participants are male:

> Some of the patients respect the males [nurses] more than the females. . . . Some of the male patients would try to get over on some of the females, and then when you have a male walk in. . . it seems like a different attitude (P3 L84-107).

One participant explained: "Men act differently in front of other men as opposed to the way they do with women. You know, they're not so willing to get physical with another male as they will with a female for some reason" (P6 L510-511).

Six of the participants believed that physicians may interact more collegially with male nurses:

> Physicians do treat male nurses with more respect. They'll come to the unit and talk with you about something, like their boat or things like that. After that, you take care of business. . . . Female physicians seem to treat the [male nurses] with more respect, too (P2 L364-371).

Another participant commented, "[physicians] just don't get real brash as often with me as with other [female] nurses in general. I don't know if there's an intimidation factor or what, but it's usually easier to deal with, as from a male perspective" (P7 L233-235).

Participants also said that female nurses were aware of the different treatment of men in nursing by physicians and could take advantage of it. One participant explained: "You'll hear those comments, 'Well, because you're a guy. . . no, you can call him because you're a guy. He does better with a [guy]'" (P2b L114-115).

Conversely, participants suggested that female nurses sometimes perceived physicians' respectful responses to a man in nursing as preferential treatment. This perception by their female colleagues could cause conflict between male and female

nurses: "[Female nurses] have resentment towards [physicians' treating male nurses with more respect]. They'll say, 'That's just because you're a male' or something" (P3b L75). Another participant explained:

> I know that the perception is that some of the male faculty doctors [treat male nurses better], and that's the perception of the female nurses, but there are some female upper level residents and fellows that will come and get my opinion. I think it's because they know my ability. But the perception from the female nurses is that it's because I'm, I'm male (P4 L173-177).

One participant explained that he must guard against the perception that he is taking sides with the physician: "I can't really stick up for the doc. I have to kind of stick with the nurses. . . so I can continue to have a good rapport with my fellow nurses" (P1b L126-127).

Many participants perceived being respected because they were part of the nursing profession. They also felt respected because of their gender and skills. The downside of the additional respect they received by virtue of being men was being asked to do work, such as calling a physician, which female nurses did not want to do. Participants also felt their gender could be a source of conflict with female nurses, being accused of receiving preferential treatment, or perceived as taking sides against female nurses.

STEREOTYPIC REACTIONS

All participants encountered in their practice *stereotypical reactions*, or prejudgments, from others about nurses who are male. The stereotypical reactions were *nursing is for women*, *men in nursing are gay*, *nursing is menial work, higher expectations for men in nursing*, and *men are viewed as muscles*.

NURSING IS FOR WOMEN

All participants encountered in their practice people who thought nursing is not a profession for men and that real men should not be nurses. One participant explained:

"You can see what society expects by watching TV or listening to people talk . . . . Traditionally a nurse . . . is female and wearing the white hat and the white scrubs, and [saying] 'Yes, doctor. No, doctor'" (P1 L476-479). Another participant noted:

> It is just a profession that has always been looked at upon as soft or feminine. . . . The problem is that stigma, that they think [nursing is] soft. I think it comes from people watching TV and not really knowing what goes on. . . . Contrary to most people's belief, it is a very physical job (P7 L173-307).

One example of social media that permeated the data was the movie, *Meet the Fockers*, which ridiculed a male nurse. One participant described how the movie related to his experience: "[The movie] has some aspects that people would make, I guess, just of males being in nursing. They would try to portray it as being less of a man" (P2 L225-229). Another participant added: "[People think] you are weak when you are a nurse and you are a male. . . . that you're not strong" (P9 L125-128). One participant described how his friends continued to joke about his career choice even after he became a practicing nurse, in ways that insinuated this: "Making you more feminine. Making jokes, you know, like you're wearing a dress, or you're wearing, you know, you're wearing the white hat" (P2 L162-164). Participants again mentioned being called "murses," slang for male nurses, even as practicing nurses.

Participants provided explanations about why society continues to view nursing as a profession for women. One participant felt it was due to a lack of exposure of the public to men in nursing: "[When I tell people I am a nurse, they are surprised because] they didn't expect that coming from a guy . . . that's the reaction. . . . because [men in nursing] are such a minority" (P5 L745). Similarly, another participant explained:

> You'd be surprised to know how many people are shocked to know that there are male nurses in this day and age. It's crazy. You would think everybody would know, but, it's interesting to see the people who are just, like, "You're a nurse" (P1 L480-482)?

Some were bothered by rejection of their skills or abilities due to their gender: "if [patients] want a female nurse for the privacy, the comfort, that's fine. If they're refusing

me because. . . they're just prejudiced against males, then that can be frustrating" (P1b L99-106).

The participants believed nursing was a good career choice for men, but the prevailing social viewpoint of nursing as a profession for women contradicted this belief. The social viewpoint suggests that a man who is nurse is less than a man. It also suggests that a man who is a nurse is less than a nurse.

MEN IN NURSING ARE GAY

Men who are practicing nurses also encountered the stereotype that *men in nursing are gay*. This stereotype affected how they practice: "You've got to put in [a young male patient's] Foley [catheter], and they'll make a joke about you being . . . 'You're not a homosexual?'" (P1 L131-133). Another commented: "You almost have to prove that you're not gay 'cause. . . right at the start of any conversation, it's . . . guilty until proven innocent" (P4 L270-271). A third stated, "That's the first thing [people] ask, they say, 'Why did you go in nursing? Because you're probably gay that's why you're a nurse'" (P9 L130-131). As one participant explained, "I think there is still a general perception that the bulk of guys in nursing are gay. . . . There was even a comment made yesterday. It's that recent" (P5 L45-47). Another participant was more concerned about the effect of the stereotype upon his family:

> The only thing I wonder about is the perception of male nurses from lay people. What is, if my daughter goes to school and it's Parent Career Day? What are other kids gonna say to her? That "Oh, your dad's a male nurse." Or, is it going to be an issue at all? I don't know. . . . "Oh, you're dad's gay," or something like that. You know, "Why is your dad [a nurse]? I thought only mommies were nurses" (P4 L234-265).

The stereotype that men in nursing are gay compels male nurses to prove themselves as nurses and as men. The belief that men in nursing are gay adds an extra burden to their professional lives.

NURSING IS MENIAL WORK

Seven participants thought that the nursing profession and the work nurses do was often underappreciated and not well respected, that *nursing is menial work.* One participant described patients' responses:

> I'm at the bedside sometimes talking to my patient and I get referred to as "just a nurse." Sometimes that does bother me a little bit, because I don't think they understand what nursing really does. But saying, "just a nurse," makes it sound like . . . anyone could do this job (P2 L180-183).

Participants perceived that physicians also see nursing as menial work: "Doctors think that you are 'just a nurse,' mostly because they think they have more education" (P9 L22-23). The lack of respect for nurses creates an environment where some of "the physicians. . . will treat nurses as servants. 'I'm the doctor. I call all the shots and, whatever I do or say goes'" (P3 L155-157). The lack of respect by physicians toward nurses causes "a lot of feuds between doctors and nurses" (P7 L229-230).

Participants believed that nursing underrepresentation at the executive level also limited nurses' influence on the decision-making process. According to one, "The [hospital] president's always the doctor and always a man" (P9 L28-29). Another explained: "It's really the hospital structure and how the rules are made. . . . [Decisions] come down without enough nursing input" (P7 L31-33).

These participants were aware of the trivialization of the nursing profession and of themselves as nurses by patients, physicians, and the hospital structure. Although others devalued nursing's contributions, the participants were proud of their profession and recognized their worth as nurses.

HIGHER EXPECTATIONS FOR MEN IN NURSING

These men continued to encounter the social bias that men in nursing should use nursing as a platform to advance to a more powerful position, that there are *higher expectations for men in nursing*. One participant explained:

> I've had a lot of people ask me when am I going to go back to school because it's like they expect me to do something besides what I am doing. . . . I'm expected to do something higher, like a CRNA, or a doctor, or administration (P1 L174-178).

Other participants described how others, including female nurses, expect men in nursing to take on leadership roles:

> I think, being a man in nursing, first of all, I think that you're expected to take more of a leadership role. I know when I walk into *any* job, as a male nurse . . . you're almost expected, and talked to, like you're in a leadership role. Even if you don't ask for it, you always kind of fall into that position. . . . I see that in people. [Female nurses] talk to me. . . like I'm already in management which I'm *not*. I'm one of them. . . . I think it's just expected that male nurses take this leadership role (P2 L255-259).

Two participants experienced the bias that males who choose to remain bedside are not smart enough to get into medical school. The first commented: "Sometimes you may get a reference about, 'What? You couldn't cut it as a doctor?'" (P2 L164-165). The second explained, "[people] think, 'Oh wow, [he, as a man in nursing] flunked out of med school'" (P6 L474-475).

Being a man in nursing who remained at the bedside subjected the participants to societal pressures. In order to meet other peoples' expectations, men in nursing would have to move away from the bedside to a more powerful, higher status position.

MEN ARE VIEWED AS MUSCLES

Study participants encountered the stereotype that men are stronger than women and thus should care for heavier and more aggressive patients. Six participants experienced the stereotypic reaction that *men are viewed as muscles*: "[Female nurses] think we've all got strong backs" (P5 L70). Another said, "If someone has like a seven hundred pound patient, . . . usually. . . it's one of us males taking care of [the patient]" (P7 L188-190). Men in nursing are also expected to care for dangerous patients:

> Sometimes I truly do think. . . they gave me that job because I'm a guy. . . . It'll be the three hundred twenty pound gorilla that's built like a little freight train and.

> . . I'm. . . having to hold him down while he's in restraints and handcuffs (P6 L572-579).

Physically strenuous or dangerous assignments that continue over time are stressful: "They'll give the male nurses the heavier patient. . . the more agitated patient. . . . That can be *frustrating*" (P4 L198-200). Another participant added that being viewed as muscles put him at risk:

> Sometimes, as guys, we're kind of expected to do certain things. . . like lifting. In the ER especially, they'll say "We need lifting help on the ambulance dock," you know. Who's expected to go? The guys. And if nobody shows up, who do they get mad at? They get mad at the guys. . . But, every once in a while when you're really busy, and you can't go. . . somebody will come up to you later and go, "We were calling for lifting help, and you didn't come," and they'll be angry at you because you didn't make it. It's like, "There's twenty-five other nurses here.". . . . It can get kind of frustrating because women, I understand, are not as strong, but they are, they do have strength. I don't want to just blow my back out. . . just because I am considered the only person who can do lifting. . . . Nobody gets frustrated with a female for not showing up for lifting help. . . . But me, they will (P1 L211-283).

Another continued:

> I'll have a patient assignment, or I'll be busy. I could be doing anything, and I'll always have a [female] nurse come from the other side of the unit or call me overhead from the other side of the unit, pod, whatever. . . . As a guy you're expected to be the strong one to move all their patients. . . . [Female nurses] always seek out the guys to help move the patients, no matter what you are doing. . . . It can be frustrating. [Female nurses] think that because you're a guy you can move a patient with fewer people. . . . But you do most of the work because they don't want to hurt themselves. . . . They don't realize that guys have to protect their backs, too. Just because we're supposedly stronger doesn't mean that we won't hurt our backs. . . . When you try to recruit more females to help, they just laugh at you and say, "You can do it, you're strong," or they tell you to go get another guy (P2 L325-353).

Participants found that female nurses did not reciprocate when men needed assistance:

> I move a lot of patients upstairs from where I work at. You know, we're all the time taking patients back or picking up patients, and it's, like, "Well it's a *guy*. *He* can take care of it," and you don't get the help that female nurses get. . . They just think that, "Well he's a guy, he can handle it." Where when the *female* nurses go up there. . . they get help a lot faster. . . . "Oh, well, she's gonna need help," and so they'll send the tech (P5 L69-86).

Another participant added:

> I would just prefer for one of my female nurses to help, maybe offer to put the Foley in for me, or I'll ask them to put the Foley in. But sometimes it can be frustrating because. . . [some female nurses] feel that you're a nurse, just like they're a nurse, and they feel that you're just being lazy and that you don't want to do your own Foleys. . . and they'll refuse, you know, to do it for you. And that can be, uh, that can be frustrating sometimes, you know. . . . When I needed a woman to, maybe, make this girl, my patient. . . feel more comfortable by doing this invasive procedure, and they refuse and accuse me of being lazy, [it] can be frustrating (P1 L211-219).

The participants were frustrated with being viewed as muscles, with encountering a prevailing belief that any tasks requiring strength should be performed by a male nurse. Men were given the heavy patients and expected to stop what they were doing to help lift a patient. Men described a work environment in which the male nurses were expected to take more risks, their welfare was not deemed as important, and the help they provided was not reciprocated.

In summary, people's responses to the participants as practicing nurses either were respectful or stereotypic. Respectful responses were perceived as the other person's regard for nursing or acceptance of the participants as men who were nurses. On the other hand, being respected as a man who is a nurse could be perceived by female nurses as preferential treatment.

Participants also experienced stereotypic reactions from others. The stereotype that nursing was a profession for women implied that real men should not be nurses. Men who chose nursing encountered the stereotype that they were gay. The stereotype that nursing is menial work devalued the profession of nursing and the men who choose it, leading to the fourth stereotype, men who pursue nursing as a career should have higher aspirations than bedside nursing and should use nursing as a foundation for more powerful positions. The final stereotype, that men are viewed as muscles placed increased demands on their time and threatened their health; moreover, it marginalized the men

because the expectations of them as nurses were different from those of female counterparts.

Creating a Niche

Despite the challenges, study participants remained in nursing. They overcame the challenges of being a man in nursing by *creating a niche* for themselves within nursing, developing a sense of comfort with their roles as both as men and as nurses. They created their niche using two strategies: *enhancing resolve* and *contributing to nursing*.

Enhancing Resolve

The participants had to deal with the challenges they faced as a man in nursing. Learning to cope with or resolve the obstacles helped them succeed. They enhanced their resolve by: *reframing a barrier*, *understanding that social norms are changing*, and *protecting self*.

Reframing a Barrier

Participants chose to deal with others' potentially derogatory or unaccepting remarks by *reframing a barrier* through the use of humor or choosing not to take comments personally. One explained: "I don't take it to heart, don't take it seriously" (P2 L209). When a patient appeared uneasy about being taken care of by a male nurse, one participant said he would "joke back to make [the patient] comfortable with the situation" (P1 L133). The participants were more likely to interpret comments made by people closer to them as humorous; comments from patients or their families were more hurtful:

> If it's someone that I don't know or just one of my patients' families, it does seem to affect me a little bit more. With my buddies. . . we know nothing hurtful is meant by it. It's just one of those things guys do when we get together. . . . So it doesn't really bother me as much, because I know where it's coming from. . . . If it came from a patient or a patient's family, someone I don't know, I think it would bother more than it would from my friends (P2 L209-218).

Some participants had accepted the fact that people have biases and had learned how to handle them. One participant explained, "I didn't take it personally and I didn't really let it affect me in the long run" (P5 L647). Another explained how he dealt with being mistaken as a doctor: "I don't have a problem with it. . . . I'm not embarrassed about it. . . . It doesn't affect me one way or the other. . . .Some people would have a problem with it, but I don't" (P3 L142-146). A third participant described:

> I'm a pretty confident kind of guy. It doesn't bother me. I don't take offense to it. I know what I am. I know what I do. I just take it light heartedly. . . . That kind of stuff just slides off my back. . . . I can't say that doesn't bother other males in the, in their nursing career because I am sure it does (P2 L173-179).

Yet another said:

> I work in a profession that is ninety something percent women. . . . I guess part of [my way of dealing with it] was my coming to terms with myself and going into nursing. . . . It doesn't really matter to me what other people think. They can think what they want to. I know who I am. My wife knows who I am. It doesn't really matter to me (P5 L104-106).

Participants' comments demonstrated that dealing with others' stereotypic responses about men as nurses required tolerance, self-understanding, and confidence in themselves as men and as nurses.

Evolving Norms

Seven of the participants resolved the challenges they faced being a man in nursing by understanding that they were living and practicing during a time of *evolving norms*. They understood that social beliefs are changing with time, and believed that in the future, society will see nursing as an acceptable profession for men. The participants compared the situation with men in nursing to changes in other profession:

> Used to be that all doctors were male, and now it's over half female. . . . It does seem like female doctors have been more accepted than male nurses though. . . . In like the last generation, things have changed so drastically, [but], you know, society has not really caught up yet (P1 L414-419).

Another participant compared the acceptance of men in nursing to acceptance of a female President:

> I think the image has changed quite a bit for men in nursing. I think it's a lot more accepted. I think it came a long way. . . . just like we haven't had a female President yet. You know why? Because people aren't ready for a female President (P3 L242-249).

Most of the participants believed that society eventually would evolve to accept men in nursing. In fact, many believed they already were seeing the changes taking place. One participant noted, "Lately, I've been seeing more and more guys coming into [nursing]. They're warming up to it" (P7 L273-274). Another participant said, "I don't think [stereotypes about men in nursing are a major issue] anymore, but I definitely think that at some point, that was a factor, an issue . . . because there's more male nurses in general [today]" (P6 L476-481). The increasing number of men in nursing has impacted the perception of nursing being acceptable for men, "I think [the number of men in nursing] is growing on its own. . . [nursing is] not really seen as just a female profession anymore. It's more seen as just a profession" (P4 L209-225). The sentiment among the participants was that as more men enter the nursing profession, the more accepted men in nursing become, and they are part of this change.

The participants acknowledged that social norms take time to change, but in the meantime they have to accept the social perception because "it is what it is" (P2 L331). One participant explained, "Every society has their own norms. . . . Not everybody has decided that having a male nurse is. . . what they want at this point" (P1 L458-471).

Participants respected the fact that social gender norms affect patients' preferences of having a male or female nurse: "If [female patients] want a female nurse because they're coming in for something very intimate. . . and they don't want that area to be seen by a young male, I respect that" (P1b L98-102). One participant explained that "every patient is going to have their own reservations about who they want to have take care of them. . . . It's dependent upon the patients themselves and their specific needs.

Everyone has their own different needs" (P2b L129-135). Participants also recognized that, within any society, some cultural groups adhere to different standards and these may never change: "There's some cultural consideration. I know that there are certain cultures that are really particular about not having male nurses, so we try to be sensitive to that" (P4 L185-187).

Participants understood that social norms change slowly. They recognized that the increased number of men who enter nursing is helping to evolve society's view of them. They were optimistic that their gender would not be a challenge in the future but at the same time they recognized that some groups of people might never change. So it was up to them as male nurses to accept and respect others' preferences.

Protecting Self

The participants were aware that patients could misinterpret male nurses' actions during care leading to accusations of inappropriate behavior. Participants *protected self* by taking measures to ensure their actions could not be misinterpreted. Three strategies participants used to protect themselves were having female chaperones, having a female provide intimate care for female patients, and correcting people who called him "Doctor."

Four men used female chaperones to ensure their professional actions were not misinterpreted:

> If you're doing peri care and [female patients] are awake and alert, they're not comfortable [with a male nurse]. . . . female [nurses] could be doing that. . . . She's all exposed there. You don't want. . . allegations, and you don't put yourself in that situation if you don't need to (P3b L124-129).

One further explained:

> If I do [feel female patients] are little uncomfortable, then I get a little uncomfortable, because I don't know how people view certain things. . . . It's difficult to predict how someone is going to react. . . . if [the doctors] order a Foley. . . . I go get another female [nurse] to do it, for obvious reasons. . . .I think [a male nurse catheterizing a female patient] could be viewed pretty questionable if someone made an issue out of it. . . . [Patients] hear these things that go on in

> other hospitals on the news. This male nurse was over here doing this. And you're a male nurse. . . . I'm a little more attentive to that nowadays (P8 L162-187).

Another participant added:

> When I got out of nursing school. . . my preceptor was a male, he said. . . "You always want. . . a female chaperone there. . . in case any accusations are just made later down the line." I carried that my whole career (P1b L196-201).

Participants also talked about having to correct patients who called them "Doctor"; they did not want to be accused of misrepresenting themselves: "I'd have to correct people, 'No, I'm not a doctor,'. . . I'd just correct them so I wouldn't get sued" (P6 L380-382).

Participants felt an extra burden of needing to protect themselves because they were males practicing nursing. They had to worry about their actions while providing care being misunderstood. Conversely, they had to defend against misperceptions about their professional role because of their gender.

Enhancing their resolve were the strategies the participants used to develop and maintain comfort in their chosen profession. They learned to manage stereotypes through humor, understanding that social norms change with time, and implementing techniques to protect themselves against presumptions related to their gender.

CONTRIBUTING TO NURSING

The study participants believed their male gender gave them something special to add to nursing, that they were *contributing to nursing* through their unique qualities as men. The participants believed men in nursing contribute to the nursing profession through *being an example*, *bringing different characteristics*, and *helping the status of nursing*.

BEING AN EXAMPLE

Seven participants believed they were *being an example* to others, embodying the idea that nursing is a good career choice for men. They viewed themselves as role models, representing a challenge to the stereotype that nursing is a profession for women:

> I can explain [why I became a nurse] to [patients] and they understand. . . . Once you just kind of explain it to them, that you enjoy your job, and you could have been a doctor, but you decided that wasn't for you, and that you're doing this because you enjoy it, and it's a good field, and there's a lot more men going into the field. You know, usually they understand (P1 L146-151).

Another participant recounted his response to people's questions about his decision to be a nurse: "I'll tell anybody: if you like to work and want to do something rewarding, I mean, nursing is where it's at" (P7 L267-268).

The study participants felt that they were examples that men were capable of being nurses and exemplified how nursing is a good profession for anyone, regardless of gender. By challenging the status quo, the participants could increase the awareness and representation of men in nursing.

BRINGING DIFFERENT CHARACTERISTICS

The participants believed that because men think and act differently, they bring unique characteristics to the nursing profession and these characteristics possibly impact the clinical environment. The increasing number of men in nursing "balance[d] the workplace out a bit" (P1 L590). Later, the participant added:

> I think men in nursing are a great thing. . . . They bring a different style to nursing, a different attitude, a certain amount of calm to high stress situations, a certain amount of strength when strength is needed . . . . All the units that I've worked on that had a lot of male nurse presence seemed to have. . . tighter units. You know, they had better team work, a lot of friendships. . . (P1b L142-149).

Eight participants believed men bring calmness and diplomacy to the work environment:

> Now there's three of us [males on the unit]. . . it made for a totally different atmosphere. . . I think it makes [the unit] a better place. It, we don't have the drama. . . . Everybody works and helps each other (P5 L831-846).

The participants also commented that some female nurses are aware of male nurses' effect on the work environment:

> Some female nurses say, 'I like to work with male nurses because you're not so catty. . . . I like it because you guys like to come in and you like to get the job done. There's not a lot of this cattiness or drama behind people's back' (P2 L270-275).

Another participant explained:

> There definitely is a difference. . . [when female nurses] think that there is blood in the air. . . . They'll point the finger at everybody and anybody, regardless if there's anything wrong. . . . [Males in general] don't point fingers at each other. If we do, we openly do it. We don't hide behind, or say it behind somebody's back (P6 L788-801).

The participants believed there was less conflict among male nurses:

> I see fewer disputes between male nurses and other male nurses than I see with females and males. I think, [with males there] is just less conflict from what I see, as far as working in a pod together and helping each other. . . (P7 L253-255).

Participants also commented that men tend to be less emotional than women. One participant noted, "[Men] are not emotional like the women. . . so men actually help balance it, the field" (P9 L481-482). Another said:

> This is not to say anything about women, but women are emotional and when they get upset, sometimes it kinda affects the way that things are done. But what I noticed is that when there's males involved. . . it's usually a cooler, smoother transaction, and I guess we're able to do more without getting as emotional about certain things (P7 L198-202).

One participant summarized the difference between the reactions of males and females: "males generally just let things kind of, blow off, roll off their back, where a female will take it more personally, I guess, like a personal insult, and then it becomes more of a conflict" (P4 L126-129).

The participants also described how men bring a different perspective to how things are done in nursing. One participant stated: "[Males] offer a new slant on the logic

of why, how things are done. . . a different point of view" (P5 L866-867). Another participant said: "You have a male perspective versus a female perspective. Sometimes, females have more insight on, I guess, certain areas, certain situations, and or different opinions than what I would have" (P3 L97-105).

One man stated, "[Male nurses] don't talk a lot. I see product getting done" (P9 L478). One participant went into great detail about the male approach to providing nursing care:

> I hear we bring more compassion to the table, more care and compassion. . . . I think guys are more task oriented, so it does help to get things done, while at the same time, being compassionate about doing it. That's probably the major [difference between male and female nurses] right there. . . . [Male nurses] are getting' stuff done, which is also getting' things done for our patient in a timely manner, which helps them to get through their process quicker, and then at the same time. . . you're doing it in a compassionate manner. 'Cause sometimes I still see the women, even in the group that I work with, . . . I'll see things that need to be done, that should be done, just taking care of business, taking care of the patient, making them more comfortable. . . . and they're [female nurses] sittin' there talkin' about other things, and to me it's like, okay, let's get everything done and take care of this patient first, and then we can talk about all of this other stuff (P5 L874-894).

Five participants described patients who preferred male nurses: "I've had some say, 'A guy nurse has been the best nurse that I've had. I feel more comfortable with them'" (P2b L131-132). Another participant commented: "A lot of times people have said that the males nurses [were] the best nurses they ever had" (P5 L724-725). A third commented: "It seems like many times male nurses are sought after by patients, because. . . patients feel like they can get along with male nurses a little easier than females from a personality conflict standpoint" (P4 L120-125).

Participants believed that male nurses bring gender-related characteristics to the workplace that improve the environment and enhance patient care. In fact, some patients preferred being cared for by male nurses and some female nurses preferred working with male nurses.

HELPING THE STATUS OF NURSING

The participants thought men contributed to nursing by *helping the status of nursing,* bringing more pay and respect to the profession:

> I think if anything. . . [men] brought a higher pay scale to the field. . . . They help with the pay. We bring more clout to nursing. I think it's made it easier for the women to get more respect in the field now, since there's a lot more men in it. Whereas I think a long time ago, [female nurses] were having a hard time. They weren't being taken seriously. It was like, "Yeah, yeah, yeah, this is a strictly women's career field." But now it's kinda moved on past that, and I think there's a lot more power in nursing now (P3 L80-187).

The participants thought that because men command more respect and higher pay in society in general, increased representation of men in nursing will result in greater respect and higher pay for nurses.

The study participants *created a niche* for themselves as nurses by developing techniques to deal with stereotypes about men and about nursing. They created a niche for themselves and other men in nursing by virtue of the unique contributions men make to the nursing profession. They viewed themselves as role models for other men considering nursing as a profession and also as change agents in the evolution of social norms about men and about nursing. In addition to their general impact on men, nursing, and society, their presence enhances the direct patient care environment. They also believed that the social biases that promote men in society ultimately will translate to higher pay and more respect for nurses.

Changing the Image of Nursing

The participants recognized that many of the problems they faced during their journeys toward becoming nurses arose from the public's image of nursing:

> People think nursing is all about butt wiping, feelings, and being touchy feely. That's the image of nursing that people have. The white hats and dresses. Look at the nurse call light in patient rooms. It has a picture of a nurse with the hat, at least at the hospitals I've been at (P2 L387-390).

Changing the image of nursing could attract more people to the profession:

> We need to educate. . . the public. Teach them about what it is we [nurses] do. . . advocating for patients, pictures in the different specialties. . . focus on the need, and stability or job security of the nursing profession (P2 L403-412).

One participant said:

> [The public needs] a better understanding of what nurses do, or are capable of doing. . . . They don't always seem to understand that there are so many aspects to being a nurse – that there's a realm that doesn't deal with bedpans and urinals. . . I talk to women who want to join nursing and they just. . . think of it as an easy job or a little fluff job and, "Oh, I get to wear cute scrubs," and that's it. They don't really understand that there's so much more that they will do. Where a guy, they're like, "Oh great. I get to change bed pans," and that's the extent of what they see. . . . Nobody ever tells them anything different (P6 L587-601).

Participants believed the social media presents an inaccurate portrayal of nurses and the nurses' role: "is always these stereotypical nurses" (P6 L741).

> [Nurses] are not represented properly [in the media] and some of it has to do with the way we let people present us. . . . You watch *House*: the only reason you have nurses in there is to pick up the crash cart or to get yelled at by House. You watch *Grey's Anatomy* and there are no nurses unless they're striking, and other than that there are no nurses. . . . In *MASH*: the same thing. The nurses were there for comic relief for the surgeons. . . . You had *HawthoRNe*. . . . which I think is a complete travesty to nurses. You had one nurse that had an "S" on her chest, and she was basically the CEO is the way they made it seem. When she came in the room, the light came on and all you heard was [angelic music]. She put her hands up and the world was saved. *Mercy*: and that's one where you had the male nurse that was like, "Well, the docs said to do it so I'll do it." I mean, he's a moron with a chip on his shoulder. Then you have the other nurses who were either a bimbo or they cried at the drop of a hat or were sleeping with everyone who moved (P6 L702-718).

The participants agreed that the persistent inaccurate media portrayal of nurses creates a negative image of nurses and nursing. Several participants commented on the lack of men in nursing in the social media:

> I think if more of the TV programs would portray more male nurses, I think overall, the society would, "Oh, that's common knowledge!" . . . I think that if there were more male nurses in general showing up, or being portrayed, I think, as a society, there would be more interest. You know 'cause right now. . . most of [the nurses portrayed on TV] are female. . . (P3 L259-265).

One participant remarked on the comedic media portrayals of males in nursing: "Movies like *Meet the Parents* don't help any" (P2 L386). Another participant added:

> I'd watch *Scrubs* you know, and the male nurse in that one is named Flowers. . . . A male nurse named Nurse Flowers. It's kind of offensive. And then you have other shows where the male nurses are homosexual. . . . You have shows where there's no male nurses, they're all female (P1 L493-496).

He did, however, like the media campaign promoting nursing: "I've seen a lot of Johnson and Johnson posters and they put male nurses on their poster which is cool" (P1 L497-499). Another participant also spoke positively about the Johnson and Johnson ad campaign:

> The Johnson and Johnson ads that show the guys nursing, I think that helps. . . They show a lot of men. . . I've always appreciated that ad. . . whether it was in print or something on TV. . . .[It] is something positive to bring guys in. . . . that it was a good career choice (P5 L928-960).

The participants believed that both males and females could be attracted to the profession for similar reasons: "if they knew some of the benefits of it as opposed to other professions" (P7 L261). A participant stated:

> Most people don't realize how varied the field is, what the opportunities are. . . and all the different things that you can do, as being a nurse. . . . It is job security. . . . [and that it has a] good work environment (P5 L963-981).

A focus on the financial rewards can attract people to nursing:

> The attraction for anybody, male or female, is that the salaries have steadily increased, and now it's to the point where the salaries are really lucrative. So I think that attracts a lot of people, but now males maybe more attracted more to it for the sole reason that you can make quite a bit of money (P4 L209-213).

The participants recommended that recruitment to nursing should be started early rather than later: "I would say if counselors in high school [and] college. . . would be putting it out there. . . . You've got to plant the seed somewhere to get the thought goin'" (P5 L951-953).

Their own experiences during their nursing journeys impressed the participants with the need to change the image of nursing, particularly men in nursing. They realized

that the things that had attracted them to nursing should be emphasized as a way to recruit both men and women to the profession.

Summary of Being a Nurse

Being a nurse encompassed the time the participants were practicing as nurses. They persisted as nurses because they received the very things that attracted them to the profession: stability, the opportunity to help people, camaraderie, and a challenge. Attaining the things that had attracted the men to nursing reinforced their perception that they had chosen the right career. The societal biases about men in nursing persisted, but they had learned methods to cope as they became more comfortable with their identity of self as man and nurse. They could see the unique contributions of men in nursing in the patient care environment and the profession as a whole. Their own experiences during their nursing journey revealed the need to present nursing more positively to the public, which could result in increased numbers of each gender entering the nursing workforce.

SUMMARY OF THE FINDINGS

This study explored the experiences of men in nursing from the time they decided to pursue nursing. The participants' descriptions of their experiences broke naturally into three phases: deciding to become a nurse, becoming a nurse, and being a nurse. Throughout their journeys, the participants contemplated their fittingness in nursing and whether nursing was a fitting profession for them. They were constantly weighing the pros and cons of being a nurse and being a man in nursing.

Deciding to become a nurse encompassed the time when participants were first exploring the idea of being nurses. Several participants were exposed to someone in nursing or the health profession, which gave them more insight to what being a nurse really entailed. The pros of becoming a nurse included financial stability, the opportunity to help people, a sense of belonging, and people being supportive of their decision to

pursue nursing. The cons of being a nurse revolved around others' stereotypical responses of nursing and men who enter nursing, an additional challenge not faced by their female counterparts. Some participants' entry into nursing was delayed because their masculinity was questioned by these stereotypes and they succumbed to social pressures of adhering to gender role norms.

Becoming a nurse included the time the participants were in nursing school and served as the transition point of wanting to be a nurse to actually being a nurse. The predominant theme was surviving the rigorous nursing program, which was a different experience for the participants because it required them to reconsider how they spent their time. Also, participants felt they were different because men are a minority in the nursing. Their masculinity was challenged and some people made the men feel unwelcomed. The participants persevered in nursing school because they felt the pros outweighed the cons. They were able to see that they were beginning to attain the things that attracted them to the profession and that men could contribute fresh ideas or perspectives to the profession. They also began to realize that their gender could also improve the status of nursing as a whole.

The third timeframe, being a nurse, comprised the time participants were practicing as nurses. Participants described how they persevered because they had learned coping methods to overcome their gender-specific challenges, were attaining the things that initially attracted them to the profession, and understood that men brought a lot of positive qualities that could impact the nursing profession and to patient care. Their experiences also gave the participants insight into what could attract more people into nursing, particularly men.

Interview data is substantiated by other data, but several observations are noteworthy additions. First, data from participant observations suggest that male nurses are very aware of gender-specific challenges but that many female nurses are unaware that traditional nursing practices could be perceived as discriminatory. Second, although

in-depth interviews mentioned the use of the term, murse, a review of the American Assembly for Men in Nursing (AAMN) website revealed an advertisement for Murseworld, an internet site that specializes in sales of scrubs for men in nursing. The advertisement augments participant statements about the limited resources for clinical attire for men in nursing and shows a broad usage of the term, murse. The AAMN stance about the use of the term murse to describe men in nursing is unknown. However, social labeling of men in nursing as murses supports the view that men in nursing are different and are a subculture of men and nursing. Additionally, observations strengthened support for the importance of male mentors or role models to men in nursing.

The major issue for men in nursing appears to be that nursing is a profession for women; this belief leads to stereotypes that question the masculinity and fittingness of these men. Since nursing is considered a profession for women, the role of nurses, including male nurses, is held in less regard compared to other health professionals such as doctors. If a man choses to enter a woman's profession, he is assumed to be gay. Men who enter nursing should also use nursing to pursue a role in healthcare that is more aligned with the masculine role such as being a doctor, an advanced practice nurse, or an administrator. While at the bedside, men should be prized for their strength. All these stereotypes shift focus away from a person's ability to function as a nurse and focuses more on whether the person fits the social perception of a nurse, which can lead to bias.

Participants understand that the beliefs of some social groups take longer to change, such as religious or ethnic beliefs. These social beliefs cause some patients to have preferences for a male or female nurse. Participants understand that in order to provide patient-centered-care, nurses must be sensitive to patients' beliefs and preferences and be willing to accommodate patients' preferences.

The men in this study had to overcome the stereotypes about men in nursing and carve out a place or niche that made nursing a fitting profession for men. While in nursing school, the participants began to realize that men contained characteristics that

could make nursing a better profession. Since men command more respect and pay, their gender could raise the status of nursing. A couple of participants began realizing that men brought different viewpoints and skills to the nursing profession. While practicing as nurses, most of the participants had begun to realize that men could help improve the status of nursing as well as the patient care environment. They could help increase the pay and respect of nurses, allow for patient and staff preference of male nurses, and serve as role models demonstrating that nursing is a good profession for men.

These participants' journeys demonstrated the evolution of their comfort and identity as men in nursing. During the choosing to become a nurse timeframe, participants had to reach two milestones. First, they had to understand what they wanted from a profession and how nursing would offer them these characteristics. The participants had an idea of what being a nurse entailed but had not yet experienced it firsthand. Second, the participants had to be comfortable with who they were as men and be comfortable with their masculinity. They began to learn how to cope with the stereotypes about being a man in nursing. In the becoming a nurse timeframe, participants began becoming comfortable with their new role as nurse. They were beginning to see what nursing was really like and decide whether it was something they still wanted to pursue. Participants became more comfortable with the coping mechanisms for being a man in nursing and also learned new ones. While being nurses, the participants were ultimately able to identify themselves as nurses who were men.

PLAN OF REMAINING CHAPTERS

Chapter Five provides a summary of the study, discussion of the findings, and implications of the findings. The conclusions of how this enhances the body of knowledge about men in nursing also are discussed. Lastly, the researcher offers recommendations for future research.

Chapter Five: Discussion and Conclusions

INTRODUCTION

Current and future nursing shortages affect health outcomes that are associated with the quality of nursing care received (IOM, 2004), as nursing care quality is related to adequate nurse staffing (Aiken et al, 2002; IOM, 2004; Vahey, 2004). Men are underrepresented in nursing, and their recruitment and retention has been suggested as a way to ameliorate the nursing shortage. The proportion of men in nursing is the highest it has been in over seven decades, but men continue to comprise only 9.6 percent of the nursing profession (U.S. Census Bureau, 2013).

Perceptions of nursing as a woman's profession create gender-specific challenges for men who wish to be nurses (Chung, 2000; Ekstrom, 1999; Evans, 2004; O'Lynn, 2007a; Villenueve, 1994; Yang et al., 2004). Studies about the challenges that men face in nursing have focused primarily on the experiences of male nursing students. Additional research is needed to explore the issues affecting men's decisions to enter nursing, their completion of nursing education, and their retention and satisfaction as nurses. Moreover, there is a need to examine how gender role theories apply to men in nursing.

The purpose of this critical ethnographic study was to: 1) Describe perceptions of men in nursing about what influenced their decision to become a nurse and how their decisions were perceived; 2) Describe perceptions of men in nursing about whether their gender affected their nursing educational experience; 3) Explore perceptions of men in nursing about how their experiences as professional nurses have been affected by their gender; and 4) Explore and describe perceptions of men in nursing about what could enhance men's participation in nursing.

The study utilized Critical Ethnography as described by Thomas (1993). Semi-structured interviews were conducted with nine men in nursing. Data analysis was guided by Carspecken's (1996) six-step coding approach. Beck's (1993) criteria were used to assure trustworthiness of the study's processes.

Chapter Five reviews the study findings and compares the study findings to the relevant current literature. Chapter Five also presents implications of the study, a discussion of the strengths and weaknesses of the study, suggestions for future research, and the conclusions.

INTERPRETATION OF THE FINDINGS

Data analysis revealed three major timeframes related to the journey of men in nursing: *choosing to become a nurse*, *becoming a nurse*, and *being a nurse*. The stages slightly differed from LaRocco's (2004, 2007) Theory of Socialization of Men into Nursing which contains four stages. The first two timeframes of LaRocco's study naturally collapsed into a single timeframe in the present study.

The men seemed to constantly consider the positive and negative aspects of being a nurse when deciding whether or not to pursue nursing as a career. All the participants, except for one, described how their experiences with a healthcare provider or having to provide care for a family member impacted their decisions to become nurses because the experiences allowed them to gain a deeper understanding of what the role entailed.

The men in the study described becoming interested in nursing for several reasons: most became interested in nursing because they were exposed to the healthcare provider role, which helped them formulate a vision of what it would be like to be a nurse. The participants felt nursing offered them stability, the opportunity to help people, and a sense of belonging. The participants noted a lack of male nurse role models in the first timeframe. Several of the participants talked about being able to relate to female nurses, but others made the decision to become nurses only after being exposed to men in

nursing. The *choosing to become a nurse* timeframe occurred when the participants were attempting to resolve the question, "Do I want to be a nurse?" Answering their questions required that they weigh their beliefs about what nursing could offer them against societal beliefs about nursing and about men.

The participants were focused on surviving nursing school during the second timeframe, *becoming a nurse*. Nursing school was rigorous and the men had to adjust to being a minority in their classes. The central question for these men in nursing school was, "Can I be a nurse?" Nursing school required sacrifice and reprioritization of their time. Nursing school also provided intellectual challenges and the opportunity to help people. Participants began to realize that men could contribute to nursing by bringing different perspectives and viewpoints. They also began to describe their experiences with others' stereotypical reactions using terms like "prejudice," "discrimination," and "bias."

Being a nurse, the third timeframe, comprised the time the men in the study were actively practicing as nurses. The question participants asked themselves during this timeframe was, "Do I want to stay in nursing?" Their earlier attractions to nursing had become a reality for them: they derived pleasure and satisfaction from helping others in their role as bedside nurses, and they were in a profession that offered stability, financial rewards, flexibility, intellectual stimulation, and a sense of belonging. They were comfortable being a man and being a nurse. Although they continued to encounter stereotypic responses to being men in nursing, their clarity about themselves and confidence in their roles as men and as nurses reduced the influence of such stereotypes. They recognized there is a unique niche in nursing for men. These men in nursing saw themselves as role models, actively contributing to a larger social movement challenging social biases about men and about nursing.

COMPARISON OF THE FINDINGS TO THE EXTANT LITERATURE

Culture affects how people perceive the world and their place in it (Berry, 1997). People may belong to more than one culture simultaneously (Breugelmans & Van de Vijver, 2004; Choi, 2001; De Bruyn & Van den Boom, 2005; Gray & Thomas, 2005; Helly, 2002, Kim et al., 2006; Levant & Richmond, 2007; Shim & Schwartz, 2007). The men in the present study describe belonging to multiple cultures: the dominant social culture, the masculine culture, the nursing culture, and the culture of men in nursing. In addition, some of them see themselves as belonging to other cultures reflecting their race or ethnicity, country of origin, and sexual preference.

Generalizations about a group of people or culture can emerge because there are common characteristics within a culture (Helly, 2002), but the differences can be used as a dichotomous differentiation technique between groups to create a label and to value or stigmatize a culture (Gray & Thomas, 2005; Park, 2005). Society has considered nursing a profession for women (Bernard Hodes Group, 2005; Edwards, 2008; O'Lynn 2007a; Williams, 1989; Wilson, 1997), and the term "male nurse" has been used to differentiate men in nursing from members of the profession as a whole (Bernard Hodes Group; Egeland & Brown, 1989; Kanter, 1977b; LaRocco, 2004). Men in nursing have been viewed as deviants or anomalies (Evans, 2002; Okrainec, 1990). The men in this study describe social generalizations about men, nursing, and men in nursing: 1) men should pursue work congruent with the masculine role; 2) nursing is a profession for women; and 3) men in nursing ("murses") are different from other nurses.

Each culture possesses its own roles and norms (Gray & Thomas, 2005; Pleck, 1981; Shim & Schwartz, 2007). Inconsistent or unattainable norms lead to role violations, which then can lead to role strain (Berry, 1997; O'Neil, n.d.; O'Neil et al., 1995; Pleck, 1981, 1995). The men in the present study report having to uphold their masculine social role and traditionally female nursing role. These two roles frequently were incongruent

and resulted in strain before entering nursing school, during nursing school, and early in their practice.

Gender-related role strain has been associated with stress, conflict, restrictions of potential, devaluation, and physical or mental health issues (O'Neil, n.d.; O'Neil et al., 1995; Pleck, 1981, 1995; St. Cloud University, 2009). O'Neil and colleagues (1995) identified six signs of gender-role conflict: 1) restrictive emotionality; 2) homophobia; 3) control, power, and competition; 4) constrained sexual and affectionate behaviors; 5) preoccupation with achievement and success; and 6) health care difficulties. None of these are apparent in the men in the current study. Since the men in the study had confirmed conflicts between their gender and professional roles, it may be that they had chosen not to talk about experiences in which they exhibited the aforementioned six signs of gender-role conflict, or the participants had learned how to manage or live with the conflict. According to Berry's (1997) acculturation framework, the men in the current study could be posited to have retained their masculine role while also integrating characteristics of the nursing role and achieving a sense of fit. The men in the current study appear to see themselves not so much as violating gender roles but as challenging traditional beliefs about gender and professions.

Two factors influence the amount of stress experienced when roles are incongruent: 1) moderating effects of such things as social support and personality characteristics; and 2) perception of the stress as difficult, benign, or an opportunity (Berry, 1997). Participants in the current study identify several potential moderating effects, such as support from family and friends, comfort in their own identity as men and nurses, and the presence of other men in nursing as role models and mentors. The men also appear to see themselves as change agents capable of challenging the social stereotypes about men in nursing. Men's abilities to deal with role stress seem to have increased as they matured as men and as nurses.

Research suggests that men in nursing may be uncomfortable with touch (Inoue et al., 2006) or restrict their touch (Evans, 2002). Findings from the current study indicate that these men may feel uncomfortable providing intimate care to younger female patients, or even to male patients, especially when patients are uncomfortable because of the nurses' gender. However, the men have learned methods that allow them to perform their professional role, be comfortable in that role, and maintain patient comfort.

Previous research has indicated that men are attracted to nursing or remain in nursing because of the desire to help others, flexibility, salary, and job security (Bernard Hodes Group, 2005; Ellis et al., 2006; Wilson, 1997). The men in the current study confirm these same factors affected their own decisions to be a nurse: some report a calling to nursing, some enjoy belonging to a group and profession they see as making a difference, and they appreciate the benefits of nursing.

Men may experience advantages in nursing as a result of their gender (Evans, 2002; Heikes, 1992; Williams, 1989, 1992, 1995). These advantages occur because masculine traits (e.g. leadership, strength), prized by society, become expected of men in nursing. However, similar to Heikes's findings, the participants in the current study felt that expecting men to possess these masculine characteristics can cause stress on men in nursing and even strain relationships between male and female nurses.

Despite the slight increase in the number of men in nursing, nursing remains a predominantly female profession. The most appropriate methods to recruit and retain more men in nursing continue to be debated (Bernard Hodes Group, 2005; Ellis et al., 2006; Kleinman, 2004; Nelson & Belcher, 2006; Oregon Center for Nursing, n.d; Wilson, 1997). The men in this study recommend more media campaigns such as the Johnson and Johnson campaign, as ways to recruit more men and women into nursing. The participants advocate for campaigns depicting male nurses caring for a variety of patients in varied settings. They also recommend focusing on the advantages of nursing as a

career: good pay, opportunities for growth, flexibility, camaraderie, and the opportunity to help people.

The current study used Pleck's (1981, 1995) Gender Role Strain paradigm as the sensitizing framework. Current study findings were examined in light of Pleck's (1995) 10 assumptions:

1. "Gender roles are operationally defined by gender role stereotypes and norms" (p. 12).
2. "Gender role norms are contradictory and inconsistent" (p. 12).
3. "The proportion of individuals who violate gender role norms is high" (p. 12).
4. "Violating gender role norms leads to social condemnation" (p. 12).
5. "Violating gender role norms leads to negative psychological consequences" (p. 12).
6. "Actual or imagined violation of gender role norms leads individuals to overconform to them" (p. 12).
7. "Violating gender role norms has more severe consequences for males than females" (p. 12).
8. "Certain characteristics prescribed by gender role norms are psychologically dysfunctional" (p. 12).
9. "Each gender experiences gender role strain in its paid work and family roles" (p. 12).
10. "Historical change causes gender role strain" (p. 12).

As indicated above, the study findings appear congruent with five of Pleck's (1981, 1995) assumptions (i.e., 1, 2, 4, 5, 10). Pleck's seventh assumption, more severe consequences for male violation of gender role norms, was not specifically explored because the current study only utilized male participants. However, the participants in this study described encountering consequences for violating their gender role norms by choosing nursing as a profession: their masculinity was challenged, they felt unwelcomed

or marginalized, and their contributions to nursing and worth as nurses were questioned. Participants also expressed concern that family members might face consequences because of the participant's career choice.

Pleck's ninth assumption that men and women encounter gender role strain between family and work roles was not specifically explored because of the study focus. Three of the assumptions (i.e. 3, 6, 8) were not fully supported.

Pleck's (1981, 1995) third assumption is that a high percentage of people violate gender role norms. On one hand, the men in this study recognize social stereotypes of nursing and understood male gender role norms. Participants also recognize that other people questioned their masculinity or fittingness because they chose to pursue a gender-atypical profession. Two participants' entry into nursing was delayed because they upheld traditional social beliefs. However, participants appear to see themselves not so much as being in violation of their gender roles, but as being change agents challenging traditional beliefs.

Pleck's (1981, 1995) sixth assumption about overconforming to gender roles when gender role norms are violated was not supported by study findings. Participants recognize that others have expectations of them as men, creating a pressure to conform to masculine norms (e.g., power, control, competition). Participants describe being willing to uphold masculine roles (e.g., lifting, leadership), but most did not feel compelled to prove themselves as men, perhaps because they do not see themselves as being in violation of the masculine gender role. The participants stated that they chose to work in the ER and ICU, specialties considered more masculine, because of the constant challenge; no data support that specialty choice is due to gender role conformity.

Pleck's (1981, 1995) eighth assumption that some gender role characteristics are psychologically dysfunctional (e.g., aggression, emotional/interpersonal orientation) was not supported by the current study findings. Again, participants recognize that others may see incongruence between socially prescribed masculine and nursing characteristics (e.g.,

caring), but the participants appear to recognize that they can demonstrate caring behaviors in a manner congruent with masculine and nursing roles. The men in the study do not interpret their gender role characteristics as being psychologically dysfunctional. Although they have experienced questioning of their fit in nursing because of their gender, the participants have become comfortable with being a man and a nurse.

UNEXPECTED FINDINGS

There were several unexpected findings in this study. The first was how visible some men in nursing feel and how that affects them. One participant chose not to take part in the study, despite assurances of confidentiality, because he felt he could easily be identified. Of those who chose to participate, some felt vulnerable because of their gender and others enjoyed the attention.

Another unexpected finding was that professional touch when providing intimate care to patients was not taught to these men in nursing school. The men described having to learn this on their own in practice unless they were fortunate enough to have a male nurse preceptor or mentor. Caring and touch are integral to nursing care and nursing school is a time that students should be taught the basic concepts and skills of nursing care.

The last unexpected finding was the lack of awareness in female nurses and faculty about the gender-specific challenges men face in nursing. The lack of understanding causes additional stress for the men in nursing and appears to indicate a lack of cultural sensitivity.

STUDY IMPLICATIONS

The current study has several implications for nursing practice. First, nursing emphasizes cultural sensitivity, yet some nurses remain unaware of their own biases about men in nursing. Lack of cultural sensitivity can affect patient care and the work

environment. Female nurses should appreciate that some patients who require intimate care may prefer a female caregiver and offer their assistance to their male nurse colleagues just as they would a male physician. The burden of difficult physical or psychological patient care should be shared and all nurses, male or female, should be equally protected from injury.

The current study also has implications for nursing education. Nursing educators must understand their own biases and how these could affect students from other cultural backgrounds. Educators must ensure they have the knowledge and comfort to teach nursing concepts to all cultural groups and that no student is marginalized or excluded. Faculty also must be aware of the effects of evolving social norms on traditional nursing skills, such as touch. Faculty should be teaching male and female students about professional touch. Educational institutions must continue to strive to hire diverse faculty that more closely approximate their student body and society, as role modeling is important to the recruitment and retention of diverse nurses.

Several implications for the professional culture of nursing arose from this study. First, the language used in nursing should be gender neutral. Second, there should be more recruitment campaigns, like those sponsored by Johnson and Johnson, which are appealing to a more diverse group of prospective nurses. Pictures of nurses used for recruitment and in journals should be ethnically diverse and show men and women performing in all capacities of nursing.

Theoretical implications are evident. The study findings indicate that evolving social attitudes and beliefs influence perceptions of gender role norms; this suggests a continued need to develop gender role theory. The role satisfaction evident in study participants points to a need for theory development about the successful adaptation of men in nursing and other gender-atypical occupations.

LIMITATIONS OF THE STUDY

One limitation of this study is that it only explored how gender affects the experiences of men in nursing. Study findings may not be applicable to other occupations or to women. Another limitation is that recruitment of men into this study was limited to those willing to participate. Despite efforts to diversify the sample, most participants were Caucasian, were heterosexual, and worked in the ER or ICU, specialties often considered masculine. Thus, findings may not be applicable to all men in nursing. However, the sample is representative of the racial/ethnic distribution of male nurses in the U.S. (Minority Nurse, 2013). The participants were recruited from a densely populated, geographically small portion of Texas. The recruitment area is considered more cosmopolitan than many areas of Texas, but nevertheless is situated in a state generally considered to hold conservative values. Thus, findings may be less applicable to men in nursing living in more socially tolerant areas of the country. Further, findings may represent the experiences only of persons who were successful in their careers and comfortable in their roles as men and nurses.

STRENGTHS OF THE STUDY

There were several strengths to this study. The study design is a significant strength. The critical ethnographic approach facilitated exploration of the culture of men in nursing in the larger contexts of social and nursing cultures. The gender and occupation of the researcher are also strengths of the study. As a man and a nurse, the researcher is a member of the culture under study. His experiences provide in-depth knowledge about and first-hand experience of what it means to be a man in nursing and the challenges faced by men in nursing.

SUGGESTIONS FOR FUTURE RESEARCH

One suggestion for future research is studies to develop and test theories related to men in nursing. Particularly needed are theories that explain socialization of men into nursing, roles of men in nursing in the context of evolving social norms, successful adaptation of men in nursing and other gender-atypical professions, and caring from a male nurse perspective.

Other research methodology could be used to explore the experiences of men in nursing. For example, a longitudinal design for a study of adaptation of men in nursing to their professional culture would better identify what skills men need, how skills are learned, and from whom and when skills are learned. A Grounded Theory design could be used to develop needed theories, such as a theory of professional touch in nursing. Increasing sample size and diversity may make findings more generalizable. Replication of this study in different settings would help confirm, add to, or refute findings from this study.

As a next step, the researcher plans to use ethnographic or critical ethnographic methods to explore how gender affects the experiences of men in nursing in administration, education, and clinical specialties where men are less likely to practice. The researcher also plans to study female perceptions of the effects of gender on male nurses' experiences in nursing. Another potential direction is using Grounded Theory to develop a theory of integration of male and nursing cultures. Further study is needed to explore experiences of men who drop out of nursing school or leave the profession of nursing after graduation.

CONCLUSION

Despite men's long history of providing nursing care, society and nursing have considered nursing to be a profession for females for over a century. These perceptions

have affected men's interest, entry, experiences, and retention in nursing. The perceptions also have influenced nursing education, nursing practice, and nursing policies.

Men in nursing experience conflict between the masculine social role and feminine nursing role. Theoretically, gender role conflict can lead to acculturative stress or role strain that may affect the career choices, professional satisfaction, and personal goal attainment of men in nursing.

The men in this study see themselves as successfully upholding the social and nursing role expectations. However, these men may not be typical of the men who never consider nursing or who consider nursing and then leave. To move nursing forward as a profession of men and women, several changes must occur. First, society must begin to acknowledge nursing as an acceptable and respectable profession for men and women. Second, more men must be willing to challenge traditional labeling of careers as masculine or feminine. Additionally, the nursing culture must become more willing to accept and include other cultures. Finally, society and nursing should strive to focus on similarities between cultures rather than differences.

Appendix A Recruitment Flyer

Research Study Seeking for Male RN Participants

A research study is being conducted to explore the experiences of male nurses to gain a better understanding of male RNs. Study participants should be:

- Currently licensed male RNs
- English speaking
- Working as an RN for at least the past twelve months
- Providing direct patient care
- Willing to share his experiences in face-to-face interviews
- Willing to have interview(s) tape recorded

Participants will be asked to complete a short demographic form. Participants will also be interviewed in an initial interview session lasting no longer than 90 minutes. The interviews will be scheduled at a time and location that is acceptable to the participant and the researcher. Follow-up face-to-face or telephone interviews may be necessary for clarification. If you would like more information or are interested in participating, please contact:

Chris Edwards, BS, BSN, RN
UTMB Nursing Doctoral Student
Email: credward@utmb.edu
Phone: XXX-XXX-XXXX (cell)

Appendix B Bio-demographic Questionnaire

Age: _____

Ethnicity: ___ White, non-hispanic ___ African American

___ Hispanic other: please specify _____

Years of experience as a Registered Nurse: _____

Patient Population:

____ Adult ____ Pediatrics

Job Specialty:

____ Med-Surg ____ Labor and delivery

____ Critical Care ____ Special procedures

____ Emergency room ____ OB/GYN

____ Oncology other: please specify area _____

Job Role:

____ Staff nurse ____ Charge nurse/head nurse

other: please specify _____

Highest Level of Nursing Education:

____ ADN
____ Diploma
____ BSN
____ MSN
____ Ph.D. or other doctoral nursing degree

Do you have a degree(s) other than nursing? If so, please specify.

_____

Is nursing your first career? If no, please specify other career(s).

_____

Appendix C Interview Guide

1. Tell me about what events, individuals, or situations influenced your decision to become a nurse.
2. Tell me how people responded when you told them you wanted to become a nurse.
3. Tell me what it has been like being a nurse.
4. Tell me how people have responded to you when you tell them you are a nurse.
5. Tell me what it has been like being a man in nursing?
6. What have you noticed about how men are treated in nursing?
7. What do you think would help increase the number of men in nursing?
8. What would you tell a man considering nursing as a profession?
9. What do you think is important to comment on about men in nursing that I did not ask?

Appendix D Subject Consent Form with Addendum

UTMB®
The University of Texas Medical Branch

OFFICE OF RESEARCH SUBJECT PROTECTIONS
Institutional Review Board

January 29, 2010

MEMORANDUM

TO: Elnora (Nonie) Mendias, PhD, RN, APRN, FNP-BC/
Christopher Edwards, BS, BSN, RN
SON/GSBS , 1029

FROM: Carmen Radecki Breitkopf, PhD
Inferim Director
Institutional Review Board 0158

SUBJECT: IRB #10-010 - **Final Approval** of Expedited Protocol
A Critical Ethnographic Study of the Perceptions of Men in Nursing about Gender Influences on Their Career Paths

Having met the requirements set forth by the Institutional Review Board by an expedited review process on **January 13, 2010**, your research project is now approved.

This project will require annual review and will expire on December 31, 2010. Research that has not received approval for continuation by this date may not continue past midnight of the expiration date.

In reviewing the protocol, the IRB determined that the study objectives are clear, the study design, to the extent possible, minimizes risks to subjects and is appropriate to accomplish the objectives. The research contribution to the generalizable knowledge justifies the potential risks, discomforts or inconvenience to the subjects. The investigators and their staff appear to have the appropriate scientific training and qualifications to conduct the proposed research. From review of the protocol and supporting documents, the IRB considered the likelihood that some or all of the subjects may be vulnerable to coercion or undue influence and determined that appropriate safeguards are in place to protect the rights and welfare of these subjects. The IRB reviewed the risks and anticipated benefits to subjects and the importance of the knowledge that may be expected to result from the research and found that the physical, psychological, social, economic and legal risks to the subjects are minimized and are reasonable in relation to the anticipated benefits. The plan for selection of subjects is equitable, the informed consent document contains all required elements, and informed consent will be appropriately obtained and documented from each subject or the subject's legally authorized representative. Adequate provisions are made to protect the privacy of the subjects and to maintain the confidentiality of data. In addition, taking into account the degree of risk associated with the protocol, the IRB determined that continuing review of this protocol does not have to be accomplished more often than annually.

CRB/sh

Attachment: Research Consent Form

301 UNIVERSITY BOULEVARD GALVESTON, TEXAS 77555-0158 (409) 266-9475 FAX (409) 266-9499 Research.utmb.edu/IRB

RESEARCH CONSENT FORM

You are being asked to participate as a subject in the research project entitled, "A Critical Ethnographic Study of the Perceptions of Men in Nursing about Gender Influences on Their Career Paths", under the direction of Chris Edwards, BS, BSN, RN, who is a student in the Doctoral Nursing Program at UTMB's Graduate School of Biomedical Sciences (GSBS). This project is supervised by Dr. Elnora (Nonie) Mendias, PhD, RN, Associate Professor at the School of Nursing and full member of the GSBS faculty.

PURPOSE OF THE STUDY

The purpose of this study is to subjectively explore and describe the lived experiences of actively practicing, male nurses in the nursing profession. This study fulfills the Ph.D. degree requirement and may lead to future scholarly research and dissertation work. Mr. Edwards is interested in learning from you more about your experiences as a male nurse. You are being asked to participate because you are a male Registered Nurse who has been employed full-time for at least 12 months providing bedside patient care in a comprehensive medical center in the southern U.S.

PROCEDURES NOT RELATED TO THIS RESEARCH

This study will initially use face-to-face interviews. There are no interventions or experiments. During this study, Mr. Edwards will interview you at least once about you as a male nurse. The interviews will be conducted at a time and place that is convenient for you. Each interview will last no more than ninety minutes and will be conducted over a period of time that lasts no longer than three months, counting from when the first interview begins until the last interview is completed. The interviews will be audio-taped and transcribed verbatim so that data from the interview can be analyzed. The audio-tapes and transcripts will be coded with a pseudonym assigned to you. Your name or other identifying information will never appear on any study documents or recordings. Both the tapes and interview transcripts will be kept in a locked file cabinet in the researcher's office. Analysis of the transcripts involves searching for any commonalities among comments made by the total number of study participants.

Following the completion of the first interview, Mr. Edwards may contact you to set up any additional interviews if needed. The need for follow-up interviews will be determined by how much information was left to talk about when the first interview ended. The second interview meeting also provides time for you and Mr. Edwards to clarify any questions he has, and for you to add any additional information you wish to share.

In addition to answering the interview questions, you will be asked to answer several biographical questions about your age, education, specialty area, years of experience at your present facility, years of experience as a nurse, and any other careers you have pursued. This questionnaire will also be coded so that no identifying information can be associated with you. The information will only be used to describe the participants used in the study. If, for any reason, you are unable to continue your participation in any of the interviews, they will be stopped without any penalty to you.

RISKS OF PARTICIPATION

The potential risks from participation in this study are few. You may become fatigued during the interview. There are no procedures or treatments associated with this research project; only conversation during the interview. Mr. Edwards will take all possible steps to assure your confidentiality by coding study data and removing your name and other identifiers from study materials. However, there remains a minimal risk of the loss of confidentiality.

NUMBER OF SUBJECTS PARTICIPATING AND THE DURATION OF YOUR PARTICIPATION

The anticipated number of subjects participating in this study will be 30. All will be recruited from comprehensive medical centers in the southern U.S. This is a community-based study and your employer will not be involved in or ever learn of your participation unless you are the one who tells him or her or any co-workers. The length of time of your participation will vary according to how many interviews you agree to have with Mr. Edwards. As explained above under "Procedures Related Only to this Research", you will be asked to participate in at least one interview session and may be asked to participate in follow-up interviews. No one interview session will last longer than ninety minutes. The interviews will be conducted at a place and time that is convenient for you. Follow-up interviews may be conducted in person or over the phone as needed. This study will begin in January 2010 and will be completed by December 2010. Your commitment of time will be only the interview sessions you agree to schedule and complete with Mr. Edwards.

BENEFITS TO THE SUBJECT

There are no direct benefits to you for your participation in this research project. By answering the researcher's interview questions, you may gain some insight into your experiences as a male nurse.

OTHER CHOICES (ALTERNATIVE TREATMENT)

There are no treatments in this study. You will meet with the investigator only to discuss the interview questions and answers you wish to provide. The alternative to participating in this study is to choose not to participate. Participation in this study is voluntary and not required.

REIMBURSEMENT FOR EXPENSES

You will be reimbursed for lost time, travel, parking, meals, etc. in the amount of $20 in the form of a VISA gift card. Your gift card will be mailed to you approximately two weeks after you have completed the final interview.

COMPENSATION FOR RESEARCH RELATED INJURY

If you are physically injured because of any substance given to you or procedure performed on you under the plan for this study, UTMB will provide you with the appropriate medical treatment. Your insurance company will be billed and any charges not covered by your own insurance or health care program will be provided at no cost to you. You will be responsible for paying any costs related to illnesses and medical events not associated with being in this study. There are no plans to provide other forms of compensation. However, you are not waiving any of your legal rights by participating in this study. Questions about compensation may be directed to the study doctor.

COSTS OF PARTICIPATION

There will be no cost to you for your participation in this study.

REASONS FOR THE STUDY INVESTIGATOR TO STOP YOUR PARTICIPATION

You may be dropped from the study by the study investigator if the study is discontinued. If this is the case, Mr. Edwards will contact you and explain the situation.

PROCEDURES FOR WITHDRAWAL

If at any time you wish to stop your participation in this study, simply contact the investigator at the

numbers provided at the end of this consent form. Upon learning of your request, your participation will be ended.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Even though in this interview study no health information is accessed, collected, or used, you must know that all study records that identify you will be kept confidential as required by law. Federal privacy regulations, provided under the Health Insurance Portability and Accountability Act (HIPPA), provide safeguards for privacy, security, and authorized access to your records. These regulations require UTMB to obtain authorization from you if it or anyone employed there attempts to use and disclose your health information. By signing this consent form, you are agreeing to participate in this study. You are not authorizing the use and disclosure of your health information related to this research study.

Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in this study's records. However, you do need to know that study records will be coded without your name and be kept confidential as required by law. You will not be identified by name in study records. A pseudonym will be assigned to you and only Mr. Edwards will know that pseudonym. The key to the code will be kept in a locked file in Mr. Edwards' office.

There are no sponsors for this research. Mr. Edwards is acting alone, but under the supervision of his faculty, Dr. Mendias, to complete his requirements for a doctoral degree. The study data, meaning the contents of your interview(s), will not be linked to you as an individual. Instead, the data you provide will be put together with data from all other participants and reported that way. You may see or receive a copy of any research reports of findings from this study at its conclusion. Please request those from Mr. Edwards.

If you sign this form, you are giving Mr. Edwards permission to collect, use and share the information you provide during the interviews. Your health information is not part of this study and you will not be asked about it nor will it be assessed. You do not need to sign this form. If you decide not to sign this form, you cannot be in the research study. Whether or not you agree to participate in the research project or give us permission to collect, use or share your interview information, will not affect the care you will be given at UTMB.

Your interview information, without your name on it, may be reviewed by people directly involved with the study, for purposes of assisting Mr. Edwards with the data analysis process. If for any reason you want to stop your participation in this study, you can at any time. However, you need to inform Mr. Edwards at the contact numbers listed in this consent form. You need to say that you have changed your mind and do not wish to continue participating in this study. At that time and thereafter, Mr. Edwards may not collect any additional interview information from you. However, he may use the information that he has already collected. It is important to learn everyone's experiences, not just those of persons who complete the research study. The results of this study may be published in scientific journals and presented as posters without identifying you by name.

ADDITIONAL INFORMATION

1. An offer has been made to answer any questions that you may have about these procedures. If you have any questions before, during or after the study, or if you need to report a research related injury, you should immediately contact Chris Edwards, BS, BSN, RN at (281) 948-4120 or Dr. Elnora (Nonie) Mendias, PhD, RN, at (409) 772-8258.

2. Your participation in this study is completely voluntary and you have been told that you may refuse to participate or stop your participation in this project at any time without penalty or loss of benefits and without jeopardizing your medical care at UTMB. If you decide to stop your participation in this project and revoke your authorization for the use and disclosure of your health information,

UTMB may continue to use and disclose your health information in some instances. This would include any health information that was used or disclosed prior to your decision to stop participation and needed in order to maintain the integrity of the research study. If we get any information that might change your mind about participating, we will give you the information and allow you to reconsider whether or not to continue.

3. If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information, you may contact the Institutional Review Board Office, at (409) 266-9475.

The purpose of this study, procedures to be followed, risks and benefits have been explained to you. You have been allowed to ask questions and your questions have been answered to your satisfaction. You have been told who to contact if you have additional questions. You have read this consent form and voluntarily agree to participate as a subject in this study. You are free to withdraw your consent, including your authorization for the use and disclosure of your health information, at any time. You may withdraw your consent by notifying Chris Edwards, BS, BSN, RN at (281) 948-4120 or Dr. Elnora (Nonie) Mendias, PhD, RN, at (409) 772-8258. You will be given a copy of the consent form you have signed.

Informed consent is required of all persons in this project. Whether or not you provide a signed informed consent for this research study will have no effect on your current or future relationship with UTMB.

_____ _____

Signature of Subject Date

Using language that is understandable and appropriate, I have discussed this project and the items listed above with the subject

_____ _____

Signature of Person Obtaining Consent Date

Last Revised 10/20/08

UTMB®
The University of Texas Medical Branch

OFFICE OF RESEARCH SUBJECT PROTECTIONS
Institutional Review Board

March 12, 2010

MEMORANDUM

TO: Elnora Mendias, PhD, Rn, APRN, FNP-BC/Christopher Edwards, BS, BSN, RN
SON/GSBS 1029

FROM: Carmen Radecki Breitkopf, PhD
Interim Director
Institutional Review Board

Subject: IRB #10-010 – **Administrative Approval** of a $25.00 Gift Card and a Revised Research Consent Form
Critical Ethnographic Study of the Perceptions of Men in Nursing About Gender Influences on Their Career Paths

The Institutional Review Board acknowledges receipt of your Request for Protocol/Consent Modifications dated 2/22/10 requesting approval of a subject reimbursement consisting of a $25.00 gift card. Subjects will receive a $25.00 Visa gift card to cover their expenses, such as fuel and parking, incurred as a result of participating in the study. The consent form was revised to reflect the addition of the $25.00 gift card. The subject reimbursement consisting of a $25.00 gift card and the revised research consent form were **reviewed and approved through an expedited review process by the IRB on 3/12/10.**

This project will require annual review by the IRB and will be due by December 31, 2010. **Research that has not received approval for continuation by this date may not continue past midnight of the expiration date**

Attached is the subject consent form with the date of the IRB approval. Please use this consent form with the IRB approval date and make additional copies as they are needed. **In accordance with amendments to 21 CFR Parts 50, 312 and 812 effective 12/5/96, consent forms must be dated when consent is obtained.**

CRB/cc

Attachment: Research Consent Form

4.500 REBECCA SEALY HOSPITAL • 301 UNIVERSITY BOULEVARD • GALVESTON, TEXAS 77555-0158
(409) 266-9475 • FAX (409) 266-9499 • Research.utmb.edu/IRB

RESEARCH CONSENT FORM

You are being asked to participate as a subject in the research project entitled, "A Critical Ethnographic Study of the Perceptions of Men in Nursing about Gender Influences on Their Career Paths", under the direction of Chris Edwards, BS, BSN, RN, who is a student in the Doctoral Nursing Program at UTMB's Graduate School of Biomedical Sciences (GSBS). This project is supervised by Dr. Elnora (Nonie) Mendias, PhD, RN, Associate Professor at the School of Nursing and full member of the GSBS faculty.

PURPOSE OF THE STUDY

The purpose of this study is to subjectively explore and describe the lived experiences of actively practicing, male nurses in the nursing profession. This study fulfills the Ph.D. degree requirement and may lead to future scholarly research and dissertation work. Mr. Edwards is interested in learning from you more about your experiences as a male nurse. You are being asked to participate because you are a male Registered Nurse who has been employed full-time for at least 12 months providing bedside patient care in a comprehensive medical center in the southern U.S.

PROCEDURES NOT RELATED TO THIS RESEARCH

This study will initially use face-to-face interviews. There are no interventions or experiments. During this study, Mr. Edwards will interview you at least once about you as a male nurse. The interviews will be conducted at a time and place that is convenient for you. Each interview will last no more than ninety minutes and will be conducted over a period of time that lasts no longer than three months, counting from when the first interview begins until the last interview is completed. The interviews will be audio-taped and transcribed verbatim so that data from the interview can be analyzed. The audio-tapes and transcripts will be coded with a pseudonym assigned to you. Your name or other identifying information will never appear on any study documents or recordings. Both the tapes and interview transcripts will be kept in a locked file cabinet in the researcher's office. Analysis of the transcripts involves searching for any commonalities among comments made by the total number of study participants.

Following the completion of the first interview, Mr. Edwards may contact you to set up any additional interviews if needed. The need for follow-up interviews will be determined by how much information was left to talk about when the first interview ended. The second interview meeting also provides time for you and Mr. Edwards to clarify any questions he has, and for you to add any additional information you wish to share.

In addition to answering the interview questions, you will be asked to answer several biographical questions about your age, education, specialty area, years of experience at your present facility, years of experience as a nurse, and any other careers you have pursued. This questionnaire will also be coded so that no identifying information can be associated with you. The information will only be used to describe the participants used in the study. If, for any reason, you are unable to continue your participation in any of the interviews, they will be stopped without any penalty to you.

RISKS OF PARTICIPATION

The potential risks from participation in this study are few. You may become fatigued during the interview. There are no procedures or treatments associated with this research project; only conversation during the interview. Mr. Edwards will take all possible steps to assure your confidentiality by coding study data and removing your name and other identifiers from study materials. However, there remains a minimal risk of the loss of confidentiality.

NUMBER OF SUBJECTS PARTICIPATING AND THE DURATION OF YOUR PARTICIPATION

The anticipated number of subjects participating in this study will be 30. All will be recruited from comprehensive medical centers in the southern U.S. This is a community-based study and your employer will not be involved in or ever learn of your participation unless you are the one who tells him or her or any co-workers. The length of time of your participation will vary according to how many interviews you agree to have with Mr. Edwards. As explained above under "Procedures Related Only to this Research", you will be asked to participate in at least one interview session and may be asked to participate in follow-up interviews. No one interview session will last longer than ninety minutes. The interviews will be conducted at a place and time that is convenient for you. Follow-up interviews may be conducted in person or over the phone as needed. This study will begin in January 2010 and will be completed by December 2010. Your commitment of time will be only the interview sessions you agree to schedule and complete with Mr. Edwards.

BENEFITS TO THE SUBJECT

There are no direct benefits to you for your participation in this research project. By answering the researcher's interview questions, you may gain some insight into your experiences as a male nurse.

OTHER CHOICES (ALTERNATIVE TREATMENT)

There are no treatments in this study. You will meet with the investigator only to discuss the interview questions and answers you wish to provide. The alternative to participating in this study is to choose not to participate. Participation in this study is voluntary and not required.

REIMBURSEMENT FOR EXPENSES

You will be reimbursed for lost time, travel, parking, meals, etc. in the amount of $25 in the form of a VISA gift card. Your gift card will be mailed to you approximately two weeks after you have completed the final interview.

COMPENSATION FOR RESEARCH RELATED INJURY

If you are physically injured because of any substance given to you or procedure performed on you under the plan for this study, UTMB will provide you with the appropriate medical treatment. Your insurance company will be billed and any charges not covered by your own insurance or health care program will be provided at no cost to you. You will be responsible for paying any costs related to illnesses and medical events not associated with being in this study. There are no plans to provide other forms of compensation. However, you are not waiving any of your legal rights by participating in this study. Questions about compensation may be directed to the study doctor.

COSTS OF PARTICIPATION

There will be no cost to you for your participation in this study.

REASONS FOR THE STUDY INVESTIGATOR TO STOP YOUR PARTICIPATION

You may be dropped from the study by the study investigator if the study is discontinued. If this is the case, Mr. Edwards will contact you and explain the situation.

PROCEDURES FOR WITHDRAWAL

If at any time you wish to stop your participation in this study, simply contact the investigator at the numbers provided at the end of this consent form. Upon learning of your request, your participation will be ended.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Even though in this interview study no health information is accessed, collected, or used, you must know that all study records that identify you will be kept confidential as required by law. Federal privacy regulations, provided under the Health Insurance Portability and Accountability Act (HIPPA), provide safeguards for privacy, security, and authorized access to your records. These regulations require UTMB to obtain authorization from you if it or anyone employed there attempts to use and disclose your health information. By signing this consent form, you are agreeing to participate in this study. You are not authorizing the use and disclosure of your health information related to this research study.

Except when required by law, you will not be identified by name, social security number, address, telephone number, or any other direct personal identifier in this study's records. However, you do need to know that study records will be coded without your name and be kept confidential as required by law. You will not be identified by name in study records. A pseudonym will be assigned to you and only Mr. Edwards will know that pseudonym. The key to the code will be kept in a locked file in Mr. Edwards' office.

There are no sponsors for this research. Mr. Edwards is acting alone, but under the supervision of his faculty, Dr. Mendias, to complete his requirements for a doctoral degree. The study data, meaning the contents of your interview(s), will not be linked to you as an individual. Instead, the data you provide will be put together with data from all other participants and reported that way. You may see or receive a copy of any research reports of findings from this study at its conclusion. Please request those from Mr. Edwards.

If you sign this form, you are giving Mr. Edwards permission to collect, use and share the information you provide during the interviews. Your health information is not part of this study and you will not be asked about it nor will it be assessed. You do not need to sign this form. If you decide not to sign this form, you cannot be in the research study. Whether or not you agree to participate in the research project or give us permission to collect, use or share your interview information, will not affect the care you will be given at UTMB.

Your interview information, without your name on it, may be reviewed by people directly involved with the study, for purposes of assisting Mr. Edwards with the data analysis process. If for any reason you want to stop your participation in this study, you can at any time. However, you need to inform Mr. Edwards at the contact numbers listed in this consent form. You need to say that you have changed your mind and do not wish to continue participating in this study. At that time and thereafter, Mr. Edwards may not collect any additional interview information from you. However, he may use the information that he has already collected. It is important to learn everyone's experiences, not just those of persons who complete the research study. The results of this study may be published in scientific journals and presented as posters without identifying you by name.

ADDITIONAL INFORMATION

1. An offer has been made to answer any questions that you may have about these procedures. If you have any questions before, during or after the study, or if you need to report a research related injury, you should immediately contact Chris Edwards, BS, BSN, RN at (281) 948-4120 or Dr. Elnora (Nonie) Mendias, PhD, RN, at (409) 772-8258.

2. Your participation in this study is completely voluntary and you have been told that you may refuse to participate or stop your participation in this project at any time without penalty or loss of benefits and without jeopardizing your medical care at UTMB. If you decide to stop your participation in this project and revoke your authorization for the use and disclosure of your health information, UTMB may continue to use and disclose your health information in some instances. This would include any health information that was used or disclosed prior to your decision to stop participation and needed in order to maintain the integrity of the research study. If we get any information that might change your mind about participating, we will give you the information and allow you to reconsider whether or not to continue.

3. If you have any complaints, concerns, input or questions regarding your rights as a subject participating in this research study or you would like more information, you may contact the Institutional Review Board Office, at (409) 266-9475.

The purpose of this study, procedures to be followed, risks and benefits have been explained to you. You have been allowed to ask questions and your questions have been answered to your satisfaction. You have been told who to contact if you have additional questions. You have read this consent form and voluntarily agree to participate as a subject in this study. You are free to withdraw your consent, including your authorization for the use and disclosure of your health information, at any time. You may withdraw your consent by notifying Chris Edwards, BS, BSN, RN at (281) 948-4120 or Dr. Elnora (Nonie) Mendias, PhD, RN, at (409) 772-8258. You will be given a copy of the consent form you have signed.

Informed consent is required of all persons in this project. Whether or not you provide a signed informed consent for this research study will have no effect on your current or future relationship with UTMB.

_____ _____

Signature of Subject Date

Using language that is understandable and appropriate, I have discussed this project and the items listed above with the subject

_____ _____

Signature of Person Obtaining Consent Date

Last Revised 10/20/08

Appendix E Low-level Codes

I. What happened

A. Experiences that helped him determine was a viable career for him

B. Someone did something to him that supported his fittingness as a nurse

1. When deciding whether to pursue nursing as a career

2. While in nursing school

3. While a nurse

4. During several timeframes

C. Someone did something to him that supported his fittingness as a nurse

1. When deciding whether to pursue nursing as a career

2. While in nursing school

3. While a nurse

4. During several time

D. Mixed Reactions

II. How he responded

A. Processed it within self

1. When deciding whether to pursue nursing as a career

2. While in nursing school

3. While a nurse

4. During several timeframes

B. Took action

III. Future plans

IV. Increasing the number of men in nursing

V. Factors that played a role in interactions

Appendix F Higher-level Codes

I. Nursing as unfitting

- A. Lack of exposure
  1. Nursing role
  2. Men in nursing
- B. Gender personality conflicts
- C. Encountering negative stereotypes
  1. My own
  2. From others

II. Finding fittingness in nursing

- A. Understanding self
  1. Self-worth
     a. With patients
     b. Other nurses
     c. People considering nursing: Passing on my knowledge
  2. Belonging
  3. Respect/pride
  4. Being challenged
  5. Enjoyment
  6. Answering a calling
  7. Stability
  8. Through experiences
- B. Learning to cope with others' stereotypes
  1. Not responding
  2. Role modeling as a man in nursing

3. Using humor
4. Protecting self
5. Understanding norms and stereotypes can change

C. Changing communication style

D. Understanding other contributions of men in nursing

1. Diversify the workforce
2. Change the work environment
3. Offer a different perspective
4. Allowing for others' preferences
    i. Patients
    ii. Nurses
5. Increase in pay & respect

III. Increasing the number of men in

A. Change perception of men in nursing

B. Bring more respect to nursing

References

Abraham, E. J. (2007). Pulse on health and nursing in India. *Nursing and Health Sciences, 9,* 79-81.

Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nursing. *Health Affairs, 23*, 69-77.

Aiken, L. H., Clarke, S., Sloane, D., Sochalski, J., & Sibler, J. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association, 288,* 1987-1993.

Angel, R. J. (2006). Narrative and the fundamental limitations of quantification in cross-cultural research. *Medical Care, 44*, s31-s33.

Anthony, A. S. (2004). Gender bias and discrimination in nursing education: Can we change it? *Nurse Educator, 29,* 121-125.

Anthony, A. S. (2006). Retaining men in nursing – Our role as nurse educators. *Annual Review of Nursing Education, 42,* 209-236.

Beck, C. T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research, 15*, 263-266.

Berg, J. A., Rodriguez, D., & De Guzman, C. (2004). Demographic survey of Filipino American nurses. *Nursing Administration Quarterly, 28,* 199-206.

Bernard Hodes Group. (2005). Men in nursing study. Retrieved on April 6, 2009, from http://www.hodes.com/MenInNursing.

Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46,* 5-68.

Brod, M., Tesler, L. E., & Christensen, T. L. (2009). Qualitative research and content validity: Developing best practices based on science and experience. *Quality of Life Research, 18,* 1263-1278.

Brown, B., Nolan, P., & Crawford, P. (2000). Men in nursing: Ambivalence in care, gender and masculinity. *International History of Nursing, 5*, 4-13.

Bruegelmans, S. M., & Van de Vijver, F. (2004). Antecedents and components of majority attitudes towards multiculturalism in the Netherlands. *Applied Psychology: An International Review*, *53*, 400-422.

Buerhaus, P. I. (2008). Current and future state of the U.S. nursing workforce. *Journal of the American Medical Association*, *300,* 2422-2424.

Buerhaus, P. I., Auerbach, D. I., & Staiger, D. O. (2009). The recent surge in nursing employment: Causes and implications. *Health Affairs*, *28*, 657-668.

Burns, N., & Grove, S. K. (2005). *The practice of nursing research: Conduct, critique, and utilization* (5th ed). St. Louis, MO: Elsevier Saunders.

Cameron, D. (2003). Gender and language ideologies. In J. Holmes and M. Meyerhoff (Eds.), *The handbook of language and gender* (pp. 447-467). Maiden, MA: Blackwell.

Carspecken, P. F. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. New York, NY: Routledge.

Chevannes, M. (2002). Issues in educating health professionals to meet the diverse needs of patients and other service users from ethnic minority groups. *Journal of Advanced Nursing, 39*, 290-298.

Chikanda, A. (2005). Nurse migration from Zimbabwe: Analysis of recent trends and impacts. *Nursing Inquiry, 12*, 162-174.

Choi, H. (2001). Cultural marginality: A concept analysis with implications for immigrant adolescents. *Issues in Comprehensive Pediatric Nursing*, *24*, 193-206.

Chung, V. (2000). Men in nursing. Retrieved on January 12, 2010, from http://www.minoritynurse.

Codier, E., & MacNaughton, N. S. (2012). Are male nurses emotionally intelligent? *Nursing Management, 43*, 1-4.

Cornell University Law School. (n.d.). *Mississippi University for Women v. Hogan* (No. 81-406). Retrieved November 12, 2008, from http://www.law.cornell.edu/supct/html/historics/USSC_CR_0458_0718_ZO.html #458_US_718n15.

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39*, 124-131.

De Bruyn, E. H., & Van den Boom, D. C. (2005). Interpersonal behavior, peer popularity, and self-esteem in early adolescents. *Social Development, 14*, 555-573.

Denzin, N. K., & Lincoln, Y. S. (2003). Introduction: The discipline and practice of qualitative research. In N. K. Denzin and Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed.) (pp. 1-46). Thousand Oaks, CA: Sage.

Drevdahl, D. J., & Dorcy, K. S. (2007). Exclusive inclusion: The violation of human rights and U.S. immigration policy. *Advances in Nursing Science, 30*, 290-302.

Dysart-Gale, D. (2007). Clinicians and medical interpreters: Negotiating culturally appropriate care for patients with limited English ability. *Family and Community Health, 30*, 237-246.

Edwards, C. R. (2008). *A critical ethnographic study of male nurses' experiences in Nursing.* Unpublished raw data.

Egeland, J. W., & Brown, J. S. (1989). Men in nursing: Their fields of employment, preferred fields of practice, and role strain. *Health Services Research, 24*, 693-707.

Ekstrom, D. N. (1999). Gender and perceived nurse caring in nurse-patient dyads. *Journal of Advanced Nursing, 29*, 1393-1401.

Ellis, D. M., Meeker, B. J., & Hyde, B. L. (2006). Exploring men's perceived educational experiences in a baccalaureate program. *Journal of Nursing Education*, *45*, 523-527.

Evans, J. (1997). Men in nursing: Exploring the male nurse experience. Nursing Inquiry, 4, 142-145.

Evans, J. (2002). Cautious caregivers: Gender stereotypes and the sexualization of men nurses' touch. *Journal of Advanced Nursing*, *40*, 441-448.

Evans, J. (2004). Men nurses: A historical and feminist perspective. Journal of Advanced Nursing, 47, 321-328.

Eveloff, D. (2003). Males in nursing… Game over: Nursing is NOT just a female profession. Retrieved on April 6, 2009, from http://www.nursingschools.com/articles/malesinnursing/

Federal Interagency Forum on Aging-Related Statistics. (n.d.). Older Americans 2008: Key indicators of well-being. Retrieved on January 11, 2010, from http://www.agingstats.gov/Agingstatsdotnet/Main_Site/Data/2008_Documents/Population.aspx.

Feinberg, R. (2007). Dialectics of culture: Relativism in popular and anthropological discourse. *Anthropological Quarterly*, *80*, 777-790.

Fogarty, G. J., Machin, M. A., Albion, M. J., Sutherland, L. F., Lalor, G. I., & Revitt, S. (1999). Predicting occupational strain and job satisfaction: The role of stress, coping, personality, and affectivity variables. *Journal of Vocational Behavior*, *54*, 429-452.

Fritzche, D. J., & Oz, E. (2007). Personal values' influence on the ethical dimension of decision making. *Journal of Business Ethics*, *75*, 335-343.

Gilloran, A. (1995). Gender differences in care delivery and supervisory relationship: The case of psychogeriatric nursing. *Journal of Advanced Nursing, 21,* 652-658.

Gliner, J. A., Morgan, G. A., & Leech, N. L. (2000). Mahwah, NJ: Lawrence Erlbaum Associates.

Goodenough, W. H. (1981). *Culture, language, and society.* Menlo Park, CA: Benjamin-Cummings.

Grady, C., Stewardson, G. & Hall, J. (2008). Faculty notions regarding caring in male students. *The Journal of Nursing Education, 47*, 305-313.

Gray, D. P., & Thomas, D. (2005). Critical analysis of "culture" in nursing literature: Implications for nursing education in the United States. *Annual Review of Nursing Education, 3*, 3249-3270.

Greenhalgh, J., Vanhanen, L., & Kyngäs, H. (1998). Nurse caring behaviours. *Journal of Advanced Nursing, 27*, 927-932.

Gruber, T. (1996). Towards principles for the design of ontologies used for knowledge sharing. *International Journal of Human-Computer Studies, 43*, 907-928.

Harper, D. (2001). Online etymology dictionary. Retrieved on February 11, 2009, from http://www.etymonline.com

Hart, M. (2005). Hospital ethical climates and registered nurses' turnover intentions. *Journal of Nursing Scholarship, 37*, 173-177.

Hayes, R. (1989). Men in female-concentrated occupations. *Journal of Organizational Behavior, 10*, 201-212.

Health Resources and Services Administration. (2000). The registered nurse population: Findings from the National Sample Survey of Registered Nurses. Retrieved on January 14, 2009, from ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00.pdf

Health Resources and Services Administration. (2004). The registered nurse population: Findings from the March 2004 National Sample Survey of Registered Nurses. Retrieved on January 14, 2009, from ftp://ftp.hrsa.gov/bhpr/workforce/0306rnss.pdf

Health Resources and Services Administration. (2010). The physician workforce: Projections and research into current issues affecting supply and demand. Retrieved on September 18, 2011, from http://bhpr.hrsa.gov/healthworkforce/reports/physwfissues.pdf

Health Resources and Services Administration. (2010). The registered nurse population: Findings from the 2008 National Sample Survey of Registered Nurses. Retrieved on February 6, 2011, from http://bhpr.hrsa.gov/healthworkforce/rnsurvey/2008/nssrn2008.pdf

Heath, I. (2008). Exploitation and apology. Retrieved on July 20, 2008, from http://bmj.com

Heikes, E. J. (1992). When men are the minority: The case of men in nursing. *The Sociological Quarterly, 32*, 389-401.

Helly, D. (2002). Cultural pluralism: An overview of the debate since the '60s. *The Global Review of Ethnopolitics*, *2*, 75-96.

Houser, B., & Player, K. (2004). *Pivotal moments in nursing: Leaders who changed the path of a profession*. Indianapolis, IN: Sigma Theta Tau International.

Inoue, M., Chapman, R., & Wynaden, D. (2006). Male nurses' experiences of providing intimate care for women clients. *Journal of Advanced Nursing*, *55*, 559-567.

Institute of Medicine. (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses.* Washington, DC: National Academy Press.

Janesick, J. (2003). The choreography of qualitative research design: Minuets, improvisations, and crystallization. In N. K. Denzin, and Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry* (2nd ed.). Thousand Oaks, CA: Sage.

Jayaratne, S. & Chess, W. A. (1984). Job satisfaction, burnout, and turnover: A national study. *Social Work*, *29*, 448-453.

Jefferies, M. R. (2007). Tracking students through program entry, progression, graduation, and licensure: Assessing undergraduate nursing student retention and success. *Nurse Education Today*, *27*, 406-419.

Jones, M. E., Cason, C. L., & Bond, M. (2004). Cultural attitudes, knowledge, and skills of a health workforce. *Journal of Transcultural Nursing*, *15*, 283-290.

Kanter, R. (1977a). *Men and women of the corporation*. New York, NY: Basic Books.

Kanter, R. (1977b). Some effects of proportions on group life: Skewed sex ratios and responses to token women. *American Journal of Sociology, 82,* 965-990.

Keogh, B., & O'Lynn, C. (2007). Male nurses' experience of gender barriers: Irish and American perspectives. *Nurse Educator, 32,* 256-259.

Kerfoot, K. (1992). Female chauvinism, male nurses and sexism: Issues for the nurse executive. *Aspen's Advisory for Nurse Executives*, *7,* 1-3.

Kim, Y., Baker, F., Spillers, R. L., & Wellisch, D. K. (2006). Psychological adjustment of cancer caregivers with multiple roles. *Psycho-Oncology, 15,* 795-804.

Kleinman, C. S. (2004). Understanding and capitalizing on men's advantages in nursing. *Journal of Nursing Administration, 34,* 78-82.

Kline, D. S. (2003). Push and pull factors in international nurse migration. *Journal of Nursing Scholarship, 35,* 107-111.

Koskinen, L., & Jokinen, P. (2007). Multicultural healthcare: A transatlantic project. *Nurse Educator, 32,* 89-93.

Laitin, D. D., & Weingast, B. (2006). An equilibrium alternative to the study of culture. *The Good Society, 15,* 15-20.

LaRocco, S. A. (2007). A grounded theory study of socializing men into nursing. *The Journal of Men's Studies, 15*, 120-129.

LaRocco, S. A. (2004). *Policies and practices that influence recruitment of men in nursing: A grounded theory of socializing men into nursing* (Doctoral dissertation, University of Massachusetts, Boston). Retrieved on October 12, 2011, from http://www.worldcat.org/oclc/340869546.

Leininger, M. M. (1984). *Care: The essence of nursing and health.* Detroit, MI: Wayne State University Press.

Leininger, M. M., & MacFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research & practice*. New York, NY: McGraw Hill.

Levant, R. F., & Richmond, K. (2007). A review of research on masculinity ideologies using the Male Role Norms Inventory. *Journal of Men's Studies*, *15*, 130-146.

Lewis, J. D., Snodgrass, M., & Larkin, F. H. (1990). Men in nursing: Some troubling data. *The American Journal of Nursing*, *90*, 30.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Liu, W. M., Rochlan, A., & Mohr, J. J. (2005). Real and ideal gender-role conflict: Exploring psychological distress among men. *Psychology of Men and Masculinity*, *6*, 137-148.

Lou, J., Hu, H., Hsu, H., & Dai, H. (2007). A study of role stress, organizational commitment and intention to quit among male nurses in Southern Taiwan. *Journal of Nursing Research*, *15*, 43-52.

MacDougall, G. (1997). Caring – A masculine perspective. *Journal of Advanced Nursing*, *25*, 809-813.

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

Matthews, S. (2001). Registered male: A discussion on men in the nursing profession. *Contemporary Nurse*, *11*, 231-235.

Minority Nurse. (2013). Nursing statistics. Retrieved on April 11, 2013, from http://www.minoritynurse.com/minority-nursing-statistics

Myers Schim, S., Doorenbos, A. Z., & Borse, N. N. (2006). Cultural competence among hospice nurses. *Journal of Hospice and Palliative Care*, *8*, 302-307.

National Institute of Nursing Research. (2007). Notice number NOT-NR-07-001. Retrieved on October 10, 2008, from http://grants.nih.gov/grants/guide/notice-files/NOT-NR-07-001.html

National League for Nursing. (2011). Nursing student demographics. Retrieved on March 13, 2013, from http://www.nln.org/researchgrants/slides/topic_nursing_stud_demographics.htm

Nelson, R., & Belcher, D. (2006). Men in nursing: Still too few. *American Journal of Nursing*, *106*, 25-26.

Okrainec, G. (1990). Males in nursing: Historical perspectives and analysis. *Alberta Association of Registered Nurses*, *46*, 6-8.

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

O'Lynn, C. (2004). Gender-based barriers for male students in nursing education programs: Prevalence and perceived importance. *Journal of Nursing Education*, *43*, 229-236.

O'Lynn, C. (2007a). History of men in nursing: A review. In C. E. O'Lynn & R. E. Tranbarger (Eds.), *Men in nursing: History, challenges, and opportunities* (pp. 5-42). New York, NY: Springer.

O'Lynn, C. (2007b). Men, caring, and touch. In C. E. O'Lynn & R. E. Tranbarger (Eds.), *Men in nursing: History, challenges, and opportunities* (pp. 121-141). New York, NY: Springer.

O'Lynn, C., & Krautscheid, L. (2011). 'How should I touch you?': A qualitative study of attitudes on intimate touch in nursing care. *American Journal of Nursing*, *11*, 24-31.

O'Neil, J. (1981). Patterns of gender role conflict and strain: Sexism and fear of femininity in men's lives. *Personnel & Guidance Journal*, *60*, 203-211.

O'Neil, J. (n.d.). Gender role conflict research program. Retrieved on April 3, 2009, from http://web.uconn.edu/joneil/Definition.html

O'Neil, J., Good, G. E., & Holmes, S. (1995). Fifteen years of theory and research on men's gender role conflict: New paradigms for empirical research. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 164-206). New York, NY: BasicBooks.

O'Neil, J., Helms, B. J., Gable, R. K., Laurence, D., & Wrightsman, L.S. (1986). Gender-Role Conflict Scale: College men's fear of femininity. *Sex Roles, 14*, 335-350.

Oregon Center for Nursing. (n.d.). Oregon Center for Nursing Media Center. Retrieved on April 6, 2009, from http://www.oregoncenterfornursing.org/media.php

Parish, C. (2003). New world disorder. *Nursing Standard, 17,* 12-13.

Park, Y. (2005). Culture as deficit: A critical discourse analysis of the concept of culture in contemporary social work discourse. *Journal of Sociology and Social Welfare, 32,* 11-33.

Perusek, D. (2007). Grounding cultural relativism. *Anthropologic Quarterly, 8,* 821-836.

Pittman, E. (2005). Luther Christman: A maverick nurse – A nursing leader. Victoria, British Columbia: Trafford.

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 11-32). New York, NY: BasicBooks.

Pleck, J. H. (1981). *The myth of masculinity.* Cambridge, MA: MIT Press.

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

QSR International. (2012). NVivo 7. Retrieved on October 5, 2012, from http://www.qsrinternational.com/products_previous-products_nvivo7.aspx

Radtke, H. L., & Stam, H. J. (1995). *Power/gender: Social relations in theory and practice.* Thousand Oaks, CA: Sage.

Romano, M. (2006). The new CNO: Male nurses battle stereotypes, low numbers on the way to landing chief nursing officer positions. *Modern Healthcare, 36,* 24-27.

Santoso, J. T., Engle, D. B., Schaffer, L., & Wan, J. M. (2006). Cancer diagnosis and treatment: Communication accuracy between patients and their physicians. *Cancer Journal, 12,* 73-76.

Scott, L. D., Hwang, W. T., & Rogers, A. E. (2006). The impact of multiple care giving roles on fatigue, stress, and work performance among hospital staff nurses. *The Journal of Nursing Administration, 36,* 86-95.

Shim, Y. R., & Schwartz, R. C. (2007). The relationship between the degree of acculturation and adjustment difficulties among Korean living in a Western society. *British Journal of Guidance and Counseling, 35,* 409-426.

Simpson, R. (2004). Masculinity at work: The experience of men in female dominated occupations. *Work Employment and Opportunity, 18,* 349-368.

Smith, J. S. (2006). Exploring the challenges for nontraditional male students transitioning into a nursing program. *Journal of Nursing Education, 45,* 263-269.

Sochalski, J. (2002). Trends: Nursing shortage redux: Turning the corner on an enduring problem. *Health Affairs, 21,* 157-64.

Spradley, J. P. (1979). *The ethnographic interview.* Belmont, CA: Wadsworth.

St. Cloud University. (2008). The gender role strain model. Retrieved on November 21, 2008, from http://www.stcloudstate.edu/counseling/GenderStrain.asp

Stickney, M. C. (2008). Factors affecting practical nursing student attrition. *Journal of Nursing Education, 47,* 422-425.

Thomas, J. (1993). *Doing critical ethnography.* Newbury Park, CA: Sage.

Tranbarger, R. E. (2007). American schools of nursing for men. In C. E. O'Lynn & R. E. Tranbarger (Eds.), *Men in nursing: History, challenges, and opportunities* (pp. 43-66). New York, NY: Springer.

U.S. Census Bureau. (2011). Age and sex composition: 2010. Retrieved on March 4, 2012, from http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

U.S. Census Bureau. (2013). Male nurses becoming more commonplace, Census Bureau reports. Retrieved on February 25, 2013, from http://www.census.gov/newsroom/releases/archives/employment_occupations/cb13-32.html

Vahey, D., Aiken, L., Sloane, D., Clarke, S. & Vargas, D. (2004). Nurse burnout and patient safety. *Medical Care, 42,* 57-66.

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

Washington University School of Medicine. (2009). Women in health sciences by the numbers: Men in nursing, occupational therapy, and physical therapy. Retrieved on April 6, 2009, from http://beckerexhibits.wustl.edu/mowihsp/stats/men.htm

Whittock, M., & Leonard, L. (2003). Stepping outside the stereotype: A pilot study of the motivations and experiences of males in the nursing profession. *Journal of Nursing Management*, *11*, 242-9.

Williams, C. L. (1989). *Gender differences at work: Women and men in nontraditional occupations.* Berkley, CA: University of California Press.

Williams, C. L. (1992). The glass escalator: Hidden advantages for men in the "female" professions. *Social Problems*, *39*, 253-267.

Williams, C. L. (1995). Hidden advantages for men in nursing. *Nursing Administration Quarterly*, *19*, 63-70.

Wilson, B. (1997). Men in American nursing history. Retrieved on November 2, 2010, from http://www.geocities.com/athens/forum/6011/

Wrede, S., Benoit, C., Bourgeault, I. L., van Teijlingen, E. R., Sandall, J., & De Vries, R. G. (2006). Decentered comparative research: Context sensitive analysis of maternal health care. *Social Science Medicine*, *63*, 2986-2897.

Yang, C. I., Gau, M. L., Shiau, S. J., Hu, W. H., & Shih, F. J. (2004). Professional career development for male nurses. *Journal of Advanced Nursing*, *48*, 642-50.

Vita

Chris Edwards was born in Webster, Texas on December 24, 1974, to Don and Kazuko Edwards. Chris graduated from Friendswood High School in Friendswood, Texas, then joined the Marine Corps Reserves. Chris obtained his Bachelors of Science in Biology in 1999 from the University of St. Thomas in Houston, Texas. Upon completing his degree, Chris moved to Tokyo, Japan where he worked as an English conversation teacher. He then returned to the United States in 2002 and obtained his Bachelors of Science in Nursing (BSN) from the University of Texas Medical Branch School of Nursing (UTMB SON) in 2004. His honors include selection for the UTMB SON Dean's List, Sigma Theta Tau International (a nursing honor society), and the Ivalee Lucile Holtz Scholarship.

Chris began his nursing career on a Medical Intensive Care Unit at UTMB in 2004. In 2005 he was admitted to the first cohort of the UTMB SON Masters in Nursing Leadership in Complex Healthcare Organizations program. In 2005 Chris was accepted into the UTMB Graduate School of Biomedical Sciences BSN to PhD program. While in the doctoral program, Chris received a number of honors including the Arthur V. Simmang Academic Scholarship, Salute to Nursing Scholarship, Regina R. and Alfonso J. Mercante Memorial Scholarship, Marie and Talbert Aulds Scholarship, Edgar and Grace Gnitzinger Scholarship Fund for Geriatric Nursing, Lois E. Nickerson, R. N. Endowed Scholarship, and the Graduate Assistance in Areas of National Need grant.

Since 2010 Chris has worked as faculty in UTMB SON and as a nurse educator in a hospital setting. Currently, he serves as the Assistant Director for Quality and Measurement at UTMB.

Chris is married to Tu-Quynh Edwards, and they have two children, Ethan and Aria. They currently reside in Friendswood, Texas.