An exploration of the educational experiences of new nurses who are men within Aotearoa New Zealand

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Abstract

Despite worldwide efforts to recruit more men into nursing, males still hold minority status within the profession, which is unsustainable for many reasons. For one, a projected health crisis looms due to the baby boomer generation facing retirement by 2035. This section of the population will require more nursing care due to an increased life expectancy with more complex health needs. To compound this problem, many of those who will be retiring are nurses themselves. New Zealand subsequently faces an increased demand for nursing care, underscored by a critical nursing shortage. Ideally, it is here that males should be available to fill this shortage, as they constitute half the population. However, men presently make up only 9% of the New Zealand nursing workforce, a figure mostly unchanged since the 1990s. Men may be unwilling to enter a career in nursing due to societal attitudes, stigma, media representations, and the ingrained feminine construct of nursing.

Consequently, this leaves an untapped pool of potential nurses who could help meet the demand of predicted population demographics. Using a descriptive qualitative design underpinned by social constructionism, this study explored the experiences of male nurses prior, during and after the Bachelor of Nursing degree. This research aimed to inform future curriculum design to support, retain, and attract more New Zealand men to nursing.

Nine participants from across New Zealand provided data via semi-structured interviews. Through thematic analysis, two overarching themes surfaced. Firstly, men often feel a sense of isolation during training that is perceived as unfavourable, but not without benefits. Secondly, participants saw that an inaccurate awareness of the scope of the modern nurse remains constructed within the public consciousness. Addressing both of these themes is imperative to ensure balanced gender diversity within nursing, but to also empower nursing as a whole.

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Contents

Tables, Figures & Abbreviations

BN	Bachelor of Nursing Degree
RN	Registered Nurse
NP	Nurse Practitioner
EN	Enrolled Nurse
NETP	Nurse Entry to Practice Programme
NESP	Nurse Entry to Specialised Practice (Mental Health)
DHB	District Health Board
ICU	Intensive Care Unit
HDU	High Dependency Unit
CCU	Cardiac/Coronary Care Unit
ED	Emergency Department
IQN	Internationally Qualified Nurse
NZQN	New Zealand Qualified Nurse
TA	Thematic Analysis
QD	Qualitative Description
SC	Social Constructionism
NZPHOV	*New Zealand Please Hear Our Voice* Facebook Page
MUHEC	Massey University Human Ethics Committee
GP	General Practitioner
NHS	National Health Service (UK)

Chapter One: Introduction

1.1 Background and rationale

Populations are increasing exponentially due to scientific advancement, improvements in health provision, and an overall increase in life expectancy. Owing to the baby-boomer generation (i.e. those born between the mid-1940s and the early 1970s) moving into retirement, New Zealand will have a population of 5.26 million people by the year 2035 (New Zealand Government, 2019; New Zealand Nursing Council [NZNC], 2013). More pressingly, projections show there will be 1.32-1.42 million New Zealanders aged over 65 by 2046 (Statistics New Zealand, 2016).

To support healthy ageing, this age group will require more equity in terms of health and social resources, equating to more health personnel. Nurses and midwives make up 50% of the global health workforce (World Health Organization [WHO], 2018). In line with predicted population demands, the world will need an additional nine million nurses and midwives by 2039 (WHO, 2018).

What will compound the problem is that a considerable percentage of the current nursing workforce will retire in the next two decades, as the mean age of the current nursing workforce is 43.4 years old, meaning 50% may retire by 2035 (NZNC, 2011; 2013). Concurrently, 27% of General Practitioners (GP) may consider retirement in the next five years, with a further 47% in ten years (Royal New Zealand College of General Practitioners, 2018). This GP shortage is likely to be mitigated with an increase of advanced practice nurses, such as Nurse Practitioners (NPs). Accordingly, urgency and priority are needed to recruit and train for these advanced scopes of practice.

The projected gap in personnel from both nursing and medicine will place a significant strain on an already depleted health system, where those most vulnerable, such as older adults and those in rural areas will most likely be affected (New Zealand Medical Association, 2004). Therefore, it is imperative and time-critical for strategy development to ensure nursing, and the NP roles are attractive as a career. Additionally, the current educational and working environs are in urgent need of an enhancement to further support student, and novice nurses, to improve workforce retention (NZNC,

2013). When addressing nursing recruitment and retention, a multipronged approach is required. However, there is still an underutilised resource within direct sight – men.

As a male RN, men in nursing is a personally compelling research topic. This topic is also of interest as an educator in an undergraduate programme at a New Zealand University. Perhaps from this research, change can be enacted to enhance recruitment and retention of male students to accompany the very few I see completing the programme. This personal reality has provided me with multiple perspectives by traversing all steps of the male nurse journey. Initially, all closest family members were nurses, including a father and a brother. So nursing, and more pertinently men in nursing was constructed in my reality, as the norm. Nevertheless, everything changed in an instant when entering nursing school. Being the only male in a class of 60 odd female first-year students, it became quickly apparent that perhaps times had not changed as much as I had anticipated.

For the most part, I generally enjoyed the undergraduate programme, progressed well, felt welcomed, and made lifelong friends with female peers and mentors along the way. Being male did occasionally present obstacles and awkwardness. But somewhat shamefully, perhaps I also reaped the rewards of a privileged position as a male *and* a minority. From the perspective of a nursing educator, the class gender ratios have still not changed. It is encouraging to see that some males have one or two comrades within the class, but I have also witnessed the few men in one year all leaving the programme, resulting in an entirely female cohort by the second year of the degree.

I am not proposing that the lack of men in nursing is a result of a forced male exodus from a female-only space; there is something much larger at play. For the majority of us who enter nursing training and make it through, we are not necessarily hard done by or actively ostracised. In fact, having a male and minority status may give us the upper hand in respect to career trajectories through accelerated promotion, or even preferential treatment. However, there are still barriers in existence that prevent men from graduating as nurses. This research aims to explore why men are still a minority in nursing in 2020 Aotearoa New Zealand, and how to address this at the start point of their careers.

1.2 Research question

This research aims to explore the perspective and realities of newly trained nurses who are men. More precisely, it seeks to explore their experiences prior, during and after the Bachelor of Nursing (BN) degree - specifically in respect to the new graduate year. This study will be focusing on the New Zealand nursing educational context only. The overall aim of this research is to use participant voices alongside the broader literature, to help inform curriculum development to support, retain and attract more New Zealand men to nursing.

1.3 Terminology

Within this thesis, if I refer to 'nurses', I am referring to Registered Nurses (RNs), as my research aims to inform and enhance the delivery of the BN and Nurse Entry to Practice (NETP) curricula, which are both RN specific training. While this study focuses on RNs, the NP role will also be included in the discussion, as NPs are first and foremost RNs.

Regarding the study population of RNs who identify as male, I will somewhat reluctantly use the term 'male nurse'. Personally, anecdotally, and from the voices in the literature, men who are nurses find the phrase ostracising (Juliff, 2017; LaRocco, 2007; Rajacich et al., 2013). Adding *male* to *nurse* implies that men *and* nursing are incompatible, or it merely serves as a linguistic marker to highlight further an already unusual situation (Lindsey, 2015). And as Rajacich et al. (2013) comments, using the phrase 'female nurse', or even female doctor is just not the norm. But for consistency and the richness of this subject, 'male nurse' will be used rather than a stilted acronym.

It is essential to briefly comment on gender in a research piece of this type. In relatively recent times gender diversity and identity politics have become both complicated and contentious within the hetero-normative (traditional gender dichotomy), and rainbow communities (LGBTQIA+). While I will be discussing gender, this will pertain to the spectrum of femininity and masculinity, and the social-cultural construction of gender roles, rather than biological characteristics (Loughrey, 2008). Hence, specific commentary on gender identification is beyond the scope of this thesis.

1.4 Thesis organisation

Within five chapters, this thesis provides an introduction, literature review, materials and methods, findings, and a discussion chapter. The introduction offers an initial overview of the current situation and the pressing need for more men in nursing. Chapter two begins with a historical overview of the journey of the male thus far, then goes on to explore contemporary literature regarding male nurses and students. The third chapter provides the rationale for the methods and methodology used, including ethical considerations, sampling, rigour and analysis methods. Chapter four presents the significant findings from all nine semi-structured interviews. And finally, chapter five provides a discussion of the results nested within the broader literature, along with strengths, limitations, and recommendations for practice and future research.

Chapter Two: Literature review

2.1 Introduction

This chapter opens with a review of the statistical prominence of the modern male nurse from a western global perspective, then narrowing to the New Zealand setting. Following this, is a synopsis of the historical back-story of men in nursing, placing predominance on British history, due to socio-cultural colonial influences experienced in New Zealand. Historical commentary finally focuses around the turn of the 20th century, where male nurses all but disappeared from the public eye.

The reader may question the relevance or worth of a historical overview. The answer herein lies with the philosophical foundation of this research, where the lack of men in nursing is forged from socio-historical constructions. Consequently, the failure to recognise men's historical contribution to nursing leaves little information regarding their professional background, and thus further fuelling alienation and isolation (Mackintosh, 1997).

A review of the broader literature was completed regarding men in nursing, with a focus on the formative educational journey. Emergent themes from the literature generated a theoretical framework. These themes included:

- Image stigma and stereotypes
- Threatened masculinity
- Isolation
- Why nursing?
- Other perks of the minority

Search strategy

Guided by the process of the integrated review, this literature review included a diverse range of research methodologies, which strengthens rigour through a more robust evidence base, while simultaneously protecting against researcher bias (Whittemore & Knafl. 2005). Results from this framework guided the level of inquiry when formulating interview questions (Appendix 7). Along with grey literature and print material, Massey

University's *DISCOVER* search engine accessed multiple databases including *CINHAIL, Scopus, MEDLINE, psycINFO, Academic Search Premier, and Australia and New Zealand Reference Centre.* Also used, was *Google Scholar* for articles with access difficulties. To ensure relevant literature was not omitted, the reference lists of modern seminal research were combed, as well as exploiting the 'as cited by' database function.

Table 1- Key Search Terms

'male nurses' OR 'nurses who are men' OR 'nurses who are males' OR 'men in nursing' OR 'males in nursing'
'male nursing students' OR 'male student nurses' OR 'student nurses who are men' OR 'student nurses who are male'

Along with the key search terms in Table 1, supplementary search terms included; '*New Zealand*', '*Aotearoa*', '*Aotearoa/New Zealand*', '*experience*', '*student experience*', '*educational experience*' and '*clinical experience*'.

Inclusion and exclusion

To fit within the scope of this thesis, inclusion and exclusion criteria were implemented. The reviewed literature predominantly came from qualitative studies but included some quantitative studies, PhD dissertations, literature reviews, and systematic reviews. Studies were only selected after the year 2007 to maintain socio-historical relevance. However, New Zealand research after 2000 was sought to capture more local context, as there is a paucity of recent New Zealand studies. Also included, was one New Zealand Masters thesis to enrich the contextual discussion. Other geographical locations selected were Australia, UK, Ireland, Canada and the US (triaged in this order of relevance). Excluded was research from other nations to maintain cultural connection to the

targeted population – New Zealand men. For instance, other countries such as Germany and the Philippines have higher proportions of male nurses, and Saudi Arabia and Jordan have 32% and 38.3% respectively (Al-Maaitah & Shokeh, 2009; Male Nurses Worldwide, 2012; McKenna et al., 2016).

Table 2 Geographical Setting of Literature Review

Geographical Setting	Number of articles
USA	16
Australia	10
New Zealand	8*
Canada	7
UK	6
Ireland	3
Others**	3

* Four articles stemming from one doctoral dissertation

** Poland, China

New Zealand's mirrored statistics of countries with colonial roots is suggestive of the presence of westernised masculinity and gender norms. The inclusion of non-western societies may therefore add a confounding influence to this study's trajectory. Other reasons for study exclusion pertained to unclear descriptions of study design, or questionable rigour (Yi & Keogh, 2016). Included in the final literature review were 53 research articles, with a closer focus on 20 studies that had comparable aims, methodology, methods and contextual similarities to this study. To provide more comprehensive contextual discussion concerning gender roles, books and articles from the disciplines of gender studies, psychology and sociology were also included.

2.2 Historical situatedness– Where did the men go?

The current snapshot

In the contemporary realm of healthcare, the presence of male nurses continues to remain a conspicuously absent phenomenon. Despite progressive societal attitudes that are increasingly supportive of diversity, inclusion and acceptance, men still exist as a significant minority within nursing. From the latest count in 2017, men comprise 9% of the nursing workforce within New Zealand (NZNC, 2018). While this percentage is similar to other developed nations, it only trumps Canada by 1.2% (Statistica, 2019). In slight contrast, the United Kingdom, Australia and the United States have 10.8%, 11.75%, and 13% respectively (Australian Nursing & Midwifery Journal, 2019; Munnich & Wozniak, 2017; Royal College of Nursing, 2015). Precise information regarding male nurse numbers in developing nations is sparse. However, China's male nurses comprise 2% of the workforce, while seemingly small, had doubled from 1% in 2010 (Li, 2018), a remarkable increase considering China currently has 3.79 million nurses (Min et al., 2018).

In stark contrast to China, New Zealand's proportion of male nurses has remained relatively static. As stated earlier, men make up 9% of all nurses (NZNC, 2018). This proportion has increased from 7.57% in 2012, meaning an additional 900 male nurses over five years (NZNC, 2013; 2016). However, in the year 2000, men made up 5.8% of the nursing workforce, which was relatively unchanged from 1990 (NZNC, 2000). This statistic means that there has only been a 3.2% increase over 26 years. While encouraging to see a spike in numbers, this momentum may be hindered due to recent publicity regarding working conditions (especially within social media), and the subsequent industrial action within the New Zealand nursing workforce.

In terms of NP numbers, in 2015, there were eight male NPs, and 134 female NP's (NZNC, 2015). Earlier in 2011, there were six male and 83 female NPs, meaning only two more male NPs have been added to the register over four years, compared to 51 new female NPs (NZNC, 2011; 2015). To contrast, females make up 43.9% of the current New Zealand medical workforce, which has increased by 3.5% in only five

years (Medical Council of New Zealand [MCNZ], 2016). While it is still not an even playing field, more females are now moving into traditionally male-dominated vocations such as medicine, defence and commercial aviation (Civil Aviation Authority, 2018; MacWilliams et al., 2013; MCNZ, 2016; New Zealand Defence Force, 2019). Conversely, within historically feminine occupations such as nursing, teaching and early childhood education, men are still a significant minority. This status is even more so for midwifery, where there are approximately six male Lead Maternity Carers currently practising in New Zealand (Midwifery Council of New Zealand, 2015).

Geographically, the bulk of male nurses tend to cluster around New Zealand's larger centres. Almost a third of men are in the Auckland region, which in itself is unremarkable, as Auckland (comprising of three DHB's) houses nearly a third of New Zealand's population (NZNC, 2016; Statistics NZ, 2019). In line with this, the Wellington and Canterbury regions have 11.8% and 11.62% respectively. Provinces with the least number of male nurses include West Coast and Tairawhiti, with 1.02% and 0.65% (NZNC, 2016). From a per capita basis (per 100,000), Auckland, Wellington and Canterbury are relatively consistent with 84-107 male nurses per capita. However, there seems to be less consistency within the smaller DHBs. For example, in West Coast there are 140 male RN's per capita, and only 59 in Tairawhiti (Ministry of Health, 2019; NZNC, 2016). Therefore, while it may be convenient to attribute regional population proportions to the number of male nurses, it does not appear this clear-cut.

Within the wider literature, there is abundant commentary and statistics regarding which areas of practice men tend to situate. Within developed nations and locally, men have traditionally veered towards working in specialities such as mental health, critical care (ICU, HDU, and CCU), emergency departments (ED) and perioperative care (Christensen & Knight, 2014; Coleman, 2008; Marks & Bevan, 2013; Tuckett et al., 2016). Within New Zealand however, there appears to be a small but notable shift away from this pattern. For instance, in 2016, there were nearly 11% of men working in aged care and 9% in acute medical units. In contrast, 7.14% worked in ED, 5.8% in critical care, and 6.2% in perioperative settings (NZNC, 2016). Just over a quarter of male nurses work in acute and community mental health, nonetheless this has dropped 6% in four years (NZNC, 2016). Men had the lowest representation in youth services (0.2%), obstetrics/maternity (0.18%), sexual health/family planning (0.09%), and school nursing

(0.07%). Furthermore, only 0.8% and 0.16% of male nurses are employed respectively in Māori and Tagata Pacifika health providers (NZNC, 2016).

One reason for this gradual shift out of traditional male frequented specialities may be due to a recent influx of Internationally Qualified Nurses (IQNs) entering practice in New Zealand. The two largest groups of IQNs are Filipino and Indian, who combined comprise 15% of the nursing workforce (NZNC, 2018). Filipinos make up 21% of all male nurses, which has nearly doubled from 2012. Similarly, Indian male nurses make up 15.7%, increasing from 10.4% in the same period (NZNC, 2016). Including other IQNs (Chinese, South-East Asian, Fijian, African and 'other'), male IQNs constitute 52% of the total male workforce. Conversely, the 'New Zealand European/Pākehā' cohort combined with the 'Other European' category of male nurses, has sharply decreased from 69% in 2012, to 54% in 2016 (NZNC, 2016). Tagata Pacifika comprises 2.2% of male nurses, and this figure has remained relatively unchanged since 2012. Māori male nurses however, have declined in numbers from 5.75% to 4.63% in the same timeframe (NZNC, 2016). Breaking down this percentage reveals that there are only 208 Māori male nurses in New Zealand, or ten per DHB.

In New Zealand, males are much more likely to be entering nursing at a later life stage than females. For instance, regarding New Zealand Qualified Nurses (NZQNs), 25% of male new graduates enter the workforce under the age of 25, compared to 44% of female NZQNs. Additionally, male NZQNs entering nursing much later in life (i.e. ages 45-59), proportionally doubles that of female NZQNs (NZNC, 2018). This trend has remained relatively static since 2006 (NZNC, 2018), and is comparable to other Western countries, implying that most men enter nursing as a second, or third career move (Christensen et al., 2018b; Juliff et al., 2017; MacWilliams et al., 2013; Munnich & Wozniak, 2017; Powers et al., 2018; Stanley et al., 2016). Nevertheless, the same barriers for men contemplating a nursing career that existed in the 1960s and 1970s remain influential today (Jamieson et al., 2019).

The early days

To the layperson and arguably, to nurses themselves, there is almost a visceral sense that men are a relatively new addition to nursing. Yet nursing has only been a female-dominated occupation within the last 170 years (Christensen, 2017). In terms of recorded history, there are written accounts of the first nursing school in 250BC India, where ironically, women were denied entrance (Ford, 2019; O'Lynn & Tranbarger, 2006).

Discussed in Roman historical accounts was the role of the *Nosocomi,* or male military nurses who would attend to Roman legionnaires wounded in battle. However, only 2.6% of Roman military deaths recorded were attributed to battle injury (Christensen, 2017). The more prominent role of the nosocomi was the maintenance of the health of the legions through the development and maintenance of potable drinking water, and proper flushing latrines (Scheidel, 2007). This contrasts the discourse of contemporary nursing education, which purveys that Florence Nightingale pioneered military sanitation methods, not until the latter half of the 19th century (Rautenen et al., 2010). Also, within Roman civilian life, physicians assistants were usually male, but there was cross-over in what constituted medical care, and that of modern nursing care (Christensen, 2017).

After the fall of the Roman Empire, historical accounts of men as carers are common-place in the middle ages. Here, it was the norm for men to attend to the sick, poor or injured, albeit within a monastic and military context (Saritas et al., 2009; Whitford & Taylor, 2018). In the Christian era (1-400AD) nursing care was usually gender-specific, where women tended to women, or provided wet-nursing to infants within the home. Hospital administration and patient care on the other hand, was provided by men (Christensen, 2017).

Later in 1095AD, monks cared for sufferers of Erysipelas (superficial cellulitis) and the mentally ill (Mackintosh, 1997). Around 1200 AD, the Knights Hospitaller (or Order of St John) defended Jerusalem during the crusades, but also built and staffed European pilgrim hospitals by night (Christensen, 2017; Evans, 2004; Ford, 2019; Mackintosh, 1997). Curiously, the Maltese Cross (Figures 1 and 2) established by the Knights

Hospitallers, is still seen in modern-day health care and paramedicine (Christensen, 2017). Yet many healthcare professionals and members of the public would be unaware of the origins of this ever-present public symbol.

Figure 1: Knights Hospitallers (Hammann, 2015)

Figure 2: Maltese Cross (Jaggery, n.d)

The 'dark ages' of nursing

From the 16th to the 19th century, nursing departed from religion, and along with it, the written history of nursing care. As monasteries dissolved, so did records of organised nursing activity, except for accounts of informal female carers named 'handywomen' (Mackintosh, 1997). A known exception was the Alexian Brothers, a religious order of

uneducated craftsmen who provided care to the poor, lepers, ‘morons’, ‘lunatics’, and who also offered public health measures, by burying the dead during the plague (Evans, 2004). The Alexian Brothers would eventually become well known for caring for the mentally ill, and for establishing the first psychiatric nursing school for men in the USA (O'Lynn & Tranbarger, 2006).

Despite the rise of secularism, churches were viewed as the panacea of health delivery, as nuns and monks possessed a vast repertoire of health knowledge (O'Lynn & Tranbarger, 2006). Many secular organisations running hospitals lacked the required discipline and subsequently employed unqualified nurses of ‘dubious and unsavoury character’ (Mackintosh, 1997; O'Lynn & Tranbarger, 2006). Dire conditions within hospitals and health were consequently seen as a failure of medicine, and nursing’s inability to progress (Christensen, 2017).

At this point in history, the general public viewed nursing as the lowest of the low, where men were absorbed into staffing lunatic asylums, and where many women saw prostitution as a more favourable occupation (Christensen, 2017). In the mid-19th century, men who were deemed unemployable in any other sense were recruited to Victorian work-houses as ‘keepers’ or ‘attendants’, but not in a nursing capacity (Mackintosh, 1997). From this period of nursing, the stage was set for change, but at the expense of the male nurse.

Florence, the reforms, and the feminisation of nursing

The pre-Nightingale era was a period where nursing was an undervalued and undesirable vocation. Florence Nightingale’s sweeping reforms of nursing and the hospital model in the 19th century were desperately needed. As a result, men’s association with nursing ended as Nightingale firmly entrenched nursing as ‘woman’s work’ (Christensen, 2017; Entwistle, 2004; O'Lynn & Tranbarger, 2006). Here, the creation of a ‘non-religious nursing sisterhood’ excluded men from participation within the hospital sector (Mackintosh, 1997). Yet this notion of a secular reform is questionable; as illustrated by commentary presenting the nightingale nurse moulded on the virtues inspired by Catholic charity hospitals:

> "Present hospital nurses do not come up to the standards of the very ideal of nurses – women of patience, gentleness, and self-devotion of the kind of the Sisters of Charity" (Williams, 1978, p. 54).

Combined with the reformed nurse's expectation to be self-sacrificing and angelic, Nightingale Schools were producing nurses in line with Victorian societal values. Here, it was only congruent that modest Victorian females were naturally equipped to nurse (Mackintosh, 1997). While intended to empower women, this Nightingalian value existed within a patriarchal and oppressive society. Nevertheless, an opportunity was created to establish careers for women across Europe, the United States, and eventually, New Zealand (Anderson, 2014; Christensen, 2017).

Nightingale however, was against the forced idleness of the middle-class woman, where the natural virtues of womanhood were piety, submissiveness, purity and domesticity (Harding, 2005; Lindsey, 2015). This Victorian social construct prescribed that women were unsuitable for work outside the home (Anderson, 2014). Accordingly, first-wave feminism remained within the Victorian class structure, with the construct of labour division between not only the sexes, but between women of differing class (Mackintosh, 1997; O'Lynn, 2012). For example, the probationer nurse under the Nightingale scheme had to fund her training and 'be a lady of character', thus limiting the participation of working-class women (Harding, 2005).

While Nightingale envisioned some sense of feminist emancipation, nursing remained vastly under-valued, low paid and unskilled compared to men's occupations, such as medicine (Harding, 2005; Palmer, 1983). While nursing shifted from the role of the servant to that of an educated professional (Mackintosh, 1997), Victorian nurses required no prior education and worked under the supervision of male doctors (Evans, 2003). This patriarchal subservience to medicine and men, preserved the power structures, thus upholding hegemonic masculinity[1] (Connell, 2005).

[1] Hegemonic masculinity: The societal, structural and institutional legitimised dominance of one gender script (i.e. masculinity) over another subordinate group – i.e. females or effeminate men (Connell, 2005).

Men were deemed by Victorian society as not only unsuitable but also incapable of providing nursing care (Harding, 2005). Combined with the Victorian norm of housing female nurses and students in on-site nurses' homes (Maggs, 1983), it is unsurprising that for the next century, not only were men ejected from nursing, but were also actively discouraged from entering altogether (Entwistle, 2004). Consequently, by 1885 British hospitals were staffed by female nurses exclusively (Christensen, 2017). Yet broader influences cannot be ignored; such as the absorption of men into the Crimean War and the industrial age, both which may have contributed to men's absenteeism in nursing (Christensen, 2017). After conscription to war or recruitment to factories and mines, for the men who remained in health-care, career options were few.

Into the asylum and beyond

After the Nightingale reforms, men all but disappeared from the general wards; the more publicly visible arena of nursing. At the time, men in nursing were viewed by Nightingale as a counter deal to the empowerment of woman into careers, but exclusion was more powerfully incited by the construct that the provision of nursing care was a role for females only (Christensen, 2017; Evans, 2004; Hart, 2004). Men consequently were consigned to asylums to provide custodial care to the mentally ill, alcoholics, or those with intellectual disabilities (Mericle, 1983; O'Lynn & Tranbarger, 2006). Here, physical strength was perceived as the pre-requisite, as this masculine trait was viewed as necessary to restrain and seclude psychotic or violent patients (Evans, 2004). Rather than possessing the title of 'nurse', men working in these institutions were labelled 'orderlies' or 'attendants' (Christensen, 2017).

Reformed female nurses were also eventually employed in psychiatric institutions. Their presence was described as having a civilising and settling effect on male patients *and* male staff (Hart, 2004; Health Times, 2019). Secondly, they also brought with them the professionalism and credibility of the general training hospitals. They were seen as more qualified and of a higher status than the male attendants (Ford, 2019; Hart, 2004), and were often from a higher social class (O'Lynn & Tranbarger, 2006). Within these institutions, men were called upon to provide rudimentary nursing care, but only if deemed unsuitable for a female to do (Christensen, 2017; Harding, 2005).

With the progress of the Woman's Suffrage movement at the turn of the 20th century, British men experienced further exclusion from nursing. In 1919 the General Nursing Council was established, but only offered membership to general trained females and in turn, dissolved training pathways for most men (Harding, 2005; Mackintosh, 1997). Any residual men joined the Army Medical Corps (Mackintosh, 1997). In the US however, from 1901 to 1955, men were banned entirely from the US Army Nurse Corps despite military nursing shortages (Evans, 2004).

After the second world war, the tide gradually began to turn for male nurses. In 1947, Britain enacted legislation formally ending discrimination and allowing male nurses to register (Mackintosh, 1997). By 1955, 10% of National Health Service (NHS) nurses were male but were again over-represented in the mental health and intellectual disability sectors (Ford, 2019). Men were permitted to join the Royal College of Nurses in 1960, and could finally train in general hospitals in the late 1960s (Mackintosh, 1997). As more British men filtered into nursing, deep-seated hegemonic structures began to work in their favour.

Under the emerging shadow of neoliberalism, the new Salmon Management System was implemented in the NHS in the late 1960s and early 1970s. The over-arching philosophy of the preceding Salmon Report was that of increased efficiency, and the introduction of the business model to healthcare (Evans, 2004). This philosophy would in effect shift power from practising nurses and nursing leaders to hospital administrators, thus abolishing the role of the matron, and ultimately depressing nursing's status in the process (Dewar, 1978). Positions of seniority were ripe for the capture of male nurses, as they were perceived to have more managerial traits (Bradley, 1989; Evans, 2004). Also, technical prowess, leadership skills, and possessing an unconditional dedication to work were constructed as masculine qualities (Williams, 1995).

Consequently, in 1987 just over half of chief nurse positions in the UK were held by men (Evans, 2004). This specific example of the 'glass escalator' effect still occurs today. Where men working in female-dominated vocations ascend the promotional ladder more rapidly, leaving their female colleagues beneath the glass ceiling, and

widening the gender pay gap in the process (Muench & Dietrich, 2019; Punshon et al., 2019; Wilson et al., 2018; Wingfield, 2009).

New Zealand men in nursing

The history of men in nursing within the New Zealand context largely mirrors that of Britain and her other colonies. Nightingale trained female nurse arrived in the late 1870s and were deemed by the then Inspector General of Hospitals (a male), as 'well trained, intelligent, and lady-like' (Harding, 2005). Two decades later, men were excluded from the new Nursing Registration Act, thus preventing them from training as nurses all together (Harding, 2005; Health Times, 2019).

Over the next half-century, men from working-class backgrounds were employed by psychiatric hospitals as attendants. These attendants provided personal care to patients, and when needed, physical restraint. But they also completed more traditionally masculine tasks such as overseeing the gardens, farms, work parties, and the general maintenance of the hospital. And of course, hospital chief administrators were always male (Prebble & Bryder, 2008).

There was a chronic shortage of female nurses in New Zealand's psychiatric hospitals in the first half of the 20th century. This shortage was due to work conditions, and the less desirable status of psychiatric nursing compared to general nursing. But more commonly, it was due to their younger age, and the societal expectation to marry and produce children (Dunsford, 1996; Prebble & Bryder, 2008). Here patriarchal constructs of masculine and feminine gender roles played out, as men were employed to manage, run, and provide the 'muscle' within these institutions. While on the other hand, high female staff turnover was due to the overshadowing of domestic and procreative duties in the home. In parallel to modern times, men usually became psychiatric attendants in their late 20s after other employment experience (Prebble & Bryder, 2008).

While the prevailing rhetoric of men in nursing is that of a marginalised group, Prebble and Bryder (2008) argue that for men working in New Zealand's psychiatric hospitals, the opposite was exact. For here, despite not having the same qualifications as female

RNs, men were vaster in numbers and actively unionised with non-nursing (and therefore male dominant) organisations. This phenomenon is supported by overseas literature, where men have a stronger interest and investment in unionisation (Snyder, 2011). Later repercussions may have subsequently become apparent, as during the 1970s psychiatric nurses won the right to retain higher pay than general nurses (who were mostly female), and again illustrating the hegemonic social order (Harding, 2005; Prebble & Bryder, 2008).

Regarding the general side of nursing, New Zealand men did experience palpable marginalisation. In the late 1940s, four training hospitals opened their doors to men. However, the course took two years to complete (opposed to three years for females), there was no educational content regarding women's or children's health, and men were only permitted to care for adult male patients. Also, male students only received theory concerning the male reproductive systems, and geriatric nursing (Harding, 2005). Evident here is the construct painting the sexualisation of men in nursing, and the resulting segregation away from woman and children, which still holds some influence today (Harding, 2005; Harding et al., 2008; NZNC, 2018).

Later, the New Zealand Armed Forces provided training for male nurses, and by 1964 there were 253 nurses on the male register (Te Ara, 2019). Finally, in 1973 two 'experimental' comprehensive training courses invited men to participate in a full range of nursing activities. But according to Harding (2005), it was not until 1977 until this experimental status lifted, meaning men were officially absorbed back into the fold of comprehensive nursing in 1980.

2.3 Themes from the literature

Image, stigma and stereotypes

Living as a male minority within the primarily feminine world of nursing fosters role strain for many men. And often, this role strain is further inflamed by enduring stereotypes (Bartfay et al., 2010; Entwistle, 2004), where societal attitudes toward male nurses stem from media representations and popular culture. For example, male nurses who appeared in twelve films were often portrayed as effeminate, incompetent, uncaring, and sometimes morally corrupt (Stanley, 2012). Additionally, in several television shows, male nurses were also cast as gay, effeminate, powerless, or playing the role of the physician's assistant (Harding, 2005; Raymond et al., 2018; Weaver et al., 2014). In all of these studies, it is pertinent to acknowledge that most of the media reviewed was from the US. Considering the global saturation of American television however, repetitive exposure to these on-screen stereotypes may implicitly dissuade many males from considering a career in nursing (Bartfay & Bartfay, 2017; LaRocco, 2007; Powers et al., 2018).

One of the most prevailing stereotypes discussed within the literature is that of the male nurse as gay (Bartfay & Bartfay, 2017; Christensen & Knight, 2014; Harding, 2007; Jamieson et al., 2019; Maykut et al., 2016; McKinlay et al., 2010; Sasa, 2019). While media representations sustain stigma and stereotypes, broadly entrenched socio-historical constructions of gender roles are also at play, such as the incongruence between masculinity and caring (Dwinnells, 2017; Loughrey, 2008; Sayman, 2015; Stott, 2007).

What constitutes caring may be constructed as an inborn aptitude of the compassionate female - i.e. the wife and the mother (Bartfay et al., 2010). Here, traditional constructions of caring as a feminine attribute can marginalise male nurses as less masculine, effeminate, or gay. Additionally, as nursing is frequently devalued as woman's work, male nurses may experience suspicion or susceptibility to accusations regarding their sexual preferences, as they are not conforming to the script of hegemonic masculinity (Connell, 2005; Easthope, 1992; Harding, 2007; Jamieson et al., 2019; Sasa, 2019). This patriarchal sentiment could have more impact in a country such

as New Zealand, where masculinity is the dominant iconography of the nation's identity, where male homosexuality (or in this case, the suspicion of) is a fundamental attack on the social order (Bannister, 2005; Murray, 2019).

Male nurses and students may receive quasi homophobic sentiment and stereotyping from many angles, further intensifying role strain (Entwistle, 2004). While often supportive, families, friends, and patients may be bewildered with a male's decision to take up nursing. Many may question why medicine was not considered instead, thus again highlighting nursing's subordinate status (Christensen et al., 2018b; Jamieson et al., 2019; Juliff et al., 2016; Powers et al., 2018). Consequently, men who are new to nursing who face ridicule or implicit disapproval may be forced to re-define relationships with friends and acquaintances (Christensen et al., 2018b; Juliff et al., 2016).

Pigeonholing male nurses as gay may also come from within the nursing profession itself (LaRocco, 2007). For example, a constructionist study by Harding (2007) found that several participants who were New Zealand male psychiatric nurses, often presumed that males working as general nurses were in fact gay. Further, if men in nursing manage to bypass homosexual stereotypes, they may alternatively be painted as having sinister motivations, such as predatory tendencies (Christensen & Knight, 2014).

Prominent within the literature was the exclusion of men from certain specialities or areas of practice. Exclusion may be due to the stigma of perceived deviant intentions, or the sexualisation of physical touch, which often sit at the forefront of the male nurse's (or student's) awareness (Bartfay & Bartfay, 2017; Christensen & Knight, 2014; Harding, 2005; Harding et al., 2008; Jamieson et al., 2019; McLaughlin et al., 2010; Sasa, 2019b). This perception may also be present within those around the male nurse, leading to a sense of exclusion or frank hostility regarding participation in certain clinical settings, such as obstetrics, gynaecology, and paediatrics (Anderson, 2014; Christensen & Knight, 2014; Harding, 2008; LaRocco, 2007; Maykut et al., 2016). Additionally, men who are unprepared or un-supported may avoid 'mucking in' when caring for females or children (McKinlay et al., 2010), which may be perceived externally as laziness, rather than anxiety or self-protection.

Men who do attend female or child centred clinical placements, frequently report being wholly unprepared for the experience regarding the barriers, discomfort and conflict they may face as males (Anderson, 2014; Moore & Dienemann, 2014; Powers et al., 2018). As a consequence, male students may feel a sense of being accommodated into clinical settings, rather than genuine integration, support and mentorship (Dyck et al., 2009).

Throughout the literature, men often discuss anxiety experienced when providing nursing care to female patients due to the fear of allegations of sexual harassment, sexual assault or inappropriate touch (Harding et al., 2008; Juliff et al., 2017; Maykut et al., 2016; Rajacich et al., 2013). Also, in a mixed-method literature review of 11 studies, men also reported heightened anxiety when providing personal care to younger female patients, or those of different cultures (Whiteside & Butcher, 2015). According to several authors, this un-ease frequently funnels men into 'safe' specialities such as ED, ICU, mental health and perioperative care (DeVito, 2016; Harding, 2008; Marks & Bevan, 2013; Tuckett et al., 2016).

Within these environments, *care* becomes redefined through a technical focus, and therefore at a glance, presents as less hands-on (Schmidt, 2016). However, in one study, the unpredictability and excitement was a significant drawcard into these areas, rather than concerns around intimate touch (Juliff et al., 2016). When working with female patients, men in any speciality may often safeguard themselves by using a chaperone when providing personal care or invasive interventions (Harding et al., 2008; Whiteside & Butcher, 2015). However, in a phenomenological study by Powers et al. (2018), men's interactions with female patients were often externally managed by unit managers or shift coordinators, where male nurses were allocated to male patients only.

Suspicion or hesitancy around allocating a female RN to a male patient would be almost unheard of, and many authors and participants have alluded to this as the double standard (Christensen & Knight, 2014; Harding, 2008; Rajacich et al., 2013). While other male participants have reported being accepting, understanding and agreeable to having their care declined (Anderson, 2014; Rajacich et al., 2013). Male students in one New Zealand study saw the provision of care to female patients as a negotiation with set boundaries, with one participant commenting "you can do this but can't do that"

(Christensen & Knight, 2014, p. 99). Providing safe care to female patients is a critical requirement which may require male RNs to remove themselves from certain care situations. However, the fear of accusation of sexual misconduct culminating in the deliberate exclusion of male nurses caring for females or children stems from men's outsider status within. But also, from the constructed stereotypes regarding men's intentionality of care.

Threatened masculinity

The socially constructed attributes of masculinity may contradict the concept of care. A frequent theme within the literature is the inability of men to provide care, as care and compassion are historically conceptualised as feminine traits (Bartfay et al., 2010; Bartfay & Bartfay, 2017; Dwinnells, 2017; Harding, 2008; Juliff, 2017; Maykut et al., 2016; Stanley, 2012). As a result, when men enter the nursing world, the role strain experienced compromises masculinity (Loughrey, 2008). This process may be a smooth transition for those who are comfortable within their gender, but for others, an over-emphasis of one's' masculinity within heteronormative gender constructs emerge (Bartfay & Bartfay, 2017; Christensen et al., 2018b; Harding, 2007; Jamieson et al., 2019). The inner drive to preserve masculinity may then influence where budding male nurses choose to locate themselves.

One way for men to combat perceived role strain is to migrate to practice areas that feed the technical attraction to nursing. As mentioned previously, specialities such as ED, ICU, and perioperative care, or 'islands of masculinity', may provide men with a safe low-touch bypass from stigma and suspicion around sexualisation (DeVito, 2016; Harding, 2005). However, they also offer a technical form of nursing care which fulfils a masculine need which many authors describe as socially gendered (Jamieson et al., 2019; Maykut et al., 2016; Sasa, 2019; Schmidt, 2016; Stott, 2007).

These areas may also be attractive to men, due to the fast pace, the adrenaline factor, and the instant gratification of life-saving interventions (Rajacich et al., 2013). However, several authors have claimed that the technical/adrenaline attraction theory toward settings of high acuity is over-simplified. Men may also thrive in areas where

RNs are empowered to be patient advocates, to promote patient safety, and where team-work is highly valued (Juliff, 2017; Schmidt, 2016). For these reasons, Juliff D (2017) maintains that males may hold a preference for the discourse of *helping,* rather than the more gendered *caring*.

The devalued position of nursing may also challenge men's masculinity. Compared to medicine, nursing is publicly perceived to have a low social status attributed to the gendered workforce, and the socio-historical assumption of the nurse as the physician's assistant (Jamieson et al., 2019; Raymond et al., 2018; Stanley, 2012; Weaver et al., 2014). This sentiment is exemplified when male nurses and students are frequently mistaken for doctors or medical students. Or, when patients, friends and family out-rightly question their motives for embarking on a nursing career (Anderson, 2014; Ierardi et al., 2010; Jamieson et al., 2019; Juliff et al., 2017; LaRocco, 2007; Meadus & Twomey, 2011; Powers et al., 2018; Stott, 2007). Additionally, secondary school counsellors and careers advisors may neglect to present nursing as a career option to young men (LaRocco, 2007). Constructed gender roles may unconsciously drive this, but often young men are purposely diverted away from even considering nursing as an appropriate career (Bartfay et al., 2010; Meadus & Twomey, 2011).

While men often report feeling marginalised or even actively discriminated against in nursing, other more deeply embedded systems may be a source of discontent. These perceptions may originate from aggrieved entitlement due to men's privileged position within a patriarchal society (Kimmel, 2010; Sedgwick & Kellett, 2015). For example, in one study, male nurses reported being treated more respectfully by physicians than their female counterparts (LaRocco, 2007). Here, hegemonic masculinity is in force, where male nurses may hold the upper hand in terms of inter-professional civility from the dominant masculine culture – medicine. Consequently, feelings of exclusion for men may exacerbate disharmony regarding men's 'rights' within nursing. Men's disquiet could be impacted further by a wider society that holds little concern for men feeling disrespected or 'othered' within nursing (Harding, 2005; Jamieson et al., 2019; Kouta & Kaite, 2011).

Another strategy to preserve masculinity is through the application of physical strength, or the presence of physical dominance. Compared to general nursing, men make up a

much higher proportion in the mental health sector, and as outlined earlier, historically this had mainly been an involuntarily process (Evans, 2004; O'Lynn & Tranbarger, 2006; Prebble & Bryder, 2008). Nevertheless, a quarter of all New Zealand male nurses currently work in mental health (NZNC, 2016). There may be many arguments why men choose to work in this island of masculinity, such as the more hand-off psychosocial nursing approach discussed previously.

One theory that persists however, arises from the roots of mental health and asylum care, where a more custodial method of containment, rather than compassionate care was commonplace (Prebble & Bryder, 2008). Physical restraint and seclusion are no longer the mainstays of psychiatric treatment. Yet this image and perception of mental health nursing may be more congruent to constructs of masculinity, meaning men in mental health may be accepted and welcomed as the norm, rather than the exception (Harding, 2005).

Inside *and* outside of mental health, colleagues and superiors may call upon men's physical attributes, or rather the construction of these masculine characteristics. Male nurses and students are more likely to be utilised to diffuse situations of agitation and aggression, which may capitalise on their physical presence, as well as physical strength (Meadus & Twomey, 2011; Powers et al., 2018; Rajacich et al., 2013). What is more, throughout the literature the theme frequently emerges where men are used as 'muscle' when it comes to lifting and manoeuvring heavy dependent patients, with participants even labelling themselves the 'ward crane' (Harding, 2005; Meadus & Twomey, 2011; Powers et al., 2018; Rajacich et al., 2013; Schmidt, 2016; Twomey & Meadus, 2016).

These processes of delegation and allocation are seemingly practical on the surface. Nevertheless, repeatedly doing so puts male staff at risk of physical and psychological harm (from assault and injury), with possible career-ending ramifications. Also, continuously relying on men for physical assistance devalues their skill and knowledge as a comprehensive RN. Accordingly, Harding (2005) concludes "…there is little to differentiate them from all the other men, orderlies, attendants and so forth who have provided their physical strength at the service of female nurses" (pg. 159).

Isolation

While the reasons males find themselves marginalised in nursing are historically rooted and multi-faceted, it is equally important to consider the journey of the student nurse during their undergraduate education. Throughout the literature, male student nurses have significantly higher levels of attrition rates compared to their female peers (Bartfay & Bartfay, 2017; DeVito, 2016; Maykut et al., 2016; McLaughlin et al., 2010; O'Connor, 2015; Sasa, 2019; Sayman, 2015; Stott, 2007). Globally, there is scant modern data regarding publicly available attrition rates from nursing schools (Eick et al., 2012; Gaynor et al., 2007), with a complete absence of New Zealand data. In one US study, males exceeded the comparative attrition rate of females by nearly a third (Kronsberg et al., 2018). Also, one dated Australian study revealed that male attrition is as high as 55.5% (Wilson, 2005).

Several authors have also concluded that school leavers and younger male students were even less likely to graduate (Mulholland et al., 2008; Pryjmachuk et al., 2009). While causes for attrition are complex, key reasons may include an absence of male role models, and curriculum feminisation, when combined leads to differential treatment and isolation (Christensen & Knight, 2014; Moore & Dienemann, 2014; O'Lynn, 2004; Powers et al., 2018). However in one longitudinal study of nursing student attrition, irrespective of gender, those who disagreed with nursing as a gendered profession (i.e. women's work) withdrew from training in higher proportions (McLaughlin et al., 2010).

The literature is awash with content concerning the lack of male role models within nursing education. This discussion pertains specifically to a general absence of a male presence within teaching faculties, clinical teaching staff, and as RN preceptors (Bartfay et al., 2010; Bartfay & Bartfay, 2017; Clifton et al., 2018; Entwistle, 2004; Gedzyk-Nieman & Svoboda, 2019; Juliff et al., 2016; Maykut et al., 2016; McKenna et al., 2016; McLaughlin et al., 2010; Meadus & Twomey, 2011; Rajacich et al., 2013). Given the nursing work-force statistics nationally and globally, this is far from surprising. However, this vicious cycle continues as men face a sense of isolation within the classroom from day one, which could account for the higher attrition during training.

Men, and especially younger men need visible exposure to other male nurses, but also needed is effective mentorship and clinical supervision throughout the degree (Entwistle, 2004; Sayman, 2015; Sedgwick & Kellett, 2015). Here, there needs to be mentorship from male nurses and male faculty members, as men may have different experiences of nursing that may not be discernible to female mentors. Also, as Clifton et al. (2018) points out *how* men role model may be more important than how *many* male role models are at hand.

Another aspect of marginalisation may stem from the content of the curriculum, and the supporting language around curriculum delivery. Due to men's minority status in the classroom and nursing itself, gendered language from teaching staff, clinical staff and peers may become the norm (Ierardi et al., 2010). The use of terminology such as 'she', 'her', and 'male nurse', have been reported by participants throughout the literature as isolating, and where men desire the use of gender-neutral language in the educational environment (Anderson, 2014; Juliff, 2017; Juliff et al., 2016; Kronsberg et al., 2018; Powers et al., 2018; Rajacich et al., 2013; Stott, 2007).

Students also comment that men are underrepresented within course material imagery, and that a gender imbalance persists within the curriculum (DeVito, 2016). This under-representation is regarding key historical figures and theorists within nursing, but also the imbalance between the subjects of men's and women's health (Bartfay & Bartfay, 2017; Meadus & Twomey, 2011; Moore & Dienemann, 2014; Rajacich et al., 2013). Also, Christensen and Knight (2014) mention the 'feminisation of the curriculum', where men's learning styles are neglected during pedagogical design and delivery.

Due to the female majority student base, undergraduate nursing programmes are tailored to female traits and learning styles (Bartfay & Bartfay, 2017; Stott, 2007). As men are the minority within the student body and faculty, feminine constructs may inadvertently rather than intentionally influence curriculum delivery, especially in terms of aspects such as care, compassion and reflective practice. This method of delivery may be isolating for males who are more motivated by the *helper* role of nursing (Juliff, 2017). For example, concerning reflective practice, participants in a New Zealand study stated "it wasn't in their nature to share the emotional stuff... it's not a bloke thing" (Christensen & Knight, 2014, pg. 100). Males may be more driven by more practical,

technical and interactive modes of learning, that ironically, contests one social construct with another.

Additionally, communication styles between men and women may also be at odds within the clinical and learning environments (Anderson, 2014; Juliff, 2017; Maykut et al., 2016; Moore & Dienemann, 2014). Men may possess a more direct communication style, but may often miss important cues when communicating, and therefore appearing less tactful at times (Christensen et al., 2018a). Because of this, male student nurses may require more support, preparation, and mentoring to build inter-personal and inter-professional skills.

Despite differences in social-emotional processes, men may also find themselves actively singled out in the classroom setting. While not necessarily born of malice, but more a by-product of existing as a minority, the names of males may be easier to recall, meaning men may frequently be called upon to participate (Bartfay & Bartfay, 2017; Carnevale & Priode, 2018; Entwistle, 2004; Gedzyk-Nieman & Svoboda, 2019; Meadus & Twomey, 2011; Powers et al., 2018; Stott, 2007). From the outside, this would seem to add value to the learning experience, as stated earlier, men may prefer a more interactive experience. However, this also adds heightened expectation on men that they will know the answer, or will always have something to contribute, which could be anxiety-provoking for some (LaRocco, 2007; Sasa, 2019). Also, there may be an added level of scrutiny and suspicion from peers regarding the notion of preferential treatment (Rajacich et al., 2013).

Standing out could also have negative ramifications, as absenteeism from classes would be more evident to teaching staff (Anderson, 2014). Also, during clinical skills laboratories, men may find themselves pressured to remove shirts to be demonstrated upon (Anderson, 2014; Bartfay & Bartfay, 2017; Powers et al., 2018). Being expected to perform as a ‘live mannequin’ may lead to body consciousness, anxiety, and an underpinning double standard which could further exacerbate isolation.

Why nursing?

From reading this literature review, there may be a sense that male students and graduates endure a perilous induction into nursing. Men indeed face unique challenges and obstacles that females may evade. It must be acknowledged however, that men may also occupy a very privileged position, and as Randelle (2019) proclaims men either experience attrition, or rapid promotion. Multiple authors have also supported the latter, claiming that men experience career expediency and higher earnings much faster than their female colleagues (Christensen et al., 2018b; Harding, 2008; Harding, 2009; Maykut et al., 2016; Muench & Dietrich, 2019; Wilson et al., 2018).

Reasons for this are complex, however pay disparities may relate to the need for maternity leave, raising dependents, and more increasingly, being called upon to care for ageing parents, all of which can interrupt or delay career progression (Maykut et al., 2016; Punshon et al., 2019). Despite this, Wilson et al. (2017) argue that preferential wages for men are due to work-place gender discrimination and that curiously, an increased level of education for the female RN does not mitigate against this pay gap. Punshon et al. (2019) also add that females are less likely to receive or even request a pay rise. A counter view to all of this is that men possess a strong drive for career development and the gaining of expertise, and are perhaps therefore more ambitious (Harding, 2008; McKinlay et al., 2010). It begs the question however, whether such traits are innate to men or are in fact, socially gendered through patriarchal value systems.

Career expediency and a desire for leadership may hold value for some men entering nursing (Ierardi et al., 2010), yet it does not seem to be the dominant drawcard for recruitment. When considering the age that many men choose to enter nursing, there may be developmental drivers at play. For those changing careers, there may be an altruistic sense of duty to give back, or a desire to help others, and to embark on a meaningful career that is born of maturity and life experience (Harding, 2009; Ierardi et al., 2010; Rajacich et al., 2013; Yi & Keogh, 2016).

Motivations may also stem from political ambition or activism regarding the promotion of social justice, where a nursing qualification may be an applicable credential (Harding

et al., 2018). Here, nursing may be the required vessel for contributing to the greater good of society, rather than just at the individual bed-side level (Snyder, 2011). Similarly, Entwistle (2004) also argues that men early in their nursing careers may have ambitions to empower the profession of nursing itself. Other attractions to nursing could be related to a need for stimulation or self-actualisation, and the diversity of career pathways available in nursing (Christensen & Knight, 2014; Christensen et al., 2018b; Entwistle, 2004; Harding et al., 2018; Yi & Keogh, 2016). Further, for many men, the prospect of travel that nursing offers appears to be a powerful motivator to enrol in BN programmes (Christensen & Knight, 2014; Harding et al., 2018; Twomey & Meadus, 2016; Whitford et al., 2018).

Another aspect that may draw men into nursing is around career stability and security. Nursing may offer men and woman financial security due to the ability to progress not only vertically, but also or laterally into other specialities and localities. For men seeking a career change, nursing may be alluring as it is known as a safe and secure line of work (Christensen et al., 2018b; Entwistle, 2004; Harding, 2009; LaRocco, 2007; McKenna et al., 2016; Meadus & Twomey, 2011; Twomey & Meadus, 2016; Whitford et al., 2018; Yi & Keogh, 2016).

This perceived security is pertinent as many traditionally male-dominated occupations are dissolving due to the precarious economic climate, and the subsequent downsizing and disestablishment of many employment positions (Christensen & Knight, 2014; Christensen et al., 2018b; Ierardi et al., 2010; Munnich & Wozniak, 2017; Snyder, 2011). One could also argue that the exponential nature of technological and scientific advancement, is also leading to the mechanisation of many male-dominated areas of work. Thus, nursing is a career that is sheltered from automation and outsourcing. Combined with global nursing shortages that are ever-present in the public consciousness (Meadus & Twomey, 2011), nursing could be desirable to men, and especially for those who may often occupy the bread-winner/provider role (Christensen et al., 2018b; Harding, 2009; Kluczynska, 2017).

Other perks the minority

Within the classroom and the clinical education setting, male students may find themselves in a seemingly advantageous position. As stated earlier, standing out and being somewhat memorable may be a hindrance in terms of added expectation and pressure to perform (Kleinman, 2004; Meadus & Twomey, 2011). Yet it may also provide superior attention around educational opportunities, especially in clinical settings where additional support is provided by staff to male students, as there could be a drive to recruit more males at the ward/unit level (Carnevale & Priode, 2018). Also, in one study, participants spoke of being worshipped by their female classmates due to their previous life experiences and 'strength of personality' (Christensen & Knight, 2014). It is unclear whether this perceived strength of personality is related to traits of masculinity, surviving the female-dominated environment (Bartfay & Bartfay, 2017), or perhaps being comfortable within their masculinity (Jamieson et al., 2019). Alternatively, maybe this level of respect and pedestalling from female peers emerges from constructed gender norms, where leadership is not only expected from males, but where these qualities also exude intrinsically from men (Dyck et al., 2009).

Female student nurses in one quantitative study also believed that their male peers would climb the career ladder faster than themselves (Gedzyk-Nieman & Svoboda, 2019). Supported by the literature, there also appears to be an unspoken rule amongst students that males are hired ahead of their female counterparts (Maykut et al., 2016; McMurry, 2011). An aspect of this is illustrated in a New Zealand study where male participants became wary that having too many other males in their cohort could dilute their minority status, and threaten their chance of obtaining a position after graduation (Christensen & Knight, 2014). However this notion that 'jobs would fall into their laps' may also be insulting to many males, meaning they purposely strive to prove themselves above their gendered privilege (Christensen et al., 2018b). Therefore this need to step up above their maleness is born of a high level of expectation that is externally placed upon men but becomes internally driven (DeVito, 2016; Sasa, 2019). Rather than attempting to prove a point however, striving to engage with educational material and experiences was described by male students as a stimulating, challenging and satisfying experience, where the act of learning a new skill-set is an enriching experience (Cook-krieg, 2011; Ierardi et al., 2010).

A critical afterword

A significant limitation in multiple international and local studies reviewed concerned generalisability. In many studies, male student participants were sampled from just one (and frequently the author's own) nursing school (Bartfay & Bartfay, 2017; Carnevale & Priode, 2018; Christensen & Knight, 2014; Christensen et al., 2018a, 2018b; DeVito, 2016; Harding et al., 2018; Jamieson et al., 2019; Powers et al., 2018; Schmidt, 2016; Stott, 2007). Likewise, in studies of male new graduates and nurses, participants were recruited from entirely localised metropolitan or provincial areas (Ierardi et al., 2010; Juliff, 2017; Juliff et al., 2016; Juliff et al., 2017; LaRocco, 2007; Meadus & Twomey, 2011). Here, generalisability is queried by LaRocco (2007), where the author recognised their study's geographic location as diverse and liberal. If recruitment occurs from one defined geographic area, the political and cultural context of that location could place male nurses as more publicly accepted, or conversely more unusual, and thus limiting generalisability.

In terms of New Zealand research, in a seminal New Zealand PhD thesis by Harding (2005), most of the 18 participants were situated in one city. It is pertinent to note that the majority of modern New Zealand literature regarding men in nursing was generated from Harding's thesis (Harding, 2007; Harding, 2008; Harding, 2009; Harding et al., 2008). In another New Zealand study of male nursing students, all five participants were recruited from one provincial polytechnic (Christensen & Knight, 2014). Also, in two more recent studies of men in fast track graduate-entry programmes (which shared the same participant pool), all eight of the participants were recruited from the authors' institutions located in one major city (Harding et al., 2018; Jamieson et al., 2019). This being the case, New Zealand's only modern research pieces regarding men in nursing, are fairly metropolitan, which limits generalisability to the experiences of men in other geographic contexts across New Zealand (Koch, 2006; Sandelowski, 1993).

Another issue of generalisability identified in the literature regarded the point on the education trajectory when data collection occurred. For example, in several studies, nursing students were interviewed from all years of the degree (Bartfay & Bartfay, 2017; Christensen et al., 2018b; Stott, 2007). Similarly, in one New Zealand study, participants were either in their first or third years of study (Christensen & Knight,

2014). On the other hand, several overseas researchers ensured students were only selected if they were in the latter half of their degrees (Carnevale & Priode, 2018; DeVito, 2016; Ierardi et al., 2010; Schmidt, 2016). And other authors interviewed male RNs only once graduated or were within their first few years of practice (Juliff, 2017; Powers et al., 2018). Qualitative research allows for less stringent standardisation around inclusion criteria. But researching the student experience from all years of the degree may compromise rigour, as the student's perception and experience of their first year of study will be dramatically different from that of the final or graduate year.

2.4 Summary

Throughout the literature, there is ample research exploring the experience and journey of men in nursing. With a little excavating, it quickly becomes apparent that historically, men have provided nursing care for millennia, yet this is not common public knowledge, nor is it embedded in most nursing curricula. Instead, men are often seen as outsiders, or oddities within the feminine world of nursing, where stigma and stereotypes concerning men's intentions or sexual preferences persist. For these reasons, men may choose to protect themselves by gravitating to certain areas of practice that are constructed as more male appropriate, such as ICU, ED and mental health. However, men may also be attracted to these areas due to a gendered attraction to hands-on technical nursing, or the excitement and unpredictability of high acuity care. Men are more likely to enter nursing later in life and may have different motivations to do so, such as job stability in an unstable world, or perhaps from a more altruistic motivation born from age and stage.

During training, men will find themselves numerically isolated within their classes, and the male peers they do have are at higher risk of failing or withdrawing. Men's isolation could be due to a feminised curriculum that may not recognise men's contribution to nursing, or that may not accommodate male learning styles. Alternatively, it could be due to a general lack of male feet on the ground in terms of faculty, peers and role models. However, male students may rely on their minority status when it comes to competing for job positions. Additionally, males may be seen as natural leaders or

destined for leadership, which may be capitalised on, but may also add un-sought expectation and pressure.

In terms of literature on this subject, the bulk of this literature review was weighted on international evidence. For in New Zealand, eight publications emerged from only three studies, most of which are relatively dated. The most modern of the two, while informative, focus on participants embarking on second careers in fast-track graduate programmes, rather than the BN experience. The only study exploring New Zealand men's BN experiences is small in participant numbers and is geographically isolated. Additionally, all of the New Zealand research appeared only to include Caucasian participants. In short, there is a specific need for an exploration of male student educational experiences of the BN programme from across New Zealand, and where participants are more diverse in age, culture and ethnicity.

Chapter Three: Materials and methods

3.1 Introduction

The overarching research question of this study was to explore the experiences of male nurses during their formative educational period. A qualitative descriptive methodology underpinned data collection via semi-structured interviews, where data analysed used thematic analysis. More focused lines of inquiry included:

- What attracted them to a nursing career?
- What were their experiences during undergraduate BN training and the first year of practice?
- In terms of curriculum design, what could be changed, added or detracted to support men during their training?

By hearing the voices of novice male RNs in New Zealand, the objective of this study is to inform education providers (i.e. Universities, Polytechnics and DHBs) regarding curriculum design and delivery, to attract, support, and retain more men in nursing.

3.2 Methodology

My philosophical and reflexive position

This study will be exploring the perceived realities of a sub-group, nestled within a dominant culture, where there are overlapping influences, such as deep historical roots, gender, and class constructions. Sitting in the qualitative paradigm intuitively felt most fitting, as this naturalistic interpretive inquiry emphasises the complexity of the human experience, where 'truth' is a composite of multiple realities, that ultimately leaves no one truth (Greenhalgh et al., 2019; Polit & Beck, 2008).

Qualitative research complements this process by giving voice to participants while also leaving room for the reflexivity of the researcher (Creswell, 2007). This will act as a guide concerning my own position within this study. As while I am 'the researcher', I am also the 'nurse', the 'male', and 'the educator'. I will subsequently have my version of events from many sides of the curtain (i.e. the patient versus the clinician; the student versus the teacher; and the male student versus the female preceptor). Hence, I must be able to bracket my experience and to be critical of my presuppositions or hypothesise regarding the experience of each participant (Harding, 2005).

It is also critical to acknowledge the impossibility of complete objectivity and the value of subjectivism within qualitative research (O'Connor, 2015). My position, combined with that of the participant means a shared understanding of events is entirely possible, if not probable (Finlay & Gough, 2003). Here, the data-gathering instrument used - the 'inter-view', can be seen as the interchange of views of common themes between researcher and participant (Kvale, 2008). Throughout the research process however, I must continuously reflect on how my position and story could influence participant responses. Here, participant and researcher reactivity will need to be monitored and discussed, to mitigate any distortion of findings (Lewis-Beck et al., 2004).

Qualitative description

In a study where experiences, views and insights are sought, a qualitative descriptive (QD) methodology felt appropriate for several reasons. Firstly, QD is a convenient method for the novice researcher, meaning the researcher is not required to possess knowledge concerning all qualitative methodologies (Bradshaw et al., 2017).

Secondly, QD offers flexibility when committing to a theory or framework (Sandelowski, 2010). This is imperative, as theoretical frameworks conceived at the beginning of the study, may shift or evolve during, or even after data collection (Finlay & Gough, 2003). This flexibility allows the researcher to be open and receptive to new themes that may be valuable, challenge preconceptions, or take the investigation down another path (Sandelowski, 2010).

Thirdly, QD is well suited to data-collection techniques such as semi-structured interviews, where the researcher seeks broad insights and rich information (Neergaard et al., 2009). While QD *is* compatible with thematic analysis (Kim et al., 2017), care is needed for the researcher not to confuse this with content analysis (Vaismoradi et al., 2013). A crucial delineation between the two is that content analysis aims to quantify and categorise frequencies of categories and themes, meaning vital contextual information may be overlooked. Conversely, Thematic analysis attempts to cut across data to extract codes and to build underlying themes from participant accounts, to seek implicit meaning and personal realities and is thus more aligned to the constructionist paradigm (Braun & Clarke, 2006; Vaismoradi et al., 2013).

Social constructionism

Social constructionism (SC) will be the overarching philosophical lens channelling this research process. SC is concerned with how knowledge is built and interpreted, and therefore uses an epistemological perspective, rather than an ontological one (Andrews, 2012). Slater (2017) also defines SC as knowledge, being social in origin, determines and maintains all human actions (thoughts, feelings, and behaviours), which are consequences of prior conditions. Harding (2005) explains further that SC is a critical awareness of taken for granted knowledge, and that the lived experience is a product of culture and history, embedded within the current socio-economic environment. In other words, truth is constructed by social and cultural institutions (Rolfe, 2000). Here, it is deduced that subjective reality is a product of social conditioning, moulded by social norms. It is therefore arguable that SC is highly suitable to the subject of men in nursing. As SC aims to challenge and deconstruct social processes, rules and discourse that are consciously, and subconsciously weaved into social realities.

Influenced by Marxism, SC critiques dominant forces and power structures such as religion, media platforms, and institutions such as education and family (Harding, 2005). Nested within critical social theory and feminism, SC also considers class systems of race, economic position and gender (Slater, 2017). Relating to gender norms, social constructionist's argue that gendered behaviours are implemented at birth through

the organisation into two heteronormative categories - male *or* female. This becomes more apparent through un-written social processes embedded in society, where gender stereotypes become *prescriptive,* rather than descriptive of behaviour, values and attitudes (Lips, 2017). For example, when discussing career choices, young children often lack cognitive schemas that pair *nurse* with *man,* and during health visits, children are likely to assume male nurses are doctors (Wilbourn & Kee, 2010). Through human socialisation and via the influence of media, culture and other social systems of control, we are therefore *not* gendered – we *do* gender (Lindsey, 2015; Lorber, 2008).

Anything outside of constructed gender roles and trajectories may be perceived by society as pathological. As within the heteronormative and binary nature of western culture, societies become hardwired to be antipathetic to disorder - or the disruption of order (Harding et al., 2008; Lindsey, 2015). Here, disrupted order manifests into 'the other', i.e. the non-white, the non-male, the non-heterosexual, and the non-rational (Klages, 2003). This societal undercurrent feeds the uncomfortable and awkward position where male nurses find themselves, positioned within the feminine construct of nursing, but under the dominant shadow of patriarchal constructions of masculinity (Connell, 2005).

SC is most fitting for a study such as this due to its functional purpose - knowledge constructed can be de-constructed. Constructions and definitions of gender roles are never rigid and always in a state of flux (Lindsey, 2015). SC allows the exploration and analysis of the socio-historical context, where gender customs and practices came into existence. In doing so facilitates the transformation of taken for granted knowledge through social action (Connell, 2011). In sum, this research seeks to unpack the epistemology concerning the loci of males and masculinity, as a minority within nursing and nursing education.

3.3 Methods

Recruitment

Through purposive sampling, all participants were recruited through the *New Zealand Please Hear Our Voice* (NZPHOV) Facebook page. This page was a member's only Facebook group that was set up in 2018 for nurses to discuss issues related to the then industrial action, but has since been used for general discussion and information sharing among RN's, ENs (Enrolled Nurses) and Health Care Assistants. Using purposive and snowball sampling methods, inclusion criteria included that RN participants were: (a) male, (b) have no longer than three years practice experience, and (c) have studied at a New Zealand BN programme.

To recruit a sufficient number of participants, an advertisement was posted twice throughout October/November 2019. This advert resulted in 12 potential participants initially contacting me via my university workplace email, and in two cases through Facebook Messenger (who were re-directed back to email). Two participants failed to return invitation emails, one was excluded for having practised for over four years, and another who had studied in a fast-track Masters programme was also excluded. Once potential participants expressed interest and met criteria, the publicly available nursing register was accessed to verify that participants were indeed practising RNs.

3.4 Data Collection

Ethical considerations

In terms of the process of gaining ethical approval, firstly a *Massey University Human Ethics Committee* (MUHEC*)* screening questionnaire (2014) was completed. I met and consulted with the Chair of the MUHEC to discuss the process of recruitment through social media. From here, it was deemed that a full ethics submission was not warranted. The low-risk application was subsequently peer-reviewed by two senior researchers from Massey University's School of Nursing (*Ethics Notification Number – 4000021383* - Appendix 2).

The administrator from the NZPHOV Facebook page was contacted with information regarding the study, and to seek permission to recruit via the NZPHOV page. Once approval was granted (Appendix 4), potential participants were invited to contact me via email. After meeting inclusion criteria, study information and informed consent were provided via email. Signed written consent was obtained before the interview process (returned by self-addressed envelope or emailed). All participants were given pseudonyms and were informed that they were able to withdraw from the study up until the final stages of transcription. Within the thesis discussion, geographic locations were not divulged, and areas of practice were kept broad (e.g. 'surgical acute care' rather than 'cardiothoracic surgical ward') to protect participant confidentiality.

This research may have cultural considerations in regards to Māori. In regards to this, I consulted with the Associate Dean – Māori from Massey University prior to ethical application. This individual was more than happy to provide advice and guidance at any point in the research process if participants who identified as Māori presented. As one Māori participant subsequently took part, the above colleague was re-contacted for advice. I was advised to allow this particular participant to review the interview transcript and amend as desired. This participant did so but did not feel the need to modify the transcript (Appendix 5).

When considering the culture of men as a minority, every effort was made to ensure the experience and process was as comfortable and safe as possible for each participant. Anonymity was honoured and protected, and participants had a full explanation of where and how their responses were used and stored, including their right to withdraw. In terms of arranging interviews, lines of communication were tailored to each participant's preference (i.e. phone, text or email, etc.). Consent forms, recordings and typed transcriptions were kept in a password-protected computer, and a locked filing cabinet both located within a locked university office.

Instrument design

The data collecting instrument selected was the semi-structured interview, as a more conversational approach was desired to allow free form responses. But also, to allow the possibility for unexpected and interesting data to emerge (Boswell & Cannon, 2018; O'Leary, 2017). This instrument was deemed to be fitting to QD methodology and specifically, Thematic Analysis, as it paves the way for the gathering of rich data, with the construction of themes stemming from the dataset.

Throughout the interview process, a question sheet was referred to by myself to ensure critical aspects of inquiry were covered (Appendix 7). Types of questions were constructed from the major themes emerging from the wider literature, but were also adapted from relevant research (Anderson, 2014; DeVito, 2016; Harding, 2005; Lloyd, 2013; Meadus & Twomey, 2011; Powers et al., 2018). Before the interview, a theme sheet was sent to each participant to aid preparation and to help 'percolate' their thoughts and memories in time for the interview (Appendix 6).

All nine interviews were conducted using Zoom video conferencing software. Interviews ranged in length from 30 to 90 minutes. A secondary back-up recording was also completed using a mobile phone voice recorder. These secondary recordings were deleted once the Zoom recording was reviewed and saved. All Zoom interviews were successful, however one participant ran out of mobile phone data and was called back via a landline.

3.5 Data Analysis

Thematic analysis

From the nine semi-structured interviews, the analysis performed used Braun and Clarke's (2006) method of thematic analysis (TA). Using TA, qualitative datasets can be systematically analysed to enable the synthesis of themes and sub-themes extracted from patterns of meaning (Braun & Clarke, 2006). This particular method of TA was desirable, as it is acclaimed for its validity and ease of use. It is subsequently

recommended for those new to TA, as it aims to clarify and simplify the tool through a 6-step non-linear iterative process (Braun & Clarke, 2016; Clarke et al., 2015; Kekeya, 2016).

Another attractive aspect of TA is that it allows the researcher to distinguish between two levels within the themes; semantic and latent (Braun & Clarke, 2006; Maguire & Delahunt, 2017). Exploring sub-surface latent themes is critical in a research piece of this type, where socio-cultural or historical constructions may underscore particular responses. Doing this however requires caution, as the researcher's interpretation of latent meanings may hold bias. This is especially true when the researcher's position, as is the case here, mirrors the journey of the participant.

Phase one of data analysis began with the researcher becoming familiar with the raw data. All interviews were transcribed verbatim by the researcher himself. Being able to interview *and* transcribe, allowed for a deeper familiarisation with participant responses, thus forming the early stages of analysis (Braun & Clarke, 2006). Once transcribed, all typed transcripts were checked against the audio/video recording. All participants were invited to review the typed transcripts. Four participants did request transcripts with two replying via email to confirm authenticity (Appendix 5).

After transcription, phase two involved reading and then re-reading all transcripts to produce initial codes. This first wave of coding was displayed using stick-it notes (Figure 3). From this, a second round of coding occurred in order to condense and streamline the initial codes (Appendix 8). Concurrently, transcripts were re-read to ascertain if any pertinent information had been overlooked. In doing so, the researcher can retain certain participant narratives that while on the periphery of the research questions, could still add rich value. This is an essential step of TA to avoid hindering data capture, but also to suit the flexibility of the underlying QD methodology (Braun & Clarke, 2006; Sandelowski, 2010).

Figure 3: Coding: First Wave

3.6 Research rigour

Due to the subjectivity of qualitative research, careful consideration was given to the rigour of this research process. Doing so allows the reader to form their own critical judgement whether this research constitutes a meaningful contribution to the wider literature (Thorne, 2020). To guide this process, *credibility*, *generalisability* and *auditability* will be discussed in detail, as these are seen as the hallmarks of trustworthiness in qualitative research (Koch, 2006; Sandelowski, 1986).

Credibility

A key consideration in this study was that the researcher himself, had not long ago been in the shoes of the participants, and that this position may impact the research trajectory born from pre-existing views of the phenomena (Denscombe, 2014; Sandelowski,

1986). To mitigate any undue influence, reflexive journaling was an ongoing process throughout data-collection. For example, after each interview the researcher reflected on his questioning and probing, and whether questions may have been too leading. It must also be acknowledged that this was a learning process, and interviewing techniques became more refined with practice. To also support credibility, several participants reviewed the transcripts to confirm that they were faithful descriptions of the interview (Sandelowski, 1986).

Generalisability

In qualitative research with small sample sizes such as this, generalisability requires careful attention. Generalisability refers to the 'lessons learned' and how these could be transferred and applied to others in similar situations (O'Leary, 2017; Streubert & Carpenter, 1999). To assist this process, contextual information was provided, such as age, areas of practice, and years since graduation (Table 3). By outlining this contextual information of the participant group, it allows the reader to determine if findings are indeed applicable to other similar populations (Koch, 2006).

Auditability

A measure of auditability is the description of a clear, logical, and a justified decision trail from start to finish. When this is present, the reader can follow the methods and see how the researcher's interpretations and conclusions were reached (O'Leary, 2017; Sandelowski, 1986; Streubert & Carpenter, 1999). Within this study, the audit trail was supported by the inclusion of processes from start to end. For example, various appendices were included, such as participant information forms, interview questions and transcript verification emails. Furthermore, contained within the text and appendices were photographs documenting the process of coding and theme production from the initial stages, right through to the eventual theme map. How participant information was recorded and stored was also outlined (Boswell & Cannon, 2018). Correspondence regarding recruitment processes was also attached. And finally, the

process of coding, analysis, and theme mapping was regularly reviewed under the guidance of the researcher's supervisor.

3.7 Summary

This section opened with the research aims followed by the methodological underpinnings that intuitively fits a study of men in nursing - qualitative description and social constructionism. Discussed also were reflexivity, ethical considerations, the recruitment process, and the method of data collection – the semi-structured interview. The process of coding and theme creation using Braun and Clarke's thematic analysis was then outlined. Finally, this chapter concluded with a discussion pertaining to the methods of research rigour.

Chapter Four: Findings

4.1 Introduction

After the coding process, the two overarching themes produced were *an isolated position within,* and *off the public radar.* These themes were by no means isolated, but instead possessed a bidirectional relationship with each other. From each of these, nine subthemes were identified, and a theme map was created (Figure 4). Using Braun and Clarkes (2006) six phases of TA, transcripts and the generated codes were continuously reviewed to ensure that themes aligned with the coded extracts and data set.

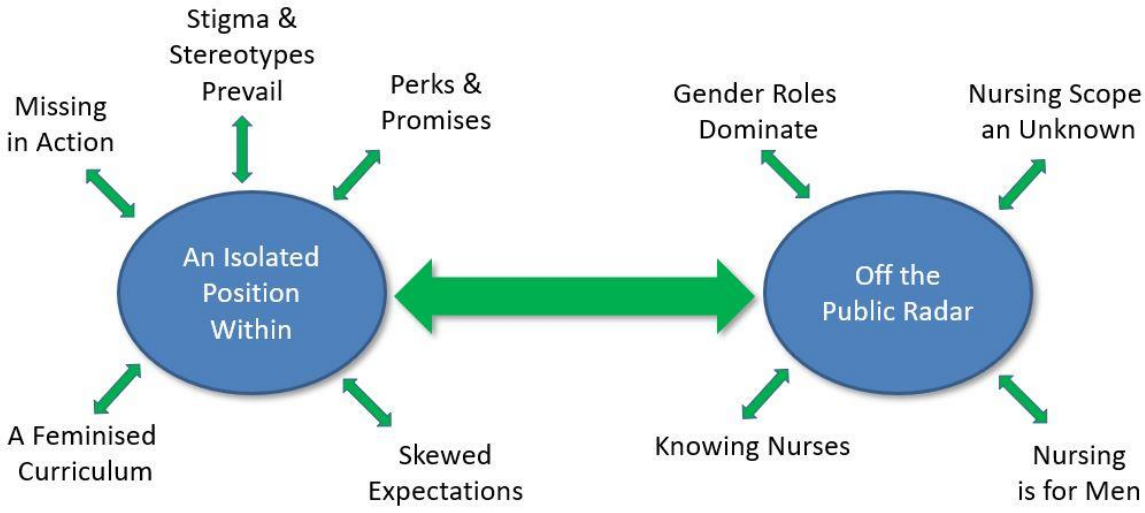


Figure 4: Final Theme Map

4.2 Participants

The final participant sample was limited to nine participants due to data saturation. Aged between 22 and 48, participants had a mean age of 31. Eight identified as New Zealand European, with one identifying as New Zealand Māori. They came from a range of locations across New Zealand, with four based in large city centres, one from a rural setting, and the rest from provincial centres. Only one of the nine trained at a university, with the rest completing their BN programmes across four separate polytechnics. All but two participants had completed or were finishing a NETP/NESP

new graduate programme. One participant completed a NESP programme in mental health, and then transferred to acute care within the hospital. Two participants worked in primary health care, with the rest working in acute hospital services. Four of the participants entered nursing education from secondary school, with a slight majority entering nursing as a second or third career change (Table 3).

Table 3: *Participant Information and Demographics*

Interview Order	**Pseudonym**	**Age**	**Years Practicing**	**Ethnicity**	**Area of Practice**	**First career?**
#1	*Steve	25	3	NZ European	Perioperative	Yes
#2	*Rob	48	2	NZ European	Aged Care	No
#3	*Sammy	28	2	NZ European	Emergency	No
#4	*Ian	30	1	NZ European	Acute Medical	No
#5	*Ben	37	3	NZ Māori	Perioperative	No
#6	*Caleb	22	2	NZ European	Acute Surgical	Yes
#7	*Shane	38	3	NZ European	General Practice	No
#8	*Pete	24	2.5	NZ European	Perioperative	Yes
#9	*Tim	25	1	NZ European	Rehabilitation	Yes

* Pseudonyms

4.3 An isolated position within

Stigma and stereotypes prevail

Most participants discussed existing false stereotypes of men in nursing from a broader societal view of *who* a male nurse is. Frequently mentioned was the media portrayal of male nurses as homosexual. Caleb speaks of both negative and positive media exposure before and during the degree.

> **Caleb:** Since starting my nursing degree I noticed I've noticed a couple of guys that have a pretty decent social media presence that are nurses and put a lot of stuff out there and discuss things. But prior to doing the degree the only one that stands out would be Gaylord yeah.

Caleb is referring to a character in the movie *Meet the Fockers* named Gaylord Focker, a male nurse who receives ridicule for his chosen profession by his militaristic father-in-

law. Regarding men who have a social media presence, Ian mentions a male nurse who he views as conforming to stereotypes.

> **Ian:** There's a Facebook nurse who is a really campy flamboyant gay male nurse. And he's just doing him, but I think that it's definitely a part of an image of a male nurse as well that, a slightly more intellectually lazy viewer might consider.

Ian's comment on 'intellectual laziness' is poignant when considering how implicit constructions of reality are formed. Sammy speaks of seeing stereotyped portrayals of male nurses in the media but seeing it for what it is - a stereotype.

> **Sammy:** The only medical TV show I've watched with interest was *Scrubs*. And they have the very stereotypical male nurse who is very flowery and quite gay on there. And I recognised at the time that that was a stereotype, and it wasn't an accurate representation.

Shane on the other hand, comments on having an acute awareness of TV portrayals of male nurses during his training.

> **Shane:** I remember seeing them on all the comedy shows and sitcoms where the male nurse would turn up, and there would be lots of shtick about their choice of sexual preference. And that was quite a big thing, I mean that was even going when I was doing my degree.

Caleb, as a younger student, mentions having some resilience against bearing the brunt of the 'shtick' he received from other males in his halls of residence regarding his sexual preference.

> **Caleb:** A few guys I lived with in the halls were a bit harsh about it, making comments about my sexuality and things like that. That were more than just jokes really. I mean it bummed me out a little bit, but I usually try and not let things like that get to me, and it's not going to get in the way of me becoming a nurse.

Pete talks about his epiphany that contradicted his formative personal reality, that male nurses were in fact, not *all* gay.

> **Pete:** You know it's actually ok for men to be nurses, and not all men who are nurses are gay. Because my Mum's a nurse, and all the men that were in her year, were all gay. So then I had this mindset that male nurses are gay.

Stigma in the media was also a concern, with one participant signalling that men have a disproportionately high presence within the media as having psychopathic or clandestine motivations.

> **Ian:** There are other nightmare stories that come out in the media about male nurses. I remember one in Germany that was killing cardiac patients over several points in his career. And one other one who was spiking bags with potassium. And then there is male nurses abusing access to controlled drugs. There's a particularly chilling Netflix series about it.

Ian also mentions what he sees as negative images of male psychiatric nurses in the media concerning the use of physical strength.

> **Ian:** Unfortunately, the only male nurses I saw in the media were psychiatric nurses who would jump on patients and restrain them, which is like a really bad image in my mind. It's like the cliché I think when I think of the male nurse in the mainstream.

Shane concludes with a somewhat more positive preconception he held before training.

> **Shane:** At the time, I thought male nurses were these super strange really intellectual types. Well, I'd never really met male nurses per se, so yeah that was my preconception what they were like… Just quite strange blokes.

It is pertinent to note that while Shane appeared to hold nursing in high esteem concerning academic requirement, he still saw men as anomalies within nursing.

The stigma around the intentionality of care was also of concern, with many participants applying caution when caring for female patients. In terms of female patients and family members acceptance of male nurses providing personal or invasive care to females, there was a varied response from participants.

> **Rob:** I only ever had one female patient that said 'no I don't want a male nursing student' ...but she also didn't want any male nurses as well.

> **Steve:** When I was a student, every female patient I had was unhappy having a male student, basically like ‘oh no we couldn’t possibly have a male nurse!’

And Ben mentioned the paradox that it was more acceptable for male doctors to perform intimate procedures, yet patients were perhaps more suspicious of male nurses doing the same.

> **Ben:** You do sometimes get people who are a bit standoffish about a male examining them... that isn’t a doctor for some reason, I don’t know what the difference is.

Strikingly, another participant seemed to have internalised this construction. Pete outlines his position from both sides of the curtain.

> **Pete:** I still don’t feel completely comfortable introducing yourself as a nurse, as you know, a male doctor is fine, as he’s a doctor and he’s doing his job... but I guess the way I see it, is that if it was my wife going into surgery, I don’t think I would be comfortable with another man, I mean doctors I think are a little bit different.

One participant also mentions receiving frank hostility from female RNs during clinical placements concerning his right to be a nurse.

> **Steve:** I actively got told that ‘I shouldn’t be in nursing because I’m a male’. I have heard this three times now.

As a male, Caleb also felt discrimination from his clinical tutor.

> **Caleb:** I was questioned by the clinical tutor once whether nursing is the right career for me. And I don’t really know if a female student would get questioned the same.

Here the very professionals who are given charge to support, foster and advocate for their students, are in fact capable of exacerbating an already isolated position.

The stigma around accusation was at the forefront of awareness, with multiple participants outlining strategies to keep both themselves *and* the patient safe. They also mention applying even more caution with younger female patients.

> **Caleb:** Sometimes, you have to practice a little bit more carefully. I know the other guys on my ward are quite conscientious about working with some woman at times, and covering themselves by having chaperones and things like that. So I think you are a bit more aware of your presence among some patients. But I think that's about looking after your own professional safety. And I think with quite younger patients, it's always best to err on the side of safety.

> **Shane:** You know, if I have a 16 or 17-year-old girl come in that needs an ECG[2] done, I'll ask a colleague and they will always do that for me without any questions, or giving me any grief about it. And I never think about it as stigma or stereotyping, it's just what makes our patient more comfortable with what's happening.

Sammy also speaks along these lines, but in his workplace, there is a blanket rule regarding chaperoning that is applied to male *and* female staff of any discipline.

> **Sammy:** In my workplace now, it's kind of a flat rule that if it's something a male would need to be chaperoned for, then it's something the female needs to be chaperoned for too. So we have a very consistent approach.

Within undergraduate and postgraduate education, two participants describe a sense of awkwardness of being the male minority during simulated physical examinations.

> **Ben:** Where it came to practicing your body assessments, all of the females were a little bit standoffish when it came to the males turn to learn the examination. Whereas we would be just kind of be typically cast as the patient. So if you were wanting to practice, you would have to find someone who was willing to… yeah it was bizarre!

> **Shane:** When you had to do your examinations, it was a bit strange and difficult. And that even happens in my postgrad stuff, you turn up, and everyone's a bit strange with having you for their partner.

[2] Electrocardiogram – The measurement of cardiac electrical activity via probes placed on the chest and limbs.

Sammy goes on to discuss his class dynamic, where having a romantic partner was protective against a sense of sexual prowess that may come with being the only male in the class. Having this assisted him in building honest and transparent friendships with his female peers.

> **Sammy:** I had a partner all the way through polytech, and she was great, and really interested in meeting the people I was training with, and they all knew her and got on well with her. So I never felt there was suspicion that I was flirting or hitting on people, so it was quite a benefit in that regard in terms of building genuine relationships with people, and building trust with people.

Missing in action

Another predominant sub-theme was that of men's absence in nursing. This absence was even noted before training in the minds of others. For example, when contemplating career choices, several participants provided commentary regarding the willingness and preparedness of secondary school career advisors and teachers. Caleb and Steve provided insight from single-sex schools.

> **Caleb:** We had career advisors at school that kind of helped me get where I needed to go, but they told me that they didn't think they'd ever had a male nurse at *school name*. So the career advisors didn't have any programme specific advice. I had to chase a lot of what I needed to know to get there. But they would facilitate that yeah.

> **Steve:** I don't think nursing was even on their radar. Unless it was doctor, accountant, lawyer or a trade, they didn't want to know you. Once I actually finished training and went back for one of their gala's, I met up with some of the teachers, and I might be one of the first graduates that has become a nurse.

Students attending a boy's school seemed to be explicitly ushered towards careers that aligned with a masculine construct such as a position of power or a trade. Likewise, Peter mentions a career advisor possibly attempting to funnel him away from nursing.

> **Pete:** I had an interview with a career adviser, and he told me I should go into health, but more towards occupational therapy.

Ben on the other hand, hesitantly describes his interactions with his career advisor as a more supportive process.

> **Ben:** Yeah it was obviously something I was interested in (nursing). So you don't want to shoot someone down and go 'oh na that's not for you' ...They did recommend I do specific subjects.

Once enrolled in a BN programme, all participants discussed their numerical minority amongst their female peers. Participants often spoke of being alone in the cohort, or having a few male peers. Some also mention the disproportionate attrition rates for men.

> **Caleb:** There were three of us when I started. But I was the only one that finished.
>
> **Ben**: In our intake, there were only about six males out of 120 students.
>
> **Sammy:** We had 120 people starting the course and six men. And we had 100 graduates with three men.

Tim mentions that his initial intake of males was encouraging and unprecedented. But, he also states he lost over half his male peers by graduation.

> **Tim:** We started with 11 and graduated with five… and they said it was the biggest bunch of males in one cohort.

Steve also spoke of the three other male students gradually withdrawing from the course, leaving just him. As a younger male, he also mentions where he found peer support.

> **Steve:** It's interesting as my entire peer group were all older than me. So one in her 50s, one in late 30s, early 40s, late 20s, and there was me at the time at 21. And that was who I hung out with. Everyone else was really immature at the time (laughs).

Caleb also felt less inclined to connect with females of his age within the cohort.

> **Caleb**: I probably wasn't part of the main clique of girls that were equal to my age, that also would have come straight out of school.

Steve and Caleb appear to have gravitated towards female peers older in age than themselves. Peter, on the other hand, discusses the dynamic with his mature female classmates in a less favourable light.

> **Peter:** They were all 30 plus, and I was almost the baby of the class, so I found they were quite motherly towards me. And sometimes that's nice and other times it's a little bit frustrating. You've got your own mother to mother you, you don't need someone else to do it, especially when you are supposed to be in a professional space.

As a mature student, Rob speaks of his ongoing connection with his female peers as being entrenched in a shared background.

> **Rob:** My support group was three other student nurses, and they were all from rural *place name*, and I'm from rural South Island. So I could relate to them on a social level. We all had similar farming backgrounds. And they are like sisters to me.

When posed whether it would be helpful to have more male peers within training, the responses were mixed. Many felt having more male camaraderie would be positive in both class and clinical placements.

> **Ian:** Yeah sure I mean I would reflect differently to male colleagues... We would hull together to have a little man-corner sometimes.

> **Shane:** It would've been good to have another guy to say 'hey how's everything going for you?' And have a bit of male chat about what's happening, or what you might be finding difficult.

> **Pete:** Yeah I do. I feel for me personally, I always felt a little bit more supported having male colleagues there, someone you can bounce back on. Or if females aren't quite getting what you are doing, or saying, or why you are doing something, there is someone there who will often have a very similar wavelength to you.

Having other men in the programme could be viewed here as a resource for resilience and camaraderie, where men may reflect, communicate, and debrief with each other more openly and honestly. One participant also mentioned the contrast and culture shock from coming from a single-sex school to a seemingly single-sex tertiary programme.

> **Caleb:** I had a good group of friends in my class as it was but, I think initially, I mean because I came from an all-boys school for seven years and then came to a nursing degree, which was a bit of a culture shock, so it was kind of good having those other two guys when I started.

Ben however, was a little more measured concerning having more male students out in clinical placement.

> **Ben:** I don't know, I think it kind of depends on the person. Yeah I don't think it should necessarily be rule or anything, or like a prerequisite.

And Tim showed no particular preference.

> **Tim:** I didn't feel either way really. It was just another student.

Also, Sammy alludes to the fact that having other males in clinical placement might hamper his chances of obtaining a desirable nursing position.

> **Sammy:** I don't know if it would have made a huge difference as most of my placements we didn't have a huge amount of other students involved in what you were doing day to day. And from the outset I had a bit of a competitive streak around treating every placement as a potential job interview. And wanting to be remembered by the people where I had done placements so I could you know, get a job if I applied later.

A further issue discussed by all participants was the lack of male role models in terms of faculty, clinical tutors and RN preceptors. When probed about a male presence on the faculty, all participants stated a clear imbalance existed, where there were few to no male RN's on the teaching staff.

> **Ben:** There would have been three. So there was one in the foundations, but he was more for academic writing, so it wasn't for health science specifically. And then two science teachers who were teaching us anatomy and physiology.
>
> **Researcher:** But they weren't nurses?
>
> **Ben:** No, they weren't nurses no.
>
> **Steve:** Probably one or two out of twentyish staff in total.
>
> **Ian:** Just the mental health lecturer.
>
> **Pete:** We didn't have any male nurses as lecturers.

This was echoed within the clinical environment, where once out of the classroom, participants generally expressed that their exposure to male RNs was also sparse.

> **Steve:** In total, in my entire training, I think I've met three.
>
> **Pete:** I never had any male preceptors.
>
> **Shane:** I didn't know of any males who were our clinical placement tutors. I didn't have any male preceptors.
>
> **Tim:** None whatsoever. And I can't remember any male RN's on the placements either, besides my nine-week placement.

Two participants mentioned that their interactions with male nurses increased as the degree progressed, especially in the mental health setting.

> **Sammy:** In my final year, I was doing a lot of mental health placements. As that was the direction I was taking at that point and, in that I did both in-patient and community, where both I worked with some great male nurses. But up until then in aged care, hospital and community, I had been only with female nurses, supervisors and female lecturers.

> **Ben:** My first interaction with a male nurse was in my placement in semester three[3].

This could be anticipated given the statistics of male RNs in mental health. Caleb, on the other hand, had quite the opposite experience while on placement in the 'physical' setting.

> **Caleb:** Pretty much everywhere I went had at least a couple. And I usually had an opportunity to work with one of them while I was there. Even in the rest homes in first year there were a couple of guys there. I can't think of any placements where there weren't at least one or two male nurses present.

Caleb's mention of male RNs 'even in the rest homes' is pertinent, as it indicates his awareness that aged care is not the usual haunt of the male nurse.

Most participants stated that having more male role models within the faculty and clinical setting would be beneficial. Two felt that having more male lecturers from day one would decrease isolation.

> **Tim:** I definitely think having male educators is a big thing, like we only had the one. It was still helpful to know that starting out, right in the front there was a male nurse. I think if you went into nursing and there were only females, and if you were the only male in the class, and I know that is often the case, and then all you had is female colleagues, and female educators, and then female preceptors, I think that would be quite overwhelming. So I think having the male lecturer and the odd male out in placement was very helpful, just to know you weren't alone.

> **Ben:** It was good seeing other dudes in it, it was good getting that kind of male integration as well.

While having more male educators was deemed important, *how* men could role model and mentor was also thoughtfully considered.

> **Sammy:** I think the one thing that would have made a huge difference for me would have been having a mentor type relationship that went across the programme, which was not necessarily from lecturers at school. You know if

[3] Semester three occurs in the second year of the BN degree.

there was a programme that linked in with men working as nurses in the local area that you could have a connection with, you know even if it was a catch-up once every two months kind of thing, I think that would have made a big difference.

Here Sammy suggests the need for a longitudinal mentoring presence. Shane spoke of the need for male-to-male formative feedback around sensitive situations that are outside of the general curriculum, where a male experiential point of view would be beneficial.

Shane: It's sort of quite strange to ask a female tutor 'how do I actually do this, or how am I going to talk to a 20 year old girl about her sexual health?' And they're just like 'oh you just be matter of fact and do this'. But if you had a male nurse who said 'well it's actually ok and you can have those conversations, you just need to learn how to word it right'. That would have been quite a bit more beneficial for us guys.

Additionally, Pete states the need for men within the clinical environment that could provide advocacy for male students. This stems from his clinical placement experience of being expected to provide heavy lifting.

Pete: And I think in a situation like that, it would have been nice to have a guy who is already working there, who maybe has the respect of his colleagues and peers who isn't being asked to do all that stuff all the time. Because as a student I felt like I couldn't ever say 'no'. So I ended up putting my back out within six weeks.

A feminised curriculum

All participants agreed that an imbalance existed in the under-graduate curriculum fed by implicitly gendered influences. This was especially true when questioned around content outlining men's contribution to nursing.

Steve: The only real male nurses that we heard of were our tutors.

Researcher: What about female theorists?

Steve: Oh, every one of them was brought up.

Rob's response was similar.

> **Rob:** No. Definitely no.
>
> **Researcher:** Any prominent female nurses or theorists?
>
> **Rob:** Of course.

Ben kindly did some homework before the interview.

> **Ben:** I've still got my notes from polytech, and there was nothing in it that had prominent male nurses or theorists. Yeah, which is a little bit odd isn't it?

Ian and Caleb both remember which prominent nurse frequently emerged, which sits within the mainstream narrative of nursing.

> **Caleb:** Florence Nightingales always a big figure talked about in nursing.
>
> **Ian:** In fact, Florence Nightingale was all we learnt about with theorists.

A similar consensus reached, was the discussion concerning the quantity of men's health content, or teaching material around male-targeted health promotion.

> **Caleb:** In terms of male-centred topics, it was probably quite disproportionate compared to how much we covered female-specific health issues.

Steve felt that gender bias existed in his course, where he sensed an inequitable coverage of topics steered by one faculty members speciality and interest.

> **Steve:** We had an entire week with a lecturer who was a breastfeeding consultant, so we had an entire week just talking about breast-feeding. But on the other hand, we never talked about the father's influence on raising children etc. So on that side yeah it's very much a woman-led education.

Pete reiterates this point when discussing an individual female lecturer whom he felt had an attitude that made him feel unwelcome.

> **Pete:** I know there was one tutor who was particularly bad, who was a feminist. And I unfortunately got her as a tutor, and I always found in her class I was

always ignored, and I felt that if I wanted to, I could've got up and walked out and she would have been more than happy.

While participants felt there was a definite imbalance in the physical domain, men were perceived as more equitably represented in mental health classes. Ben's observation however, closely mirrors Steve's previous comment.

> **Ben:** There was a quick lecture on men's health issues, but that was it. I mean it was only a one-hour lecture. Whereas when you go through all the female anatomy and all the female health problems, you had a lot more. The majority of the semester would have been taken up by learning about menopause or pregnancies and all that. And you know it's still important, but I think men deserve a little bit more than an hour in a semester. And I mean the only time men did frequently pop up was in mental health. So like learning about depression and that kind of stuff. I mean, men did get a bit of a mention then. But that was it.

> **Tim:** In terms of mental health, there was a predominant theme of youth suicide and successful suicide were predominantly male. So that was definitely covered yeah.

In Rob's case, he attributes this more balanced coverage to public awareness of the demographics of his region.

> **Rob:** Well here it's quite prevalent, amongst younger males with suicide. At that stage *name of town* was going through quite a high suicide rate, which was quite well known in the media. So that was promoted quite heavily and acknowledged in our classes, that males were overrepresented in suicide and mental health.

Shane's perception was that men were more widely discussed, as the tutor was actively more inclusive for the benefit of the men in the audience.

> **Shane:** We had quite a few chats about all your typical stuff like tradesmen males, farmer males and how hard it is to get in, and actually get them to talk about their health. But I think a lot of that stemmed from the fact that there were three blokes in my classroom, and the tutor actually picked up on that and used that quite a bit. So not so much what was in the curriculum but how the tutor steered it.

In terms of visual representation in core textbooks, two participants made remarkably similar statements where the females in the images were usually the nurse.

> **Shane:** You'd have the male who was the patient, but not so much the male who is the clinician doing the work.

> **Ben:** I think in illustrations they were usually being examined on, they were never the examinee. So not really pictured as doing the actual nursing.

Sammy saw that men's representation in the general curriculum was around keeping safe when faced with the risk of allegation.

> **Sammy:** To be honest the only recognition of men in nursing was around things like professional safety, so as a male nurse, protecting yourself and your patients in terms of certain procedures or situations and circumstance you find yourself in. So making your patient comfortable and safe, and making yourself safe from allegations of inappropriate behaviour.

Conversely, Caleb felt underprepared for situations that may arise for him as a male.

> **Caleb:** I think a lot of the girls are told to look after themselves in terms of things like sexual harassment and stuff like that, but I don't really feel like that was addressed for me as something that I needed to look out for.

Another common theme was that of men having a different learning style than females. And that the current curriculum design does not attempt to bridge this due to their low numbers.

> **Caleb:** Men and women's styles of learning and working can be quite different. I think because there is so many girls coming through, it's kind of treated as the standard, and men might need different supports or a different way of approaching things.

> **Ian:** A lot of the pedagogy didn't incorporate a lot of gender specific things, and it was more implicit that as there is so many females, that you are going to have maybe feminine influences.

Pete goes into more specifics regarding his preferred method of learning.

> **Pete:** I always enjoyed the hands-on practical situations and scenarios, so where you do something then give feedback on what you've done. It was always a lot more easier to analyse something tangible, something physical that you could touch, see, hear, taste. And there wasn't always a lot of that, and you were often just sitting in a group talking or chatting, and I just got very bored very quickly and tuned out.

Ben reiterates this when discussing possible reasons men may withdraw early in the degree.

> **Ben:** Maybe it's because the 1st year is really theory orientated, and I don't know, traditionally guys like getting their hands into it physically. So maybe the practical aspect of it might get them a bit more interested.

Skewed expectations

When discussing the expectations placed upon the male nurse and student, responses were mixed. Several participants felt clinical staff and colleagues had higher expectations of their knowledge, skill and ability. Ian speaks his situation at the beginning of his new graduate year, where he should have been mentored, but where his preceptor went on leave due to injury.

> **Ian:** I don't think anyone thought to allocate me a new preceptor, and I didn't really advocate for myself, I just thought 'yeah I can just go with the flow'. Which I did, but I didn't really get any consistent feedback or targeted improvement.

It is difficult to ascertain whether Ian was 'left to it' because he was a male, or perhaps he was deemed competent by his superiors. Rob underscores this uncertainty.

> **Rob:** As soon as you went into any placements you were automatically singled out, as being someone that would have, not a better work ethic, but would be more knowledgeable about their job. And they were always keen to teach you and always keen to train you. But I don't know whether that was because I'm male or because of the person I am.

While Ben is not afraid to advocate for himself, he speaks in general regarding the reluctance of males, and particularly younger males to seek guidance and support.

> **Ben:** As a whole, we are a little bit stubborn. And again it depends on the person. I mean I'm not scared to ask for help or anything. But there are a few of the males who have come through, who are a couple of years younger than me, they find it very hard to ask for help.

Rob referred to the detrimental effects of high expectations in the acute setting regarding his peer during clinical placement.

> **Rob:** He was expected to be doing so much more than what he was. He's actually a quiet and reserved person. And he went and did a placement in ED, and because he was so quiet, he was deemed to be incompetent.

The question is, would a quiet and reserved female student in this scenario be deemed incompetent? Shane makes a similar observation.

> **Shane:** People just expect you to be really smart, and have this amazing clinical knowledge, that is one thing I have felt quite a lot. Like even during the degree when you were on a ward, if you didn't know something you felt like everyone was like 'oh... you should know that' and I was like 'why?!'

A common theme expressed by participants was the notion of being handled too delicately and being deprived of honest feedback.

> **Sammy:** One of the things I found was that I got really great feedback, and sometimes I found myself doubting whether it was based purely on how I was performing, or was some of it wanting to encourage me continue as a male in nursing. But I felt like I needed to be made extra welcome and extra encouraged.

> **Ian:** I've always thought maybe people treat you too preciously, they want to make sure none of the males leave or something, so I'm sceptical of praise, you just want to make sure you keep males on the ward, that kind of thing.

Regardless of kind-hearted motivations, not providing honest feedback and targeted learning objectives could be detrimental to long-term confidence and competence. Some participants also spoke of low expectations of men coming from female RNs.

> **Caleb:** I mean I was a patient last year, and I had a nurse tell me that all male nurses are lazy and useless!

Ian diplomatically hypothesises that these attitudes are attributed to ingrained gender roles, which theoretically may excuse men with a more 'laid-back', or possibly even a lazy work ethic.

> **Ian:** I can't really tell fully if there's a problem, or an attitude towards male nurses, it's probably said very privately, and not around me. And I wouldn't detect it, those kinds of people might be really nice to me, but might be thinking 'oh god typical male nurse, didn't do this or do that, or left the room a complete mess' …they've all got husbands so they have this perception of men in general. And maybe it places the advantage of the fact they're not expecting much (laughs).

In terms of high expectations, several participants made it clear that during training, the ongoing rhetoric was that they would gain rapid employment upon graduation due to their maleness. However, upon graduation this was not always the case.

> **Shane:** I missed out on the new grad programme at the hospital.

> **Caleb:** I remember all through my degree hearing 'you're a guy you'll get a job just like that' and that didn't really work out for me.

Whether expectations are high, low or not communicated, Rob reaches a fitting conclusion regarding the potential ramifications of standing out.

> **Rob:** If we stand out and do a good job, we stand out for all the good reasons. But if we don't… by god we stand out for all the bad reasons and we're stuffed!

Perks and promises

Many advantages and drawcards of being a male nurse were discussed, such as the promise of job security and career diversity within nursing.

> **Sammy:** There is a huge range of careers available within the one qualification, and you've got huge flexibility to go overseas.

> **Ian:** I did also understand that going into the course, that nursing would be least likely to be replaced by technological advancements, you know truck drivers and all sorts of work is going to get thrown out by automation.

Ian's comments are of intrigue, as he is referring to the future security of traditionally masculine occupations. Peter compares nursing to medicine regarding geographical stability and training expectations.

> **Pete:** We see doctors and registrars every six months jump from hospital to hospital, there's not really job security you're always looking for the next best thing, 'what else can I learn, where else can I go?' I have a job that is secure, I know where I'm going to be tomorrow, I know where I'm going to be next year if I choose to still be there.

Career expediency was also closely aligned with maleness by some participants both within the under-graduate and post-graduate context.

> **Rob:** And I think as a male, if you are competent and confident you will transition up the ranks fairly quickly, as per my example. I have been offered more than one job in different areas since I've been here, just through people I have met.

> **Ian:** As a student I actually kind of felt promoted as a male, like a nurse kind of got in trouble for trying to guarantee me a job, where she was really eager to keep me.

Shane, an RN working in primary care, felt his colleagues and patients viewed his minority status at the practice as a curiosity that had positive implications for him.

> **Shane:** There is a lot more interest, as you are that anomaly in the workplace as there was the female nurses, then all of a sudden there was a male there. And that was across the board too so that was from the female GPs and the male GPs. They were just super interested in what you were doing and what you were going to do, and how they can help you get there. Going into primary health, it was just a strange thing to everybody. So you'd turn up to this GP practice and

> everybody was just like ‘you’re a nurse? Sweet I’m going to come see you?’ So you’d have this big influx, and I just got all of the guys who were coming in for a chat. Then you’d just have everybody going ‘oh we will go see what this male nurse is like’.

Rob, Ian and Shane have each provided personal examples of how the glass escalator of career expediency may favour men due to their minority status. Or perhaps it could also be argued, that they are three competent and therefore promotable RNs.

4.4 Off the public radar

Nursing scope an unknown

A universal theme that surfaced from all nine participants was more men would be drawn to nursing if they had an accurate awareness of what nursing entails in the 21st century. For example, several participants referenced nursing’s gendered position.

> **Pete:** We view nursing as this lovely pretty lady who dances around on a ward and showers people.
>
> **Shane:** For me working in the trades you always thought, it wasn’t really a man’s role, that’s what females choose to do.
>
> **Ian:** I would have never suspected nursing for me in my teen years. I probably would have thought it was only for girls to be honest.
>
> **Caleb:** I know when I was at school, nursing was never really something that was presented as an option the same way other careers are, such as medicine or physio.

Here, their prior constructs of what they thought nursing was are deeply ingrained with societal gender roles. Moreover, Steve adds the external pressures he faced from his family.

> **Steve:** I know I had it from my Dad and my grandmother, ‘it’s not a real job’. A generation ago it was a woman’s job. I got asked about nine times during my training ‘is this *really* what you want to do?’

Ian goes further and unpacks the connotations of the word ‘nurse’.

> **Ian:** Socially and linguistically, we have the word ‘nurse’ which means feeding a young one, so breastfeeding and things like that. So it’s really embedded quite deep when you look at it at that level.

Ian’s interpretation is the incongruency with the nurse and all things masculine. Caleb comments on the possible incompatibility between nursing and the iconic image of the New Zeeland man.

> **Caleb:** I think we are moving away from it now, but I think, there is quite a typical image of the bloke in New Zealand, and nursing doesn’t really always fit that stereotype.

Concerning these social constructions, participants also mention the devalued nature of nursing within the public eye, while providing solutions to combat this.

> **Ian:** Maybe just avoiding the issue of nurses as the doctor’s assistant, as it’s still promoted like that. And I think you need to erase the more nurturing stigma.

> **Rob:** It’s not well recognised that nurses are qualified as they are. To get guys to stay and make the undergraduate degree more attractive. I would be pushing them into some of the more specialised areas, and not so much into the general field, because of the perception of nurses being handmaidens. So spending a week in the first year going around specialised areas and talking to nurses, and talking specifically to male nurses who work on the floor, so they can learn the different pathways you can go down.

Sammy reiterates Rob’s comments regarding attrition and the first-year experience.

> **Sammy:** The ones who dropped out maybe liked the idea of nursing, but the reality once they were in clinical and in training wasn’t what they expected.

Most participants agreed that as a young male in school, that nursing was never within their awareness as a feasible career possibility. They were keen to offer some strategies to capture younger men’s interest. Rob provides some background commentary when asked why more men do not enter nursing.

> **Rob:** Ignorance. I don't think they quite realise the potential you can have once you get into nursing. Before I started nursing, I didn't realise how many different fields you can get into, because it is not publicised. I counted it one day you can get into about 150 different streams of nursing, and that's just not well known out in the general public.

In line with this, participants were especially emphatic with promoting the scope and possibilities of nursing. Ben and Tim suggest using various forms of media campaigns.

> **Ben:** If you can get them when they're young it's a lot easier. The biggest moment is when someone is still at school and they're thinking about that pathway to choose afterwards. Could be like ads, or maybe national campaigns or something like that. Little weird ads in between your videos on YouTube or something. I think social media is going to be the bigger platform to get more interest.

> **Tim:** I know there is a lot of work going on in the Police to increase female numbers, and I think that would be effective for nursing as well, having the exposure of a male nurse.

Caleb on the other hand, speaks of his experience engaging with nursing programme promotional material and what could be improved.

> **Caleb:** A lot of promotional material doesn't really seem to factor men in terms of advertising nursing degrees. I did look through a few different providers before I started. I think it would be good to have more male representation in the promotional material by the uni, I mean I helped out at the open days when I was at *name of university* so, encouraging the male nursing students to get involved in that sense.

Ben and Pete both put forward capitalising on promoting specialities, or the islands of masculinity that men frequently dominate.

> **Ben:** You've always got the career days and stuff like that at school. I think maybe, trying to promote the areas in nursing that are more kind of male-dominated I suppose.

> **Pete:** We see probably the vast majority of male nurses who graduate, like you go down to ED and there is always loads of males down there, and the same with theatre. Maybe we need to promote those areas more. And that's not to say push women out of them, but if that kind of work is attractive to men, let's push it to them.

Ian agrees with this approach, but also points out the irony.

> **Ian:** if you want to get guys, go for the more technical action-packed stuff. And that's trying to address a stereotype with another stereotype of course!

Gender roles dominate

The men in this study made frequent reference to assumed gender roles that they encountered in clinical practice. Ian and Pete mention their feelings about being over utilised for physical tasks due to their maleness.

> **Ian:** Female staff will come up to me and say 'Oh Ian I need your muscle', and I'm not a big dude, I'm pretty average height and stuff and it's like 'are you just saying that so I'll feel like a big strong man or something?' I mean, you wouldn't say that to another female staff you know.

> **Pete:** It's not ok for you to use me as a manual labourer because I'm not a manual labourer, I'm a nurse!

Steve also discusses being used for his presence to de-escalate aggressive patients, although he is hesitant to attribute this entirely to his gender.

> **Steve:** You were kind of crowd control as well. You were getting sent into there to calm things down etc. Especially if they were an aggressive male …But I'm also quite a chill person as well, so that may have had something to do with it …But we also had other chill nurses on the ward too, but they kind of stayed clear so the male thing probably had quite a bit to do with it.

In Sammy's situation in his new graduate year, having an equal gender ratio in the mental health unit had its benefits.

> **Sammy:** Working in a mental health intensive care locked ward, the physical danger was there quite often. And you certainly felt a lot more settled and safe when you had an even mix of men and women working.

Another common theme was that of the assumed doctor, or where patients, staff and others felt being male contradicted the nursing role.

> **Ian:** Despite the uniform, and especially the older people, they see me with a stethoscope around my neck, and ask if I'm a doctor.

Or the assumption that nursing is merely a stepping stone to medicine, or perhaps implying that the male nurse is a failed medical student.

> **Caleb:** Now and again people sometimes ask if I'm going to pursue medicine, or why I didn't pursue medicine in the first place. I just had to explain that nursing is kind of what interested me.

> **Shane:** So I've had quite a few people ask 'when are you going to finish your training and become a doctor?' Usually I just laugh as I find it quite funny it's like 'oh you know, just because I'm a guy doesn't mean I want to be a doctor'.

> **Pete:** I've even been asked it by a few doctors, where they will turn around to you and say 'you're a guy why did you do nursing?'

Peter and Tim discuss the constant need to reassure people and defend their position that they chose to nurse, and did not fall back from a pursuit of medicine.

> **Tim:** There is the constant expectation that one day I'll try to become a doctor. Or just constantly asked 'why nursing?' Or I feel like people need to give me reassurance that I made the right decision. Almost like they feel I wouldn't be happy with my decision.

> **Pete:** When you get mistaken for a doctor, there's almost like a negative push-back from some people like 'oh you're a nurse you're not good enough to be a doctor?' So that kind of attitude "oh why aren't you a doctor? Why would you want to be a nurse? And my father in law asks me when I'm going to finish my doctor training all the time. He's a typical New Zealander; woman equals nurse, man equals doctor.

Indirectly relating to this, Shane adds insight regarding the expected career trajectory of the male nurse.

> **Shane:** A lot of peoples thoughts around what I should do with my career stem towards clinical nurse management or NP, and those are kind of the only two things, so your either going to be in management, or a specialist by yourself, and that's kind of the only two roles they talk about for a male.

Pete added commentary where he thought male nurses are positioned within the hierarchy of medicine.

> **Pete:** I think maybe men get a little bit more respect from some of the doctors, and I don't want to say you are part of a boys club, but I think traditionally men hold more respect and aren't really going to be walked over, as traditionally nursing is seen as subservient to doctors, and that is changing. Where the majority of nurses, male or female will stick up for themselves, but there is another level of respect shown to men, just because they are men.

Caleb emphasises Pete's point but also speaks of patient attitudes towards male and female nurses.

> **Caleb:** It might seem like an unfair advantage but, I kind of feel as if, that some of the younger female patients I work with do face a bit of sexism from male patients, or even male staff at times that I don't feel like I face much really. I think there is kind of an inherent level of respect that is afforded to some men.

It is remarkable that both Pete and Caleb both mention an 'inherent or another level of respect' shown to men that sits outside of professional hierarchical structures.

Knowing nurses

When asked to explain their journey towards nursing, it became evident that all participants were channelled into nursing via the influence of people in their everyday lives. Some grew up with parents as nurses, meaning nursing was their norm from a young age.

> **Caleb:** My mum's a nurse as well. So I kind of grew up seeing what she did and what it was about, so that peaked my interest.

> **Tim:** With Mum being a nurse, it was always in the back of my mind, so I was brought up with that caring and empathetic mentality.

For Ben and Pete, their exposure to nursing was born of personal experience of being a patient, or from involvement with the care of a loved one. These experiences seem to promote a more altruistic attraction to nursing.

> **Pete:** I've unfortunately been in and out of the health system myself …So being in and out of hospital, I really wanted to kind of give back.

> **Ben:** My grandad had a stroke, well he had a couple of strokes and every now and then he'd come out to the farm and we'd look after him …So getting his stuff kind of sorted sparked a bit of interest there. Yeah I like the idea of helping people out and yeah it was good, it felt like a good purpose.

For others, it was exposure later in life from partners, friends and colleagues that caught their attention. This was especially true for Shane and Sammy who entered nursing as a second career.

> **Shane:** When I met my partner she was studying her nursing degree. So I got to listen to what she was doing everyday, and had a few mates who were nurses which sort of got my interest up on it.

> **Sammy:** There was a nurse who worked on our ski-patrol and was doing the ski patrol part time in winter. So we had a medical clinic on our ski field where we worked quite closely with nurses.

Rob and Steve speak of their pathway into nursing being fostered by male nurses in their lives who they regard as mentors. Rob refers to a male nurse who works contracts in the Australian outback.

> **Rob:** I have a friend who has been doing that for 12 years. He was one of my mentors before I started nursing, and in fact he's one of the reasons I even started nursing.

> **Steve:** Talking to one of my mum's friends, he was ex-police who went and worked in the mental health aspect of nursing. We get along really well, so we were having conversations around where to go, and career choices etc. And he was one of the people who actually convinced me to go into nursing. And that was an interesting experience because he's an interesting character and he's not what you'd expect for… well for a mental health nurse I suppose he is what you would expect!

Steve's final comment here is salient, as he is perhaps connecting the custodial nature of police work with the societal construct of the male mental health nurse.

Nursing is for men

All participants provided relatively consistent response when queried which speciality or aspect of nursing excites them. Several spoke of thriving in autonomous roles and enjoying the challenge of the unpredictable.

> **Rob:** You don't have the back up of lots of people to call on, or you've got to really think hard. I quite enjoy the levels of support you don't have …Yeah the pressure and thinking on your feet.

> **Caleb:** I'm quite keen to get into an area like ICU or ED ...the appeal of places like ED is quite a flexible workload, and you have to think on your feet a lot of the time.

> **Pete:** And ED's the same, constantly people are coming through needing resus, and you never know what you are going to get.

Relating to this, Ian outlines a hypothetical promotional scenario that could showcase the adrenaline factor of these areas of nursing.

> **Ian:** You would have to promote its military roots that it has, so the discipline and intelligence, and the action behind it. Because the current stigma is that 'nursing' implies a whole lot of warmth and caring and breastfeeding, so things that dudes don't do. So you'd have to make it more like 'shit! Here comes a guy

> on a stretcher who's bleeding out and we gotta patch this up and chuck this bag of fluids in and correct the hemodynamic'.

It is noteworthy that Ian suggests shifting away from the everyday nursing discourse of caring. In connecting with the military roots, Sammy's future aspirations are also fitting.

> **Sammy:** I'd really like to do some disaster relief or deployment type nursing.

Sammy also observes that perhaps the adrenaline factor and having autonomy are natural male attributes.

> **Sammy:** Among the men we all were pretty keen on doing mental health, ED, or ICU. It's a bit more of an exciting and adrenaline filled role. And there is a higher degree of autonomy and uncertainty …And it just felt with natural characteristics that I felt I had, and that potentially a lot of males might have.

For Ben, teamwork, a common goal, and a flattened hierarchy were prized aspects of nursing, but it was also something he did not take for granted.

> **Ben:** I like the teamwork in it. It's a very kind of, multi-disciplinary team environment. So like through our new grad year, you hear about how your other class mates are going on the wards. And there is a huge separation between the different specialties, like you're nurses and then, you're registrars and you're consultants and all that. In theatre there's a unified… I don't know, it's just a nice teamwork environment. You know we are all there for that patient. I feel comfortable talking to the consultants on a personal and professional level. Whereas I don't think you'd get that experience or opportunity on the wards.

A common consensus across most participants was that as men, the technical or practical aspect of nursing was a prime attraction. And that this preference may push men into certain specialities.

> **Ian:** Males tend to deviate towards technical roles like ICU and things like that. In terms of my gender being a male nurse, I think I'd love to, especially if I was younger, I think I'd be in ED right now. So some kind of technical area.

> **Steve:** At the time I was looking at a half practical half lab kind of job, which nursing I have since found out has some aspect of that. Where I am now is

> absolutely brilliant (theatre) as I get the best of both worlds. Yep. I'm the go-to tech guy in my department at the moment.

While Ben also enjoys the technical aspect, the immediate results of theatre nursing also provide him satisfaction.

> **Ben:** Orthopaedics is kind of where my heart is. And like just being able to help physically put those pieces back together I think, you know it's real hands-on and immediate. Whereas you could be nursing someone for 4-5 weeks and you might not be sure if there has been much of an improvement.

Pete compares his theatre position to his role before nursing, and comments on the somewhat transferability of previously learnt skills in a male-dominated occupation.

> **Pete:** I used to work for *name of family member* installing heat-pumps. And I would always swear to him black and blue that I'd never be a tradesman in my life, I'd never work with tools, and I hated it and never enjoyed working with them. But everything I learnt from him, I do in theatre, I put drills together, I'm putting screws in plates. It might not be heat pumps, but it's such a hands-on practical job.

Several participants conclude with some strategies to promote autonomy and the technical qualities of nursing to men. Rob also suggests that these qualities may align to innate male attributes.

> **Rob:** Get out there and show them how technical it is. Show them where they can go and what they can do. Appeal to the engineering and mechanical side of guys, and the more hands-on in terms of specialising.

> **Pete:** I think publicising a bit more that there is ED, theatre, interventional radiology, cardiology. There is so many places to go if you want that hands-on stuff.

> **Caleb:** Nursing has undergone a lot of change over the last few decades, and it has really progressed to a really autonomous career. I think just raising the profile of that in public.

When considering the technical nature and excitement of high acuity areas, most participants agreed these should be promoted to males, to improve male recruitment.

4.5 Summary

From this study, homosexual stereotyping and stigma relating to their intentions to be nurses were still issues some of these nurses faced throughout their training. To mitigate this, having more male mentorship from faculty and clinical preceptors, as well as having the chance to debrief with other male students was something that could form more robust support systems and foster resilience. Creating curriculums that were more generally inclusive of men in nursing was also seen as a priority, especially in terms of incorporating males learning styles. Realistic and equitable expectations of males were also desired, as well as honest formative feedback. To attract more males to nursing, participants felt the need to promote the diversity and stability of nursing, and to promote specialities that traditionally attract men. These specialities were more likely to appeal to male attributes due to their technical nature, as well as the excitement and unpredictability of the work. Participants also spoke of the need to expose male students early in the degree to the scope and breadth of nursing to stave off attrition.

Chapter Five: Discussion

5.1 Introduction

Identified in the findings were two overarching and interconnected themes; *an isolated position within,* and *off the public radar.* Emanating from these were a further nine sub-themes. While many of these themes had negative ramifications for male students, they were not always without benefits for these nine men. This discussion chapter explores the significance of these themes in light of contemporary literature. The chapter concludes the strengths and limitations of this study, the recommendations for practice, and future research opportunities.

5.2 An isolated position within

Stigma and stereotypes prevail

The societal construction of 'the male nurse' is heavily influenced by the mass media (Bartfay & Bartfay, 2017). This research found that participants and those external to them faced negative media stereotypes, with a predominant theme of assumptions of sexuality. This view was congruent with the literature, where male nurses in television and film were portrayed as gay or effeminate (Bartfay et al., 2010; Bartfay & Bartfay, 2017; Harding, 2005; Raymond et al., 2018; Stanley, 2012; Weaver et al., 2014). Other media stereotypes that provoked discomfort portrayed male nurses as having psychotic tendencies, having a more custodial role, or just generally as oddities (Bartfay & Bartfay, 2017).

While often dismissed, the influences of these stereotypes cannot be ignored, as they often cast male nurses outside of the conventional heteronormative constructs of masculinity (Weaver et al., 2014). These negative and out-dated portrayals not only diminish the credibility of male nurses, but can be discouraging and dissuasive for men considering nursing as a valid career choice (Bartfay et al., 2010; LaRocco, 2007; Powers et al., 2018; Stanley, 2012; Weaver et al., 2013). Weaver et al. (2014) even

suggests these media portrayals are partly responsible for the low numbers of male nurse recruits.

For those students who battle through these media constructions, many may still receive ridicule regarding their sexuality from friends or acquaintances (Christensen et al., 2018b; Juliff, 2017; Juliff et al., 2016). Some participants even discussed their world-view, where they assumed all male nurses were gay due to narrowed childhood schemas (Jamieson et al., 2019). Participants in this study were reasonably resilient toward these stereotypes. However, some did mention that perhaps nursing went against the grain of the 'typical kiwi bloke' (Bannister, 2005). The tension of living within a heteronormative society and existing in a feminine occupation could arguably create the need to emphasise one's masculinity (Bartfay & Bartfay, 2017; Christensen & Knight, 2014; Harding, 2007; Jamieson et al., 2019).

One convenient way to preserve masculinity would be for the male to position himself into specialities such as ED, ICU, perioperative, or mental health, where men are generally more visible (DeVito, 2016; Harding, 2005). Yet over half of the participants were working, and thriving outside of these islands of masculinity (Harding, 2005), in areas such as medical/surgical wards, aged care, and general practice. This finding is in line with New Zealand statistics that show men are beginning to diversify their choice of speciality (NZNC, 2016).

Another consideration of these male normative specialities could be the view that they are 'low touch', due to a higher requirement for technical or psychosocial nursing interventions (DeVito, 2016; Harding, 2008; Marks & Bevan, 2013; Schmidt, 2016; Tuckett et al., 2016). Yet none of the participants in this study explicitly stated this as a reason for their current speciality. Implicitly and explicitly, some were made to feel that men do not belong in nursing, yet in contrast to the literature, none reported being actively excluded away from female-focused clinical placements, such as obstetrics or gynaecology (Anderson, 2014; Christensen & Knight, 2014; Harding, 2008; LaRocco, 2007; Maykut et al., 2016).

Most participants were comfortable with having their care refused by female patients. But many stated they had minimal preparation to nurse females in training, and that the risk of accusation of inappropriate touch, or sexualised behaviour was an ever-present concern (Bartfay & Bartfay, 2017; Harding, 2008; Jamieson et al., 2019; Juliff, 2017;

Maykut et al., 2016; Powers et al., 2018; Rajacich et al., 2013). Participants additionally expressed that they applied even more caution with younger female patients, or those of a different culture (Juliff et al., 2016; Whiteside & Butcher, 2015).

During personal cares or procedures with females, all participants were comfortable with the use of chaperoning or requesting female RNs to take over if they felt unsafe (Whiteside & Butcher, 2015). Yet some felt a double standard existed, that if a doctor were doing the same procedure, a chaperone seemed less of a requirement (Christensen & Knight, 2014; Harding, 2008; Rajacich et al., 2013). Others felt that irrespective of gender or position, a chaperone should consistently be used in all situations (Whiteside & Butcher, 2015). Of significance, one participant also actively felt male nurses should not be performing such procedures, but it was ok for male doctors as it was 'part of their job'. This participant may have internalised the stigma around men's intentionality of care, and their position within nursing, which may signal toward the devalued status of nursing compared to medicine.

Another area of concern pertained to the male students experience within the laboratory environment. Due to their minority, several participants reported being forced into an awkward position during physical examination simulation labs. Here they allude to the apparent discomfort of their reluctant female lab partner. Anderson (2014) writes of a similar scenario, but infers the male himself experiences the discomfort. In contrast to other studies, none of the participants stated they were utilised as live topless mannequins for demonstration purposes (Anderson, 2014; Bartfay & Bartfay, 2017). Similarly, another participant sensed that having his female classmates being aware of his relationship status, protected him from an assumption he was in nursing with an ulterior motive, and thus allowing him to form genuine friendships. This was echoed in a study by Christensen and Knight (2014), where male students felt the stigma of having predatorial tendencies when forming friendships with female class peers.

To further head off constructed stereotypes, planting the proverbial seed may be required that would inform young people that men not only merely exist, but thrive in nursing. Strategies to mitigate negative media portrayals need channelling through recruitment materials that showcase positive and realistic imagery, messages, and examples of excellence from male nurses (Carrigan & Brooks, 2016; Stanley, 2012). One avenue could involve exposing secondary school students to nursing in a way that

celebrates its autonomy and diversity (Stanley et al., 2016). Rather than pedestalling men, the focus here needs to be the scope of nursing in the 21st century (Raymond et al., 2018), where men are portrayed equally to females in terms of visible presence.

Providing a more gender-balanced image of nursing to younger audiences, such as those in primary school or pre-school, could be valuable. Doing so may counter the formation of stereotyped schemas in young children, and may also alter the way they evaluate and process gender roles more generally (Jamieson et al., 2019; Wilbourn & Kee, 2010). This would be positive not only for male nurse recruitment, but for the profession as a whole. As seeing equal representation within nursing may help children re-conceptualise gender norms, and boost the status of this traditionally female occupation, while also addressing the formation of ambivalent sexism (Clow et al., 2015).

Within these 'seed planting' exercises, careful consideration should be given to the way male nurses present themselves, or their representation within multi-media. Here, uniforms, scrubs or apparel should be gender-neutral or gender-specific (Carrigan & Brooks, 2016), rather than the frequently observed male nurse or student wearing feminine tunics with back-pleats. As seeing male nurses forced to wear more feminine styled uniforms only serves to paint the picture of an un-accommodated minority.

In light of stereotypes and stigma, male students may require more equitable support from nursing school faculty. Class-wide discussion regarding the socio-historical constructions of gender roles may be beneficial earlier in the degree (Entwistle, 2004; Harding, 2007; McKinlay et al., 2010). Springboarding from this, more male-focused topics could be facilitated, such as preparation regarding touch, personal cares, and chaperoning when nursing females (Juliff et al., 2016; Meadus & Twomey, 2011; Whiteside & Butcher, 2015). Here, the aim should be the provision of culturally safe care, but where male students are empowered to develop strategies to safeguard themselves in clinical practice.

From a faculty standpoint, strategically placing men together in class groups could foster reliance and support for the male minority (Anderson, 2014; Christensen et al., 2018b; Entwistle, 2004). Also, by doing so during physical assessment lab groups, males would have the option to partner together. This would circumnavigate the potential for mutual awkwardness of having no choice but to pair with females.

Missing in action

Akin to the literature, all participants found themselves a part of the minority during training. What is notable however, is their numbers were under that of New Zealand's nursing 9% gender ratio, with some participants being the only male in the class (NZNC, 2018). It remains a challenge to ascertain New Zealand's number of male student nurses training, but these participant's experiences appear consistent with the broader literature. Further, most participants stated that the rate of male attrition they observed was proportionately higher than their female peers (Bartfay & Bartfay, 2017; Maykut et al., 2016; Sasa, 2019; Sayman, 2015). While male participants often sought out each other, those without the option found support and friendship with older female students or those who shared a similar background. Yet one younger participant spoke of feeling 'mothered' by the mature female students. While well-meaning, this may impact on self-efficacy and confidence.

While stigma, stereotypes and constructed gender roles can impose a personal barrier to recruitment, external factors may also exist. In line with the literature, several participants provided accounts of school career advisors who were either under supportive, or unprepared to provide direction for a nursing career (Bartfay et al., 2010; Bartfay & Bartfay, 2017; LaRocco, 2007; Meadus & Twomey, 2011; Neilson & Jones, 2012). One notable point of difference, was that careers advisors from single-sex schools were even more reluctant to foster an interest in nursing.

Another finding was that once enrolled, all participants noted a lack of males amongst the teaching faculty (Clifton et al., 2018; Gedzyk-Nieman & Svoboda, 2019; Juliff, 2017; Rajacich et al., 2013). Participants were also hyper-aware of the absence of male role models while on clinical placement, particularly outside of mental health (Carnevale & Priode, 2018). Many commented that having an increased presence of men in the clinical and educational setting from day one would decrease feelings of isolation (Bartfay et al., 2010; Meadus & Twomey, 2011). Additionally, having more male teaching staff could enhance the institution's responsibility toward increasing the number of male students through targeted recruitment and mentoring (Clifton et al., 2018).

Participants agreed that having a more equitable male presence during their training could offer more focussed interventions. Several felt a longitudinal male-to-male

mentoring programme would be useful, where students could access one person in a pseudo clinical supervision role throughout training and beyond (Carrigan & Brooks, 2016; Lim & Sanchez-Vera, 2013; Powers et al., 2018; Younas et al., 2019). Here, experiential insight could offer tailored support for more sensitive scenarios, or to foster strategies for communication and conflict resolution (Christensen et al., 2018a; Clifton et al., 2018; Sayman, 2015; Sedgwick & Kellett, 2015; Younas et al., 2019).

Placing men together in clinical placements, class streams, and sim-lab groups would mitigate isolation (Anderson, 2014; Entwistle, 2004; Meadus & Twomey, 2011). Doing so may facilitate more open peer reflection and debriefing that males may feel less comfortable doing with female peers (Entwistle, 2004; Sayman, 2015; Sedgwick & Kellett, 2015). Also, male faculty staff could be called upon to initiate and support this comradeship via the formation of male support groups (Anderson, 2014; Christensen & Knight, 2014; DeVito, 2016; Juliff et al., 2016; Kronsberg et al., 2018; Maykut et al., 2016). These groups should include students from all years, as those close to graduation may value mentoring 'greener' students (DeVito, 2016; Maykut et al., 2016). For similar reasons, and where possible, Powers et al. (2018) also suggest pairing male students with male RN preceptors.

A feminised curriculum

All participants shared the view that the content and delivery of the undergraduate degree remains largely female-centric (Christensen & Knight, 2014; Juliff et al., 2016; Sasa, 2019). Within the taught theory, they all reported a complete absence of men's historical and theoretical contributions to nursing. While widely reported, this omission does not reflect the reality that men have been part of nursing since the pre-Christian era (Bartfay & Bartfay, 2017; Carrigan & Brooks, 2016; Christensen, 2017; DeVito, 2016; Evans, 2004; Marks & Bevan, 2013; Sasa, 2019). The only prominent nurse of any gender recalled by participants was Florence Nightingale, suggesting that a more diverse inclusion of male *and* female historical figures is needed (Carnevale & Priode, 2018; Lim & Sanchez-Vera, 2013; Rajacich et al., 2013). Many participants also felt the curriculum needed bolstering to offer a better balance between male and female-specific health considerations and health promotional activities.

Within study material and text-books, how males were visually represented was also noted. Participants stated males would play the subject or the patient, while the person performing as the nurse was usually female (Carnevale & Priode, 2018; Carrigan & Brooks, 2016). Underscoring this, discourse within study material, lecture content and general class discussion may require careful attention to remain gender-neutral. One solution is that when referring to nurses *or* doctors, the pronoun 'their' should replace 'her, him, he or she' (Anderson, 2014; Bartfay & Bartfay, 2017; Carrigan & Brooks, 2016; Powers et al., 2018).

Differences in learning and communication styles between male and female students may also remain unacknowledged during curriculum design (Anderson, 2014; DeVito, 2016; Maykut et al., 2016). Participants felt that due to low male numbers, this would be a low priority, or is just not on the radar of faculty and teaching and learning consultants. Yet male participants craved more practical 'hands-on' simulated learning. They also felt that front-loading excessive theory and reflective activities, which they viewed as a more female focussed pedagogy, might be a cause for male attrition early in the degree.

Curriculum design does not deliberately exclude male interests and learning styles; it merely occurs as men are not the typical customer. Nevertheless, the prevention of male attrition should be a priority. At present, the majority of nursing faculty and clinical staff members are female. Therefore it may prove valuable that staff undergo awareness-raising education to highlight the potential vulnerabilities of male students (Maykut et al., 2016). For female teaching staff, this process could address and mitigate overt or subtle bias that may occur in educational content and delivery (Meadus & Twomey, 2011; Powers et al., 2018; Rajacich et al., 2013; Sayman, 2015).

Skewed expectation

Participant's unanimously agreed that the expectations of them during their training differed from their female peers. For example, during clinical placements, participants experienced higher expectations from clinical staff in regards to knowledge, skill and ability (Dyck et al., 2009; Powers et al., 2018). Several also felt increased expectations from nursing and medical colleagues within their new graduate year. Here, instead of

experiencing the support from a preceptorship programme they were entitled to, some felt they were ‘left to it’ and just had to step-up (DeVito, 2016; Maykut et al., 2016; Sasa, 2019). It is difficult to ascertain with complete certainty whether these expectations were due to genuine competence, or their maleness. But participant’s did suspect their gender was an influencing factor. Within this scenario, males were less likely to seek assistance or advocate for themselves (Maykut et al., 2016).

In contrast to the literature, participants felt less expectation to perform within the classroom setting. Several studies reported that lecturers often singled out male students leading to un-warranted pressure and anxiety (Bartfay & Bartfay, 2017; Meadus & Twomey, 2011; Powers et al., 2018). A reason for this could be due to the simple fact that men’s names were easier to recall (Christensen & Knight, 2014). It is also pertinent to note that their absence from class would be highly evident to teaching staff, further compounding anxiety (Anderson, 2014). Participants in this study however, mainly felt pressure within clinical placements, where many spoke of unfair scrutiny and a double standard from clinical tutors due to their gender (LaRocco, 2007; Rajacich et al., 2013). Here, if males did not meet heightened expectations due to being reserved or less out-spoken, they would be deemed incompetent.

Conversely, participants also sensed low expectations of male nurses and students from female RNs, where men were perceived as lazy. This is congruent with the literature, where men may be stereotyped toward being less inclined to participate in the ‘domestic’ side of patient care, such as keeping the bed-space tidy (Gedzyk-Nieman & Svoboda, 2019; McKinlay et al., 2010). As one participant stated, he felt pigeonholed in the ‘lazy husband’ category. This attitude may be therefore benign and born of projected gender roles within the traditional marriage structure. What is concerning however, is that this construction of ‘how men behave’, could deprive males of honest feedback, or even enable them to get away with providing substandard nursing care.

Several participants also stated they frequently missed out on truthful constructive formative feedback from faculty and clinical teaching staff. The reason cited for this was the need to retain men in the programme. Yet they did not seek preferential treatment as this led to uncertainty regarding their progress and confidence, as there was a sense of being left to ‘wing it’. These men also resented the notion that the ‘job was in the bag’ once they graduated (Christensen & Knight, 2014; Christensen et al., 2018b).

For these reasons, there was often a strong drive to prove oneself through academic success to combat assumptions of male privilege (DeVito, 2016; Dyck et al., 2009; Sasa, 2019).

Perks and promises

Male students are not guaranteed instant employment upon graduation for merely being male. But what is evident is that once employed, participants were aware they are more likely to advance up the career ladder more rapidly than their female counterparts (Christensen et al., 2018b; Harding, 2009; Maykut et al., 2016; Muench & Dietrich, 2019; Wilson et al., 2018). Having minority status may also provide positive experiences within the clinical setting. In contrast to other studies however, participants did not value this position in terms of shoulder-tapping and preferential hiring (Christensen & Knight, 2014; Maykut et al., 2016; McMurry, 2011). What they did value, was their minority status opening up more learning opportunities (Carnevale & Priode, 2018). Several attributed this to being seen as a curiosity from not only colleagues and clinical staff, but by patients themselves, who were very willing to be the patient of the sole male nurse.

One attractive aspect of nursing that participants felt needed targeted promotion towards men is the career diversity and flexibility that comes with a nursing qualification (Christensen et al., 2018b; LaRocco, 2007). For one, it offers variety not only via the scope of nursing but through the opportunity for travel (Christensen & Knight, 2014; Harding et al., 2018; Twomey & Meadus, 2016; Whitford et al., 2018). Additionally, nursing offers the opportunity for fast-tracked immigration, as it is frequently upon governmental desirable skill lists (United Kingdom Visa Bureau, 2020).

More importantly, nursing offers employment security in a changing world where many traditionally male-dominated industries are either dissolving or facing automation (Christensen et al., 2018b; McKenna et al., 2016; Meadus & Twomey, 2011; Whitford et al., 2018; Yi & Keogh, 2016). This point is even more pertinent in light of the current pandemic, and the subsequent instability of the world economy, meaning men may more likely turn to nursing (Lim & Sanchez-Vera, 2013). It is therefore crucial to

promote the security of nursing alongside its career flexibility within recruitment strategies.

5.3 Off the public radar

Nursing scope an unknown

One of the most striking findings from this research was the notion that men do not flock to nursing due to deep-seated preconceptions. These social constructions are mainly due to the idea that nursing is, and always has been the work of women, which is in contrast to the reality of contemporary nursing (Harding, 2008; Jamieson et al., 2019; Neilson & Jones, 2012; Sasa, 2019; Wingfield, 2009). This is especially true for younger males, as this schema of nursing begins in early childhood (Wilbourn & Kee, 2010). Further reinforcement may subsequently occur via secondary school career advisors, where a young male considering a career in health, will likely be pushed toward acceptably masculine occupations such as medicine or physiotherapy (Glerean et al., 2017; Neilson & Jones, 2012; Rajacich et al., 2013). From this study, the latter is more apparent in single-sex schools.

The societal view of nursing is still blind to the vast scope of the profession, but instead, pictures the nurse as Pete frames it; ‘this lovely pretty lady who dances around on a ward and showers people’. This Nightingalian throw-back is compounded by the linguistic connotations of the word ‘nurse’ which intrinsically implies caring and nurturing; traits that sit uncomfortably outside the mould of masculinity (McDonald, 2013; Stott, 2007; Wingfield, 2009; Zhang & Liu, 2016). Also, nursing is still devalued and painted with a hegemonic brush as subservient to medicine, where men may be opposed to occupying the role of the hand-maiden (Brown, 2009; Connell, 2005; Harding, 2005; Jamieson et al., 2019).

Addressing this image of nursing is paramount to attract and retain males into the profession. But more critically, addressing false stereotypes and the devalued status of nursing serves to empower the profession as a whole (Schmidt, 2016). As reducing the skills, knowledge and professionalism required by the nurse as ‘woman’s work’ may also incite the attrition of female nursing students (McLaughlin et al., 2010). It is here

that the depth and breadth of nursing needs showcasing to young men *and* women to foster nursing as a rewarding and empowering career choice.

Participants in this study recognised that having an awareness of the array of nursing specialities early in the piece would be valuable in terms of retaining men. By allowing students to have some level of exposure to multiple specialities or nurse specialists in the first year of the degree would enable them to see future career possibilities, and encourage perseverance through more general placements (Kuehnert, 2019). Whitford (2018) argues further that this exposure needs to occur before the degree in the pre-orientation phase.

Guidance counsellors and career advisors may benefit from education regarding the scope of nursing, but also require support and resourcing to assist them in identifying students with attributes or interests that fit nursing (Carrigan & Brooks, 2016; Meadus & Twomey, 2011; Whitford et al., 2018). From this, it is then imperative that men are not just token insertions within nursing school promotional material, as this is often the first port of call when considering a nursing career (Clifton et al., 2018).

Recruitment campaigns that utilise social media platforms to illustrate men within nursing may be beneficial (Whitford et al., 2018). These would need to show men working in a diverse variety of settings, while simultaneously advertising the flexibility and advancement opportunities of nursing. Male students and faculty members should also appear in equal numbers within events such as career expos and university open days. Having alumni or male nurse graduates present at such events could also provide insight into the opportunities ahead for potential students (Carrigan & Brooks, 2016; Maykut et al., 2016).

Gender roles dominate

Confronting heteronormative gender roles emerged as a source of conflict for many participants as they journeyed into nursing. Firstly, men resented being used for their physical build when being unfairly allocated heavy manual handling tasks, and being at increased risk of injury (Meadus & Twomey, 2011; Powers et al., 2018; Rajacich et al., 2013). Here, participants also felt exceedingly perplexed when they did not perceive themselves as having a typically masculine physique. Using men for ‘muscle’ only

serves to devalue their skill and knowledge, and jeopardizes their training and careers if an injury occurs. It also devalues female RNs through learned helplessness, where a male can be called upon, where in fact, all RNs should be utilising 'no-lift' manual handling skills and equipment that is not dependent on strength.

In any health care setting, a male presence may be over-relied upon for de-escalating episodes of agitation or aggression (Harding, 2005; Meadus & Twomey, 2011; Rajacich et al., 2013). Once again, this expectation may surface from the historical over-representation of males in the psychiatric setting, where custodial care and restraint were common practice (Christensen, 2017; Evans, 2004; Harding, 2005). Men in this study who found themselves thrust into this position, could not say for sure whether it was because of their calming presence, or for their gender.

Some also stated that having an equal staff gender mix within a shift meant patients were less prone to escalation. This observation contrasts other studies that question whether men are naturally hard-wired to avert or defuse aggression (Daffern et al., 2006; Harding, 2005). Additionally, according to one systematic review, male nurses are more likely to be the recipients of physical violence in the health care setting (Edward et al., 2016). For this reason, men involved in de-escalation scenarios should be doing so based on competence and confidence, and not because of their gender.

In comparison to the literature, all participants have faced the assumption that they are either doctors, or are somewhere on their medical training trajectory (Anderson, 2014; Juliff et al., 2016; Meadus & Twomey, 2011). Additionally, others faced speculation that they were not good enough to be doctors, and nursing was subsequently a less desirable 'plan B' to fall back on (Bartfay et al., 2010; Powers et al., 2018). This view often came from people close to them, such as family and friends, where male students had to justify that they actively chose to nurse. This only serves to diminish nursing's position further, entrenching role strain for prospective male nurses, and ultimately risking further attrition (Loughrey, 2008; McDonald, 2013; McLaughlin et al., 2010).

The construct of nursing's existence under the patriarchal shadow of medicine produces unexpected spin-offs for men. Many participants felt there was an inherent level of respect afforded to male nurses and students, that their female counterparts were not always privy too. While patients were a source of this respect, on many occasions, medical staff were more respectful and accommodating to men's learning needs

(LaRocco, 2007). Additionally, it is an external expectation that men in nursing expedite their careers to positions of authority and leadership (Harding, 2005; Lim & Sanchez-Vera, 2013). Perhaps this desire to climb the career ladder mitigates role strain through moving into more traditionally masculine roles, such as management (Wingfield, 2009). However efforts must be made when promoting the opportunities of nursing to males, that it is done sensitively regarding gender pay gaps and avoids further disadvantaging females (Muench & Dietrich, 2019; Punshon et al., 2019).

Knowing nurses

Another finding of this research that coincided with the broader literature was that many participants entered nursing later in life, as a second or third career change (Christensen & Knight, 2014; Christensen et al., 2018b; Entwistle, 2004; Harding et al., 2018; McKenna et al., 2016; Snyder, 2011). This phenomenon is rarely accidental and occurs for many reasons, such as the employment stability of nursing discussed earlier, or perhaps the shifting priorities of middle adulthood. A key reason for this later entry however is that nursing is simply not a popular choice, or even within conscious awareness for male school leavers (Mooney et al., 2008; Neilson & Jones, 2012).

For many males, nourishing the idea of nursing as a credible career takes exposure over time. Men may find themselves within working relationships, or rubbing shoulders with RNs within their former employment setting where they observed nursing in action (Harding, 2009; Schmidt, 2016; Snyder, 2011). One participant's exposure to nursing occurred via a partner studying nursing, where intrigue in nursing almost emerged through osmosis.

Others discussed their first taste of nursing through being a patient of nursing care themselves, or having to provide care to a sick family member (Harding, 2009; LaRocco, 2007; Rajacich et al., 2013; Yi & Keogh, 2016). Many stated finding themselves in the position of the carer was personally fulfilling, leading them to seek a career where they could make a difference (Entwistle, 2004). And for those who were recipients of nursing care, they felt a strong desire to give back (Christensen et al., 2018b).

Family members or friends who were nurses themselves were frequently a source of encouragement. Several participants described this mentorship and guidance as pivotal in their decision to begin training (DeVito, 2016; Harding et al., 2018; LaRocco, 2007; McLaughlin et al., 2010; Meadus & Twomey, 2011; Mooney et al., 2008; Yi & Keogh, 2016). Having access to an RNs perspective, support and encouragement appeared critical for enticing males of any age into nursing.

For younger males straight out of secondary school, having a parent as an RN appeared to smooth the pathway toward nursing. These men seemed to have resilience toward the outsider position of males within nursing. Perhaps this is owed to everyday exposure to nursing during childhood, meaning for them, nursing becomes entrenched as the norm (Snyder, 2011). Additionally, several participants attributed that having an RN as a parent, instilled within them an empathetic and caring nature, which may be protective against gender role strain (Schmidt, 2016).

Nursing is for men

Findings from this research suggest that the traditional discourse of 'care' is often viewed as innately incompatible with masculinity (Bartfay & Bartfay, 2017; Dwinnells, 2017; Harding, 2008; Maykut et al., 2016). Here, nursing concepts such as compassion and empathy, become culturally coded as feminine (DeFrancisco et al., 2007). A more masculine version of care consequently becomes conceptualised as the technical, scientific or exhilarating aspects of nursing, where the focus shifts to the autonomy required to harness the unpredictable nature of certain specialities (Harding, 2005; Jamieson et al., 2019; Rajacich et al., 2013; Stott, 2007).

Several participants explicitly suggested the aforementioned male attributes need showcasing to attract more men into nursing, as men often divert themselves into the islands of masculinity, such as ED, ICU or perioperative care (Harding, 2005; Snyder, 2011). But as Anderson (2014) points out, skilled technical care is not dependent on gender, and ironically, more traditionally feminine traits such as compassion, empathy and direct physical care are drawn upon in areas such as ICU (Harding, 2005). And as Ian pointedly remarked, directly promoting technical or 'heroic' nursing activities would just be addressing one stereotype with another.

Perhaps it is more imperative to unravel what nursing care means in 21st-century, and in the process, deconstruct caring as an innate female privilege (Carrigan & Brooks, 2016; Rajacich et al., 2013; Zhang & Liu, 2016), where men have to hide their care behind technology (Schmidt, 2016). Achieving this can be done by undoing gender norms and re-constructing nursing as an amalgamation of characteristics, both feminine and masculine, or by exploring care from a male perspective (McDonald, 2013; Zahourek, 2016).

Promoting nursing in a manner that empowers men to care requires careful consideration and critique of the recent history of nursing. In doing so, care can be de-constructed and de-gendered to recruit and retain more men, but more importantly, to cease the disempowerment of the female majority, and therefore nursing as a whole. Promoting nursing to both males *and* females should, as one participant stated, embody nursing's intelligence and discipline. Here, the image projected should show nurses as professionals within a healthcare team, rather than merely existing under the hierarchical shadow of medicine (Harding, 2005; Schmidt, 2016).

University websites and social media pages could tailor strategies to engage with the wider male population, such as the *#MenDoCare* campaign rolled out by the University of Dundee (Clifton et al., 2018; Weaver et al., 2014). Additionally, this could occur through nursing bodies or government-wide workforce recruitment efforts, such as Australia's *Men in Nursing*; an e-book resource that illustrates the personal stories of male nurses (Australian College of Nursing, 2019; Yi & Keogh, 2016).

While re-branding nursing care should shift away from the dominant feminine discourse of warmth, compassion and nurture, it may be better to question why men cannot be comfortable possessing these values too. For all students, critically examining these socio-historic gender roles early in training is vital for changing the conversation, and to diversify and empower nursing.

5.4 Strengths and limitations

Strengths

While this research has a relatively small sample size, participants come from a wide geographical distribution across New Zealand. Participants also vary significantly in age and life-stage, with half coming straight to nursing from secondary school, and the remainder changing career later in life adding depth and variation to participant experiences. This study also is unique, as other research from New Zealand sampled either from single campus BN programmes, or from Masters fast-track nursing degrees.

Limitations

Due to the self-select nature of a research piece of this type, it must be acknowledged that those who enrolled in the study may be motivated to participate as they have particular grievances to air. This could explain why, for the most part, participants did not come from specialities where male nurses are the norm such as critical care or mental health. Additionally, as a result of the snowball recruitment method, several participants were in the same class during their training, which questions true data saturation. Finally, while there was one participant of Maori descent, all other participants were NZ European which may impede generalisability to different cultures and ethnicities.

5.5 Recommendations for practice

Attracting and recruiting more men into nursing requires multiple strategies. Firstly, secondary school career advisors need targeted support and guidance to promote the scope and diversity of nursing to males, but also to be supported to match student attributes to the profile of the profession. Importantly, this approach should not be limited to co-ed schools.

Secondly, tertiary education providers and nursing bodies must consider how they portray nursing within recruitment material and media. Here, images should showcase nursing as a non-gendered profession, where men and women are numerically equal. But also, the prevailing message should be a gender-balanced representation of skill,

knowledge and expertise, and where nurses are equals within the multi-disciplinary team.

Men also need equal representation within open days, careers fairs or other recruitment campaigns. While male faculty staff should be present at these, priority should be placed upon having male students available to provide potential applicants with experiential insight. For males who are facing a career change, championing the flexibility and stability of a nursing career would prove valuable, especially during periods of economic uncertainty. For males who already hold tertiary degrees, two-year fast-track nursing programmes need showcasing as an enticing training pathway.

Increasing the male presence within training programmes is of paramount importance to increase male student numbers. Ring-fencing a quota of male faculty and clinical teaching positions would mitigate isolation for male students, but would also enhance guidance for effective recruitment strategies. Having more men within the teaching staff is needed to provide support and advocacy for situations that put male students in vulnerable positions, such as caring for females or children.

Building more male-friendly content into the curriculum content that moves beyond merely removing gendered pro-nouns will also address the current isolation male students experience. To start with, discussing the socio-historical position of nursing concurrently with the social constructions of femininity and masculinity would begin to lift the lid on the stigma and stereotypes men in nursing face. Here also, the inclusion of more men's health topics in the curriculum is required.

As men may possess different learning styles to the female majority, re-training staff could spur pedagogical adjustments with the goal of equity within content delivery. Staff must also be made aware that while usually an unconscious action, always singling men out within the class and clinical settings can have negative impacts upon their confidence and competence. Equitable support and expectations must be based on individual student needs and not their gender.

Male support groups could provide opportunities to debrief and discuss strategies for issues they may face throughout their training. Grouping men together in educational settings and clinical placement may also reduce isolation. Along with this, longitudinal mentorship could be of use, where male students receive clinical supervision from a single male RN throughout their training and new graduate year. The purposeful pairing

of male students with male preceptors would provide role-modelling and advocacy in situations where their gender attributes may be exploited, such as for heavy lifting or de-escalation.

What is of the utmost importance, is that all students begin their training with an accurate image of nursing in mind, where they have a reality-based awareness of the scope and possibility the profession holds. Early in the degree, student's of any gender would benefit from some level of exposure to multiple specialities to spark interest and foster long term career planning.

To re-balance the gender make up of the New Zealand nursing workforce, hosting several avenues of public awareness campaigns are needed. This would make nursing more attractive to all, but especially men. These campaigns would need to deconstruct the devalued status of nursing, and re-brand it as a profession as diverse and esteemed as other health professions, including medicine.

This process of re-education should begin with young minds in primary, secondary, and even pre-school settings. Here, nursing must be presented in a gender-balanced manner. But more pressingly, it should be showcased as a highly-skilled and autonomous profession, where it no longer exists under the dominant shadow of medicine.

5.6 Future research

Several possibilities for future research can springboard from this study. Firstly, tertiary providers do not publicly provide numbers of males within their nursing programmes. Quantitative analysis could be employed to establish a snap-shot of male student numbers and levels of attrition across New Zealand, which could even establish if regional patterns were occurring.

Secondly, mixed-method research could gauge the New Zealand public perception of male nurses and the nursing profession as a whole. This could then guide the creation of public awareness campaigns. Surveying the understanding of school students (of any gender) and secondary school careers advisors may also add another level of richness and detail to this process.

Thirdly, while this research included one participant of Māori descent, another participant spoke of the Māori male nurses as 'the unicorn in the room'. Seeking out the

voices of this minority within a minority is desperately needed to target recruitment strategies and subsequently better serve Māori populations. Seeking the views of male nurses of other ethnicities and cultures is also important, as these populations of male nurses are growing exponentially.

5.7 Study conclusion

This research has provided insight into the positive and negative experiences for male nursing students and novice nurses in 21st century New Zealand. From this exploration, multiple strategies for recruiting more men, and equally as importantly, retaining men in nursing education emerged. Before broaching the diversification of the gender makeup of the nursing workforce, the societal constructs of the nursing profession must first shift.

Within the public consciousness, nursing needs re-branding and empowering. Emphasis should show a profession that holds diversity and opportunity within its scope of practice, and where it is a stable career in an unstable world. It also needs celebrating as a health profession that values teamwork within a flattened hierarchy amongst all health professions.

Efforts are needed to make nursing attractive to men, but not at the expense of females. Caution must be applied, so that males are not encouraged to exploit their minority status within nursing, alongside their advantaged position within a patriarchal society. Eroding the public rhetoric of nursing as ‘woman’s work’ that is subservient to medicine needs precedence. Doing so will empower nursing as a whole, making it an attractive and rewarding career for any gender.

Appendices

Appendix 1 – Research Invitation

MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

Are you a Registered Nurse and a male?

Are you within the first three years of your career?

Did you train in New Zealand?

My name is Max Guy I am currently undertaking a Master of Health Science degree through Massey University.

For this, I am interested in hearing about the *formative experience of male nurses in New Zealand*, with a specific focus on the undergraduate degree, and the first year of practice.

From this, these stories aim to inform curriculum design to help support male nursing students and new graduates, with the ultimate aim of enhancing recruitment and retention.

I am looking for *male RN's who trained in New Zealand, and have been practicing for no longer than three years.*

If you choose to take part, an interview will take place via a video link (using your computer or phone), which will take approximately 30-45 minutes. This will be at a time of your choosing, but requires a stable internet connection.

If you are interested, or if you know anyone that may be interested, please do not hesitate to contact me on:

m.guy@massey.ac.nz

Yours Sincerely

Max Guy RN PGDip

Philip Ferris-Day (Supervisor)

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research. Ethics notification number: 4000021383

Appendix 2 – Participation Information Sheet and Ethics Approval

An exploration of the experiences of new nurses 'who are men' within New Zealand Aotearoa

PARTICIPANT INFORMATION SHEET

About the researcher

The researcher is Max Guy, who is completing a Master of Health Science (Nursing) at Massey University. Max is a Registered Nurse who has worked for several years in acute care within New Zealand. He is also a Tutor and Clinical Teaching Associate at Massey University's School of Nursing. This research project aims to explore the experience of the educational journey of the nursing student, and the novice nurse who identify as male.

The aim of the research is:

- From the perspective of novice nurses who are men (0 – 3 years post-graduate experience), what have been their experiences prior, during and after the BN degree.
- This study will be undertaken within the New Zealand Aotearoa setting.
- This research aims to inform educational providers and new graduate programmes how to further support students and new nurses who are male.

You are invited to be a part of this research, and to share your personal experience of being a new nurse who identifies as male.

About the participants

This study is seeking to interview eight to ten Registered Nurses who are male, and within their first three years of practice.

Additionally, participants need to:

- Be currently registered with the New Zealand Nursing Council
- Have gained their Bachelor of Nursing Degree through a New Zealand tertiary institution
- Have access to technology that will support an interview via webcam (i.e. stable broadband internet, computer with working camera and microphone)

Once recruited, participants will be given a pseudonym to protect confidentiality. In addition, places of work (i.e. DHB, hospital, ward/unit/clinic etc), tertiary institutions and geographical locations will be kept anonymous.

What will participation involve?

- If you choose to be part of this research, you will be asked to take part in a semi-structured interview using Zoom video-conferencing. Here a Zoom link will be provided to you so there is no need to install extra software.
- This interview will take 30-45 minutes at a time that suits you. The video and audio will be recorded (Participants will have the opportunity to turn the video off if desired).
- Face to face interviews will also be an option for participants who are located in reasonable proximity to the researcher (Manawatu).
- Prior to the interview, informed consent will need to be signed and returned to the researcher (this process will be negotiated for your convenience (i.e. either self-addressed envelope or emailed scan).
- Several days before the interview is scheduled, a document will be emailed to you with 'question themes' included. This aims to prepare you for the interview, and help you 'percolate' your thoughts and memories so the richest stories can be heard. After the interview, if you have any follow up thoughts, stories or questions, you are welcome to contact the researcher to share these.
- After the interview is complete, the researcher will transcribe the interview, and send you an interview summary document. The purpose of this is to verify that your story is captured authentically.

Risks

- Participants will not be intentionally exposed to any harm during this research.
- There is some potential to feel uncomfortable while sharing some of your experiences.
- The researcher will take every effort to make the process as comfortable as possible, and participants have the right to decline to answer questions to prevent such discomfort.

Benefits

- Information gathered from you will be used to inform practice around how education providers and District Health Boards can further support and retain men early in their nursing careers. You have a unique opportunity to be part of this, and to have your voice heard.

About the data

Raw interview data will be stored securely in password protected electronic files or within a locked filing cabinet for five years. After this period, data will be deleted or shredded.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study at any time, until such time as the interview data has been anlysed, after which it cannot be removed. This will occur two months after the interview (a specific date will be provided during the interview).*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *ask for the recorder to be turned off at any time during the interview.*

Project Contacts

You are invited to contact the researcher and/or supervisor if you have any questions about this project.

Max Guy RN

Master of Health Science (Nursing) Student

College of Health

Massey University

0220859583

m.guy@massey.ac.nz

Philip Ferris-Day RN

Lecturer

College of Health

Massey University

+64 (04) 801 5799 extension 63598

P.Ferris-day@massey.ac.nz

Your consideration is greatly appreciated.

Yours sincerely

Max Guy RN PGDip

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research. Ethics notification number: 4000021383.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz."

Date: 05 July 2019

Dear Mr Max Guy

Re: Ethics Notification - **4000021383** - **New ApplicationAn exploration of the experiences of new nurses 'who are men' within New Zealand/Aotearoa**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:
"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext 85271, email humanethics@massey.ac.nz."

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Human Ethics Low Risk notification

Appendix 3 – Participant Consent Form

MASSEY UNIVERSITY
COLLEGE OF HEALTH
TE KURA HAUORA TANGATA

An exploration of the experiences of new nurses 'who are men' within New Zealand Aotearoa

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time up until TWO months after the interview.

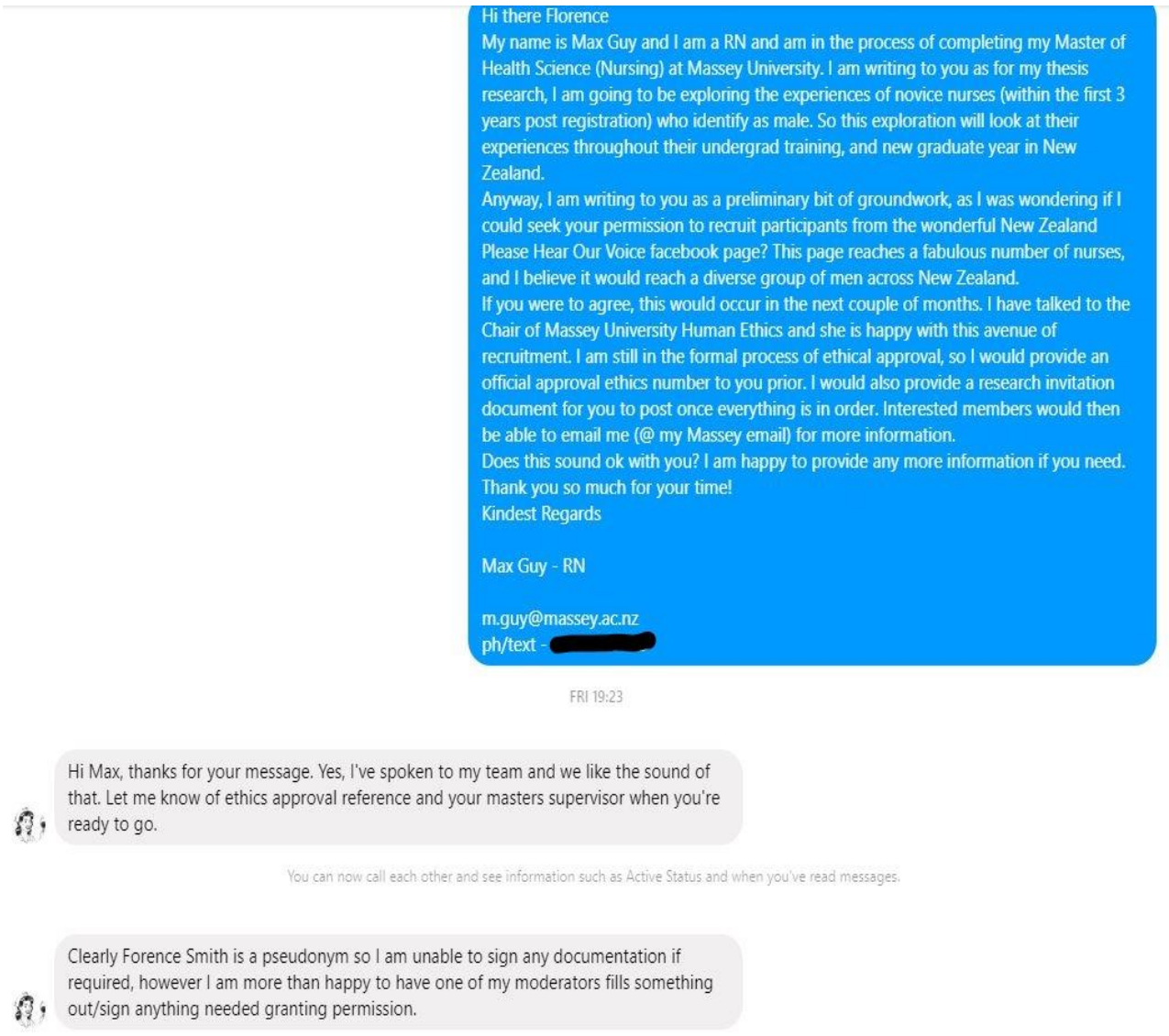
1. I agree/do not agree to the interview being sound recorded.
2. I agree/do not agree to the interview being image recorded.
3. I wish/do not wish to have my recordings returned to me.
4. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

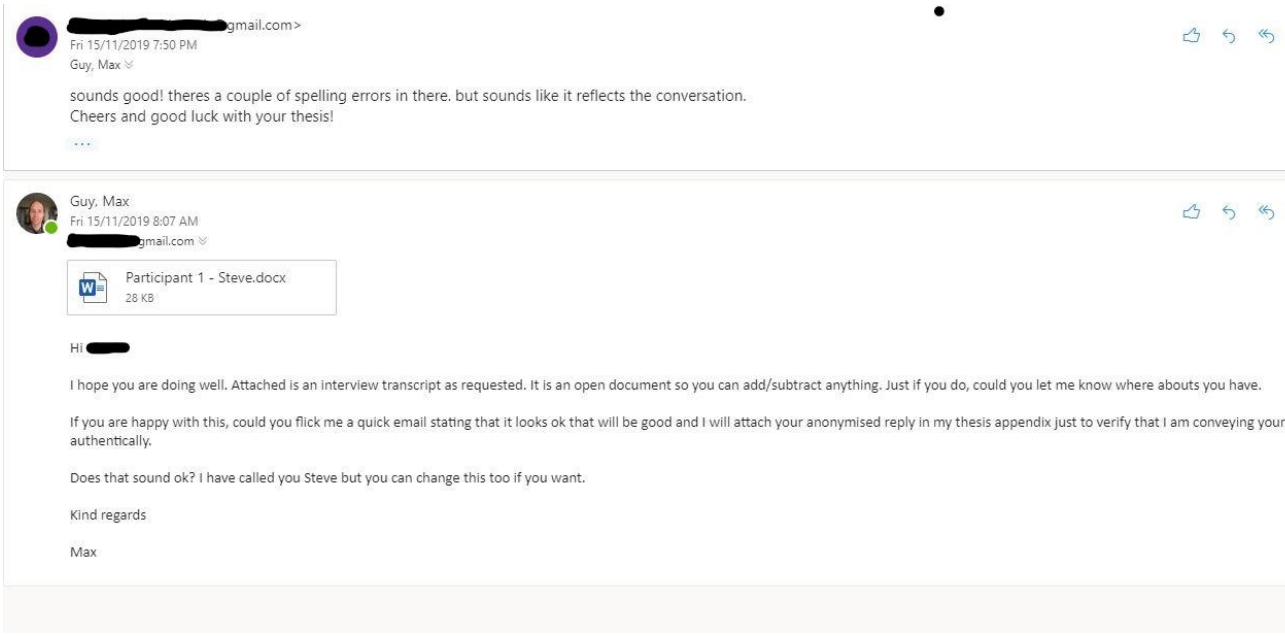
I _____ hereby consent to take part in this study.

Signature: _____ Date: _____

Appendix 4 – Recruitment Permission



Appendix 5 – Transcript Verification



[redacted]gmail.com>
Fri 15/11/2019 7:50 PM
Guy, Max

sounds good! theres a couple of spelling errors in there. but sounds like it reflects the conversation.
Cheers and good luck with your thesis!

...

Guy, Max
Fri 15/11/2019 8:07 AM
[redacted]gmail.com

Participant 1 - Steve.docx
28 KB

Hi [redacted]

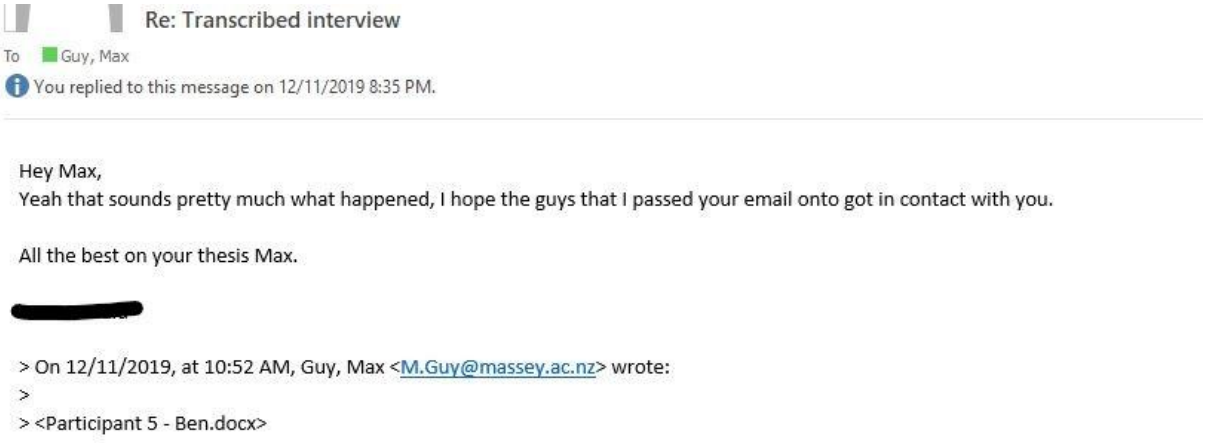
I hope you are doing well. Attached is an interview transcript as requested. It is an open document so you can add/subtract anything. Just if you do, could you let me know where abouts you have.

If you are happy with this, could you flick me a quick email stating that it looks ok that will be good and I will attach your anonymised reply in my thesis appendix just to verify that I am conveying your authentically.

Does that sound ok? I have called you Steve but you can change this too if you want.

Kind regards

Max



Re: Transcribed interview

To Guy, Max

You replied to this message on 12/11/2019 8:35 PM.

Hey Max,
Yeah that sounds pretty much what happened, I hope the guys that I passed your email onto got in contact with you.

All the best on your thesis Max.

[redacted]

> On 12/11/2019, at 10:52 AM, Guy, Max <M.Guy@massey.ac.nz> wrote:
>
> <Participant 5 - Ben.docx>

Appendix 6 – Interview Preparation Form

Interview with Max

Below are the common themes of the interview. Please read these a few days before the interview takes place. The aim of this is to help you reflect back, and be aware what kinds of things I may ask – and to avoid being 'put on the spot'.

- Reasons, encouragement and support for taking up nursing.

- Areas in nursing that are interesting (specialities etc).

- First exposure to male nurses (in person, media, popular culture etc).

- The image of the male nurse in New Zealand.

- How well men are supported in the undergraduate degree, and the new graduate year.

- The advantages and disadvantages of being male in the classroom, the clinical environment and beyond.

- The inclusion of male centred topics within the curriculum (e.g. male specific health issues, prominent men in nursing etc).

- Role models within the educational and clinical environments.

- Level of clinical supervision and debriefing opportunities for men during clinical placements.

- How **you** would like to see nursing education changed in order to attract, support and keep more men in nursing.

Appendix 7 – Interview Guide Sheet

Participant Question Guide

Questions adapted from (DeVito, 2016; Harding, 2005; Lloyd, 2013)

Demographic details gained prior to interview:

- **Introduce self**
- **Thank participant**
- **Outline research**
- **Explain recording/storage**
- **Offer video on/off**
- **Any questions?**

The following set of questions relate to your experiences prior to and during your training. By 'training' I am also referring to your new graduate year. As I am wanting to capture your experiences during this formative period.

- Age
- Ethnicity
- Area of practice

****RECORD****

1. *Tell me about your employment/educational experience prior to your nursing training?*
   So what attracted you to a career in nursing?

2. *Which area of nursing have you worked in since graduating? Where do you envisage your career taking you? Why does this area interest you?*

3. *Do you remember the very first time you came into contact with a male nurse? Tell me about that?*

4. *Here in New Zealand, why do you think more men don't go into nursing?*

5. *When learning about nursing theory, did you ever learn about prominent male nurses or male nursing theorists? If so who? How were men represented within textbooks and course material?*

6. *During the degree, was there any educational content around 'male specific' health conditions or health promotional activities?*

7. *How many male nurses were you exposed to during your education and clinical placements? Were there any that stood out for you? For what reasons?*

8. *2 part question - From your perspective, did your gender have any benefits or disadvantages with respect to your training and your first year of practice?*

9. *Who did you personally consider key mentors or role models during your training and first year out? Male or female*

10. *How many male peers did you have in your class during your degree? How did you connect with your male peers? How did you connect with your female peers?*

11. *During clinical placements, did you ever have other male students on the in the same facility/unit? Was/would this have been helpful to you? Why?*

12. *Were you or your male peers offered any extra support throughout the degree? What about in the new grad year?*

13. *Do you think there are any constraints upon men's participation that women do not experience?*

14. *How do patients (or patient families) respond to you as a nurse/student who is male?*
    Regarding your gender, were there any events or responses (positive or negative) from patients or their families that stood out for you?

15. *Tell me about how it is providing personal care to patients? Has this ever caused any issues or discomfort? What kind of preparation/support/debriefing was provided by teaching staff?*

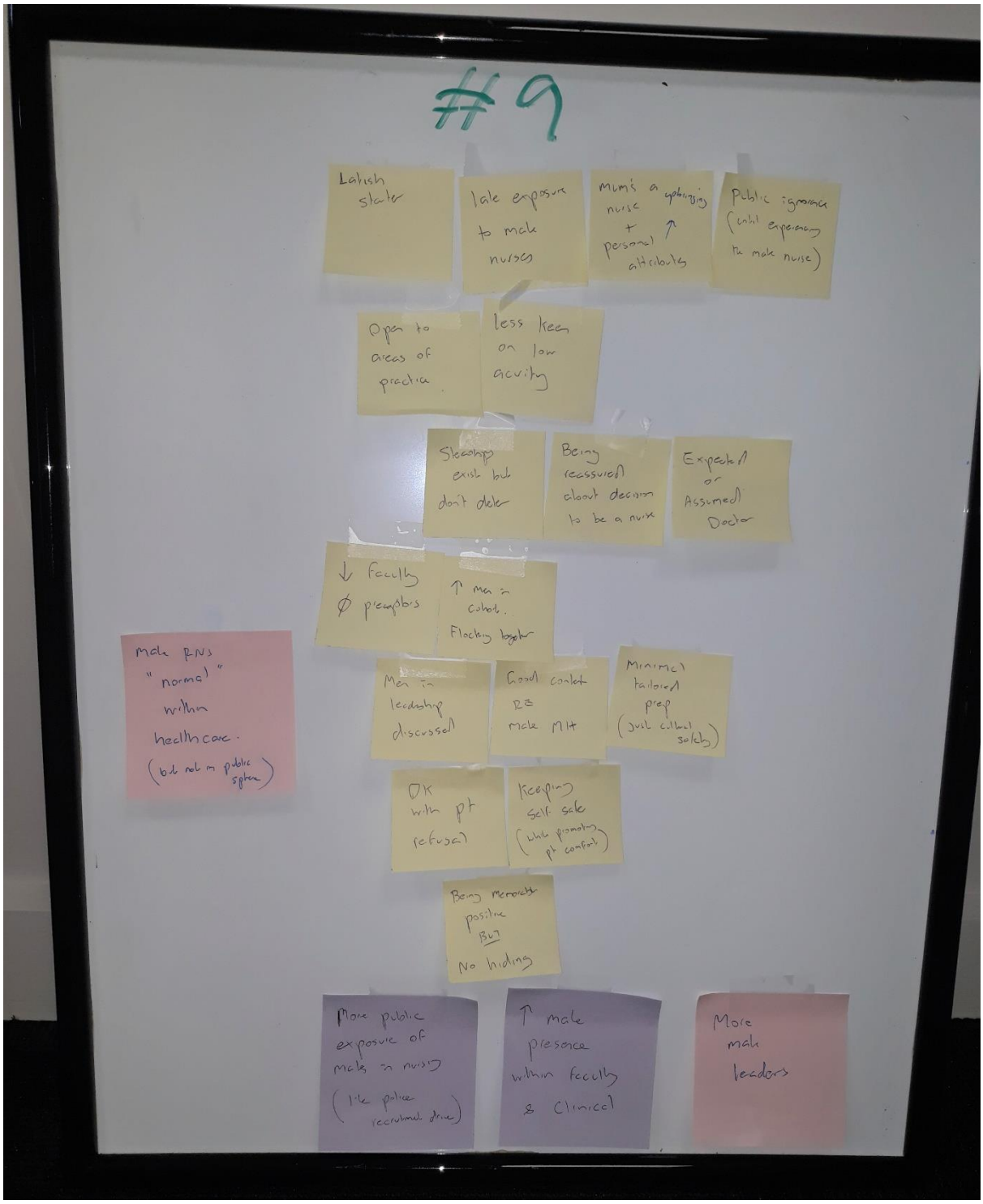
16. *Hypothetically, imagine you were in a position to design a nursing degree and/or new graduate programme. What would you put in place to support men to ensure they complete the training and stay in nursing long term?*

17. Finally, how do you think we could attract more men to nursing?

18. Is there anything further you would like to add?

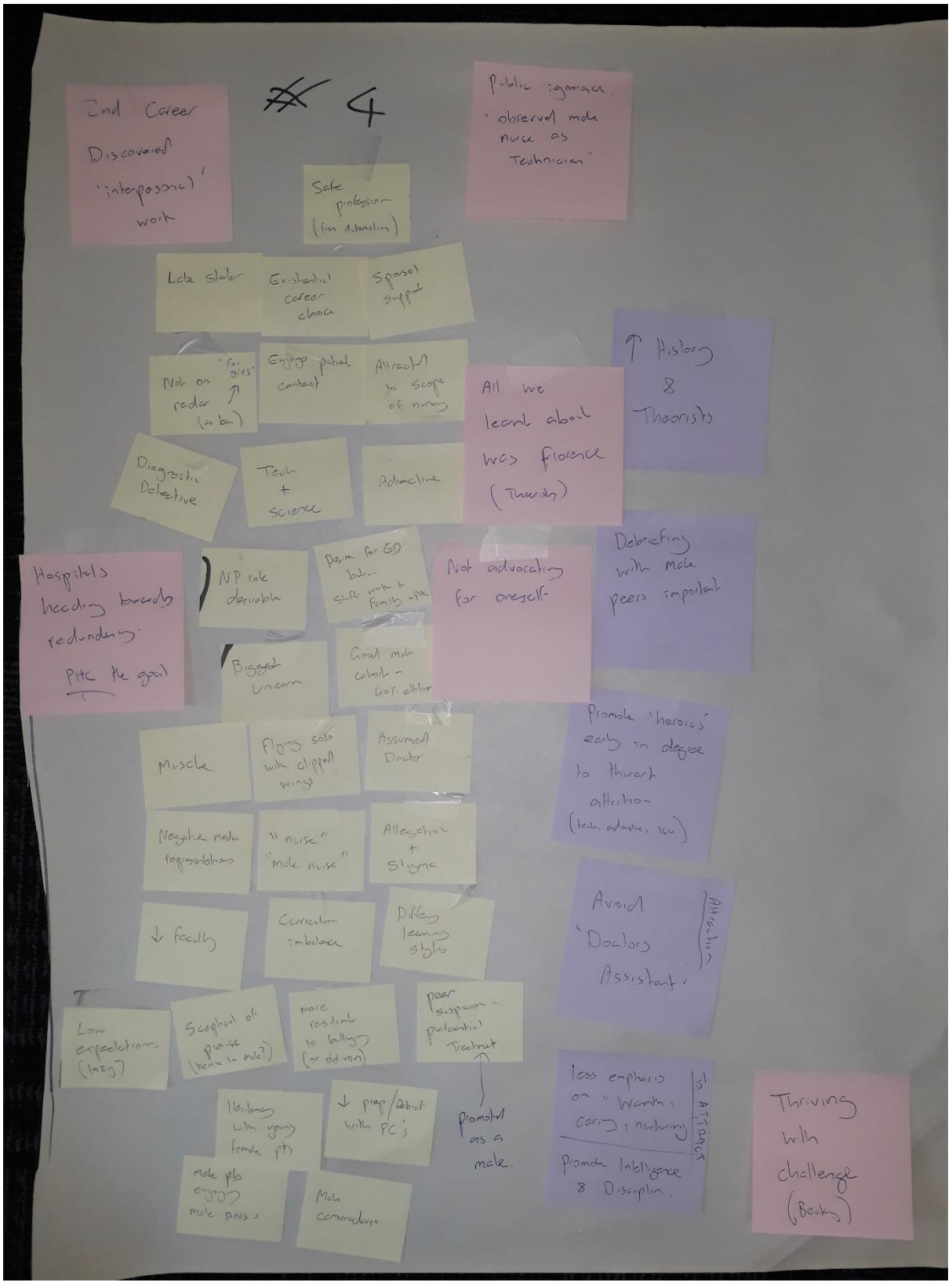
Conclude

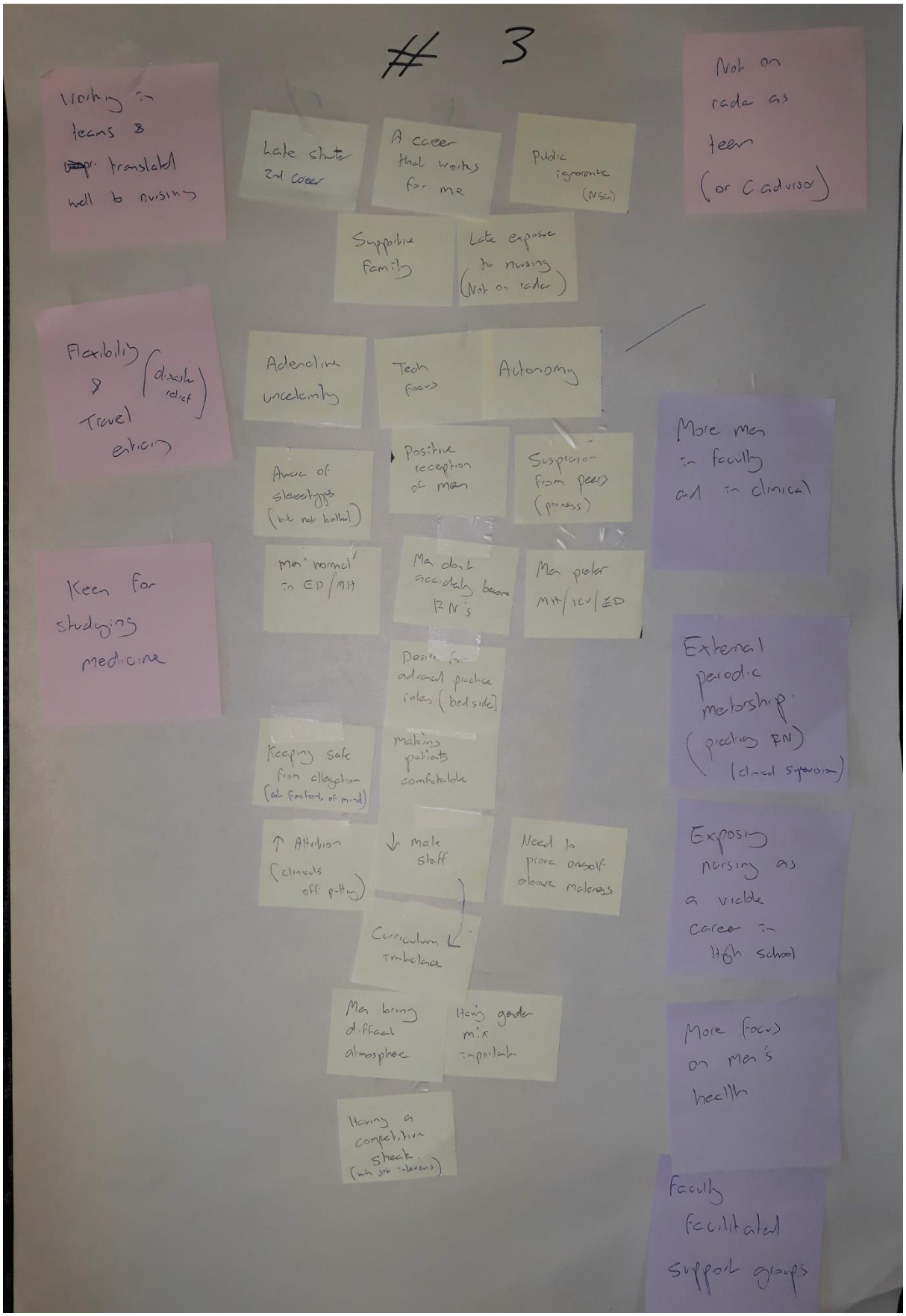
Appendix 8 – Second Wave Coding Boards

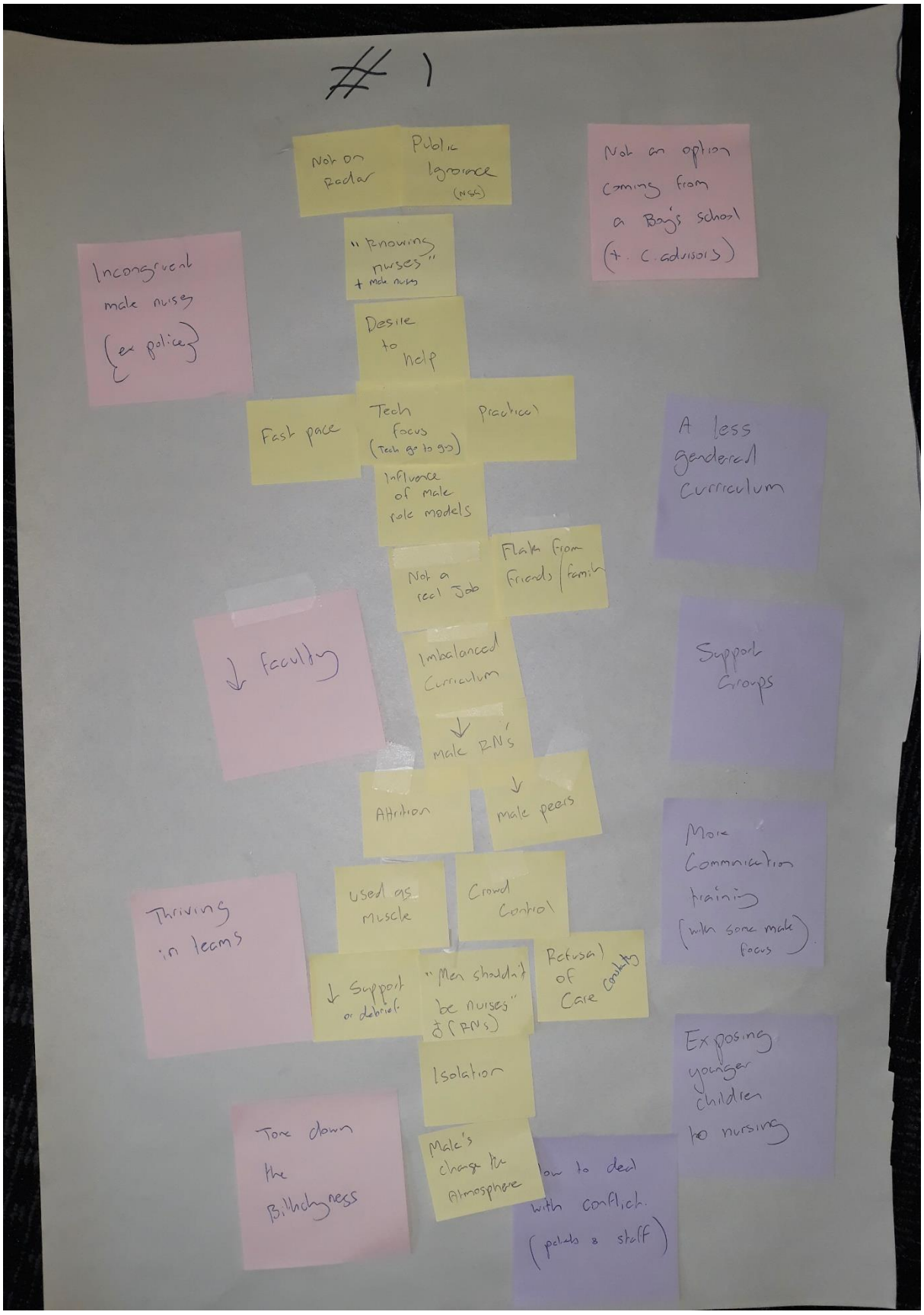

#9
Lavish starter
late exposure to male nurses
Mum's a upbringing nurse + personal attributes
Public ignorance (inhibit experiencing the male nurse)
Open to areas of practice
less keen on low acuity
Stereotyp exist but don't deter
Being reassured about decision to be a nurse
Expected or Assumed Doctor
↓ faculty ∅ preceptors
↑ men in cohort. Flocking together
Male RNs "normal" within healthcare. (but not in public sphere)
Men in leadership discussed
Good content re male MH
Minimal tailored prep (just cultural safety)
OK with pt refusal
Keeping self safe (while promoting pt comfort)
Being mentally positive But No hiding
More public exposure of males in nursing (like police recruitment drive)
↑ male presence within faculty & Clinical
More male leaders

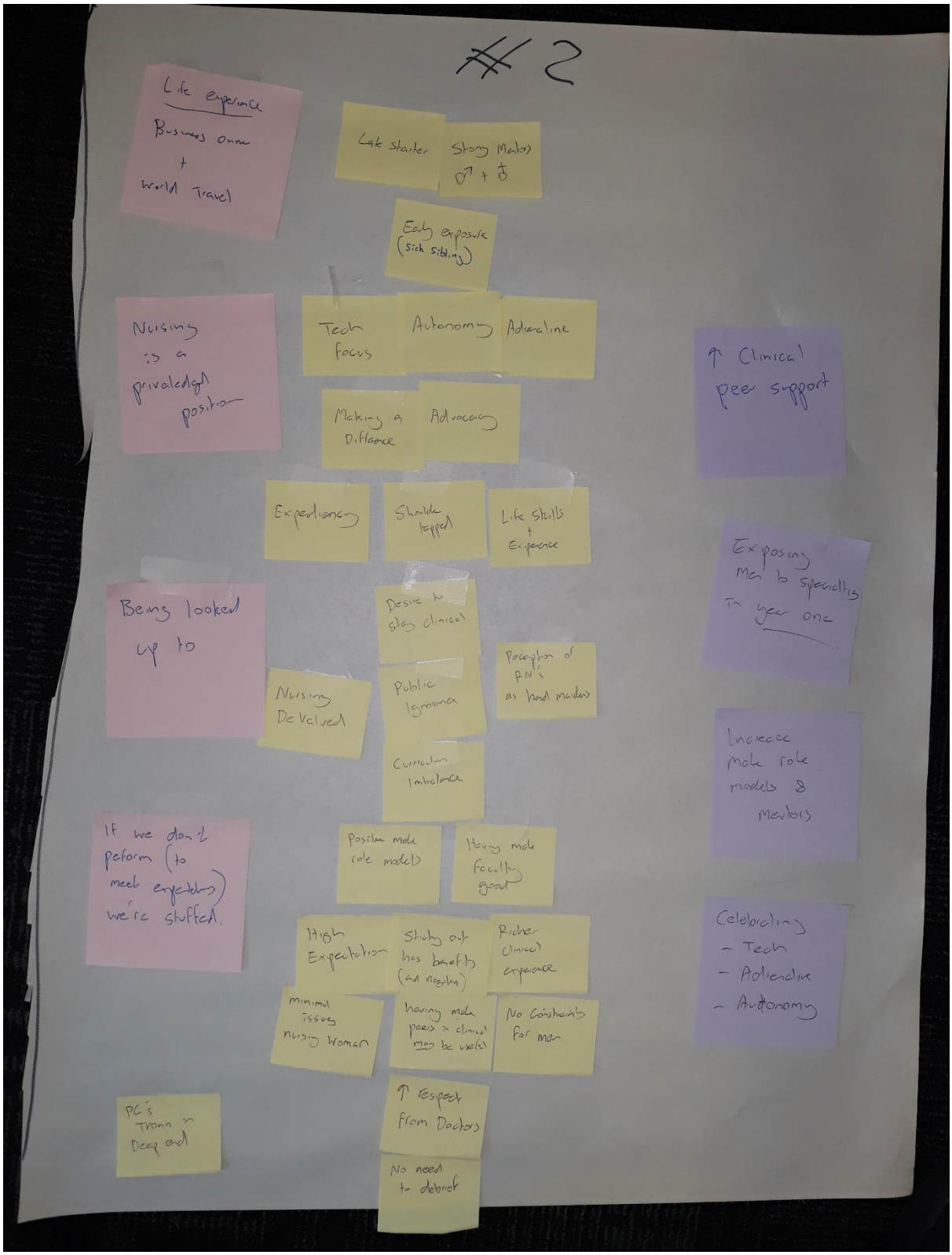

#6
School leaver (a minority)
'mums' a nurse (early childhood)
Desire to work in health "helping"
"Very few guys my age doing it"
practice nurse early exposure (No men)
Career & Travel opportunities
Career advisors under prepared (but helpful)
Public ignorance (NSH)
Only remembers Florence
Men change ward atmosphere
Adrenaline (Plenty on Rel)
Desire for ED/ICU
Tech (engaged science)
As a male... Help open much more supportive than BN
Friends Surprised but supportive
Media Stereotypes (gaylord)
Early exposure → More men in promo material + open days
male students & staff ok.
Sexuality questioned (in halls)
Womens work
Incompatable with Blokie
Tutor questions career choice
↓ male faculty
Culture Shock (from Boys school)
Lost man standing (attrition)
Promote Autonomy of nursing
Aligning with mature students
Curriculum Imbalance
Good balance of clinical role models
Adapt Curriculum to men's learning styles
especially with young females
Self protection (allegation)
minimal prep (PCs ♂)
Good Debrief
Females → Create friction
OK with pt refusal
Why not medicine?
Solidarity between men (in clinical)
↓ formative support
Scrutiny ? cause
Males are Lazy
Jobs will fall into Your lap! (NSH)
Innocent respect towards men

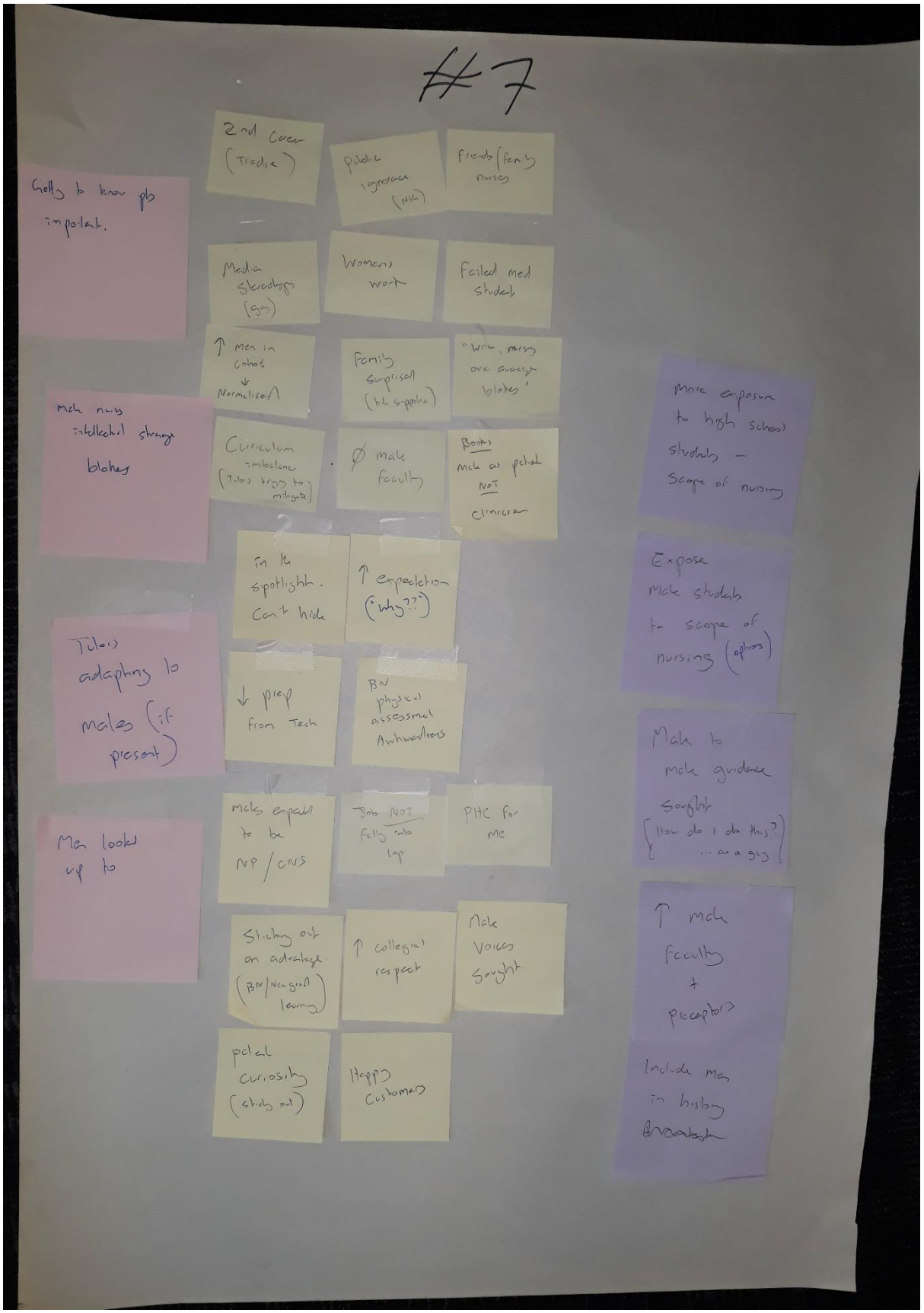

#S
Late starter
2nd career
Interest in nursing growing up (sick family member)
Career Advisor supportive
Social media ads
"Not academic enough"
In OT b.c interest in Practice nursing
1st exposure MH preceptor semester 3
Macho culture (deterrent)
↓Practical Year 1 (deterrent)
Promote male dominated specialties
Engage being amongst men
Thriving in team with flattened hierarchy
Common goal
↓ exposure as young child (just female practice RN's)
Task focus
Instant results
Hands on (Interactive attraction)
Increasing exposure of scope of nursing to children (> high school)
Awkward practical exams
Curriculum imbalance
No male faculty
Class: - Men older - females Younger
"Nice to be around other male nurses"
going it alone
Positive feedback (with Terminology)
male preceptors as role models
male RN mentors (Degree a bogged)
No prep/debrief with PC's
Suspicion of Male RN's but not male Doctors
Year 1 ↓ Theory overload
Men less "bitching"
Craving Constructive feedback
good gender mix diffuses aggression
Increasing male preceptors (but not all the time)
" bringing it "
Textbooks: - men to examinee


2nd Career
Discovered 'interpersonal' work
#4
Safe profession (from Attraction)
Public ignorance
'observed male nurse as Technician'
Late starter
Existential career choice
Sparse support
Not on radar (as kid)
"for girls"
Engage patient contact
Attracted to scope of nursing
All we learnt about was florence (Theorists)
↑ History & Theorists
Diagnostic Detective
Tech + Science
Adrenaline
Hospitals heading towards redundancy
PHC the goal
NP role desirable
Desire for GD but... staff, mates + family - PHC
Not advocating for oneself
Debriefing with male peers important
Biggest Unicorn
Good male cohorts - b/c attrition
Muscle
Flying sob with clipped wings
Assumed Doctor
Promote 'heroics' early in degree to thwart attrition (tech, adrenaline, ICU)
Negative media representations
"nurse" "male nurse"
Allegation + Stigma
↓ faculty
Curriculum imbalance
Differing learning styles
Avoid 'Doctors Assistant'
Attraction
Low expectations (lazy)
Scepticism of praise (because is male?)
more resilient to bullying (or did we?)
peer suspicion - patriarchal Treatment
promoted as a male.
less emphasis on "warmth, caring, nurturing"
Promote Intelligence & Discipline
to Attract
Thriving with challenge (Becky)
Resilience with young female pts
↓ prep/debrief with PC's
male pts enjoy male RNs
Male camaraderie

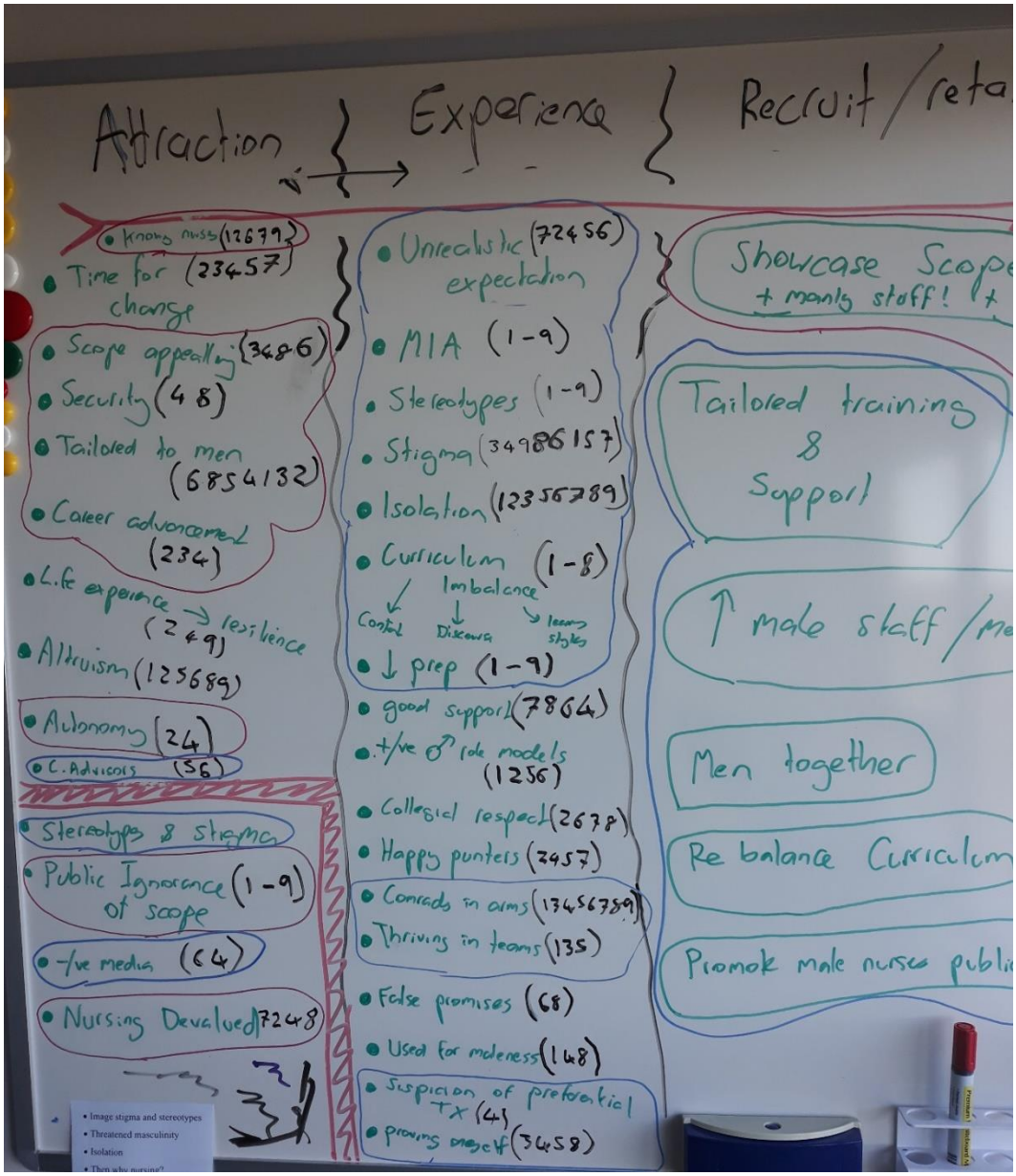

3
Working in teams & translated well to nursing
Late start 2nd career
A career that works for me
Public ignorance (NSW)
Not on radar as teen (or Cadvisor)
Supportive family
Late exposure to nursing (Not on radar)
Flexibility & travel entry (disaster relief)
Adrenaline uncertainty
Tech focus
Autonomy
More men in faculty and in clinical
Aware of stereotypes (but not bothered)
Positive reception of men
Suspicion from peers (process)
Keen for studying medicine
Men 'normal' in ED/MH
Men don't accidentally become RN's
Men prefer MH/ICU/ED
Desire for advanced practice roles (bedside)
External periodic mentorship (practicing RN) (clinical supervision)
Keeping safe from allegation (at forefront of mind)
making patients comfortable
↑ Attrition (clinicals off putting)
↓ male staff
Need to prove oneself above maleness
Exposing nursing as a viable career in High School
Curriculum imbalance
Men bring difficult atmosphere
Having gender mix important
More focus on men's health
Having a competitive streak (with job interest)
Faculty facilitated support groups


#1
Not on Radar
Public Ignorance (NSA)
Not an option coming from a Boy's school (+ C. advisors)
"knowing nurses" + male nurses
Incongruent male nurses (ex policy)
Desire to help
Fast pace
Tech focus (Tech go to go)
Practical
A less gendered curriculum
Influence of male role models
Not a real Job
Flak from friends/family
↓ faculty
Imbalanced Curriculum
Support Groups
male RN's
Attrition
male peers
More Communication training (with some male focus)
Thriving in teams
used as muscle
Crowd Control
↓ Support or debrief
"Men shouldn't be nurses" (RNs)
Refusal of Care
Isolation
Exposing younger children to nursing
Tone down the Blithedness
Male's change the Atmosphere
low to deal with conflict (peers & staff)


#2
Life experience
Business owner
+
world Travel
Late starter
Strong Males ♂ + ♁
Early exposure (sick sibling)
Nursing is a privaledged position
Tech focus
Autonomy
Adrenaline
↑ Clinical peer support
Making a Difference
Advocacy
Experiencey
Shoulder tapped
Life Skills + Experience
Exposing Me to specialties in year one
Being looked up to
Desire to stay clinical
Perception of RN's as head makers
Nursing De Valved
Public Ignorance
Curriculum Imbalance
Increase male role models & Mentors
If we don't peform (to meet expectations) we're stuffed.
Positive male role models
Having male faculty good
High Expectation
Strong out loss benefits (and nursing)
Richer clinical experience
Celebrating
- Tech
- Adrenaline
- Autonomy
minimal issues nursing woman
having male peers in clinical may be useful
No Constraints for men
↑ respect from Doctors
PC's Tromm in Deep end
No need to debrief


#7
2nd Career (Tradie)
Public ignorance (NHS)
Friends/family nurses
Media stereotypes (gym)
Womens work
Failed med student
↑ men in cohort → Normalised
Family surprised (bt supportive)
"Wow, nursing are aweseom blokes"
Curriculum timeframe (Tutors trying to mitigate)
∅ male faculty
Books male as patient NOT clinician
In the spotlight. Can't hide
↑ expectation ("why???")
↓ prep from Tech
BN physical assessment Awkwardness
Jobs NOT fully embedded
PHC for me
Males expected to be NP/CNS
Stigma as an advantage (BN/Neurosurg learning)
↑ collegial respect
Male voices sought
patient curiosity (study out)
Happy customers
Male guidance sought (How do I do this? ... as a guy)
↑ male faculty + preceptors
Include men in history
Male nurses intellectual strength blokes
Tutors adapting to males (if present)
Men looked up to
More exposure to high school students – Scope of nursing
Expose male students to scope of nursing (options)

Appendix 9 – Final Wave Coding Summary



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