“It’s uncomfortable for us to be called sisters.” An exploratory study into the experiences of male nurses in a Johannesburg hospital, South Africa

A Research Report submitted in partial fulfilment of a Master of Arts in Industrial Sociology by coursework and Research Report.

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15 March 2016

Declaration

I Joshua Kalemba, do hereby declare that this research is my original work and that to the best of my knowledge and belief, it has neither previously been submitted nor currently being submitted to any other University for a degree or any other award. Where someone else's work has been used, due acknowledgement has been given and reference made accordingly.

Signature: _____

Date: 15 March 2016

Dedication

This thesis is dedicated to my son, Yandisa Joshua, with a hope that he will one day realise that education is a “weapon” to fight ignorance and poverty and a key to open doors for success, his mother Thandokazi, who has been a constant source of support and encouragement during the challenges of graduate school and life. I am truly thankful for having you both in my life. This work is also dedicated to my late father Esau Kalemba whose good examples have taught me to work hard for the things that I aspire to achieve, and my mother Busisiwe Rosemary Kalemba for her love, encouragement and support. I would also like to dedicate this thesis to my two sisters, Naomi and Sunganani Kalemba and my brother Esau Junior Kalemba.

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Acknowledgements

Throughout the process of this research I have been lucky enough to have several people whose kindness, patience and intelligence contributed greatly to my own academic pursuits.

Firstly, I would like to extend my gratitude to Dr Knowledge Rajohane Matshedisho for supervising the writing of this dissertation, for challenging and supporting me and for making invaluable critical comments throughout the process of this document.

Secondly, I would like to extend my sincerest thanks to my family and friends. It was only through their support, sacrifice and encouragement that this project was able to become reality. Every day I am reminded how lucky I am to have such great people in my life.

Lastly, I would like to thank God for making all of this possible, and the 15 male nurses who participated in this study. Any omissions are unintentional and regretted. The shortcomings and weaknesses in the treatment of the subject are entirely due to me.

Abstract

The aim of this study is to understand the experiences of male nurses as they work in women-dominated workplace. The focus of other studies has been on: the 'glass escalator' and the hidden advantages for men in the so called 'female' professions; masculinity at work; the experiences of men in female dominated occupations and the experiences of men in caring professions.

In South Africa, many studies on masculinity have been carried out that focus on the gender issues of southern Africa such as, causes and prevention of intimate partner violence; young men and the construction of masculinity, implications for HIV/AIDS, conflict, and violence; contemporary masculinities particularly the gendered cultural politics and hegemonic masculinities/masculinity in South African: culture, power and gender politics. But there is a dearth of literature on the issue of men in gender concentrated occupations, like nursing, in South Africa.

This study seeks to fill the gap in understanding of how South African men experience their masculine gender identity in the context of engaging in work which is supposedly feminine by employing a qualitative, semi-structured interview approach of 15 male nurses of a hospital in Johannesburg, South Africa. This study argues that male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace.

Keywords: *Hegemonic Masculinity, Post Structuralism, Southern Africa, Male Nurses and Gender Relations.*

Chapter 1: Introduction

1.1 Rationale

In South Africa, there is a paucity of research on the gender identity of male nurses in a traditionally feminine workplace like hospitals/clinics. A few notable studies have been conducted on the involvement of men in gender concentrated occupations such as nursing. These studies include, but are not limited to, the historical accounts of Evans (2004) and O'Lynn (2007) on the presence of men in the nursing profession; Searle's (1965) and Mellish's (1990) historical accounts of the nursing profession in South Africa, and elsewhere; Evans's (1997) account of the advantages of the minority status of male nurses in nursing; Simpson's (2004) work on the motivations and aspirations of men in gender typical occupations and O'Connor's (2015) work on the gender aspects of career choices for men who choose to nurse and how a masculine identity can be negotiated within the profession in Ireland.

This study aims to expand on the work of O'Connor (2015) by shining some light on South African male nurses in the Johannesburg area, with a particular focus on how these men maintain a masculine gender identity in the workplace. Using a process of configuration, misconfiguration and reconfiguration of the male nurse's masculine gender identity in the workplace, this study will argue that male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace.

This study utilises Connells (1995) concept of masculinity, especially her conception of hegemonic masculinity to make the connection between masculinity and gender and workplace relations in Johannesburg South Africa. This study also makes use of Connell and Messerschmidt (2005) concept of hegemonic masculinity and her emphasis on the fact that it reproduces gender hierarchies and inequalities in society. As argued by Connell and Messerschmidt (2005) the practices that are responsible for conceptualising hegemonic masculinity must be understood as complicated, vibrant and contradictory. Therefore, hegemonic masculinity is not uniform or stable but instead it is experienced differently across situations, time and space, at local, regional and global levels (Morrell, 2001).

This chapter aims to provide the researcher's view of the problem, and provide a justification for the study. As such this chapter is structured as follows: the background of the study; the problem statement, the aims and objectives of the study; the research questions; the significance of the study and the summary of the study's outline.

1.2 Background

The dominance of women in the nursing profession is well-documented (Marks, 1994; Burns, 1996; Walker, 1999; Marks, 2001). As a corollary, there is a paucity of men in the nursing profession. One frequent reason put forward is that women have a natural desire to nurture (Beck, 2000; Law and Arthur, 2003). Even Florence Nightingale – the nursing pioneer – held this view.

Burns (1996) reports that Nightingale was responsible for creating the linkage of modern nursing to femininity, and that this can be attributed to the fact that nursing was considered as a menial job because it was mostly the uneducated and untrained women who cared for the sick. However, Nightingale's reforms changed this by opening the training school, which provided educated women who wished to care for the sick some respectability through a profession (Miers, 2000). The school only admitted women as students, as during this time it was not socially acceptable to admit men to train at the same time and place as women. This tradition was to perpetuate the linkage of nursing to femininity, and this link persists to date. As a result women have since dominated the nursing profession across the globe. Consequently, only 6% of nurses in the United States are men; with 11% in the United Kingdom (LeMoult and NMC Stat, 2006) as cited in Panopio, 2010; and 7% in South Africa (Wildschut and Mqolozana, 2008).

It has been argued, however, that the paucity of men in modern nursing belies the history of healthcare. Men in ancient Greece, Rome, Babylon and India were responsible for caring for the sick in 'nursing type roles' (O' Lynn, 2007). Historically the most important evidence of the presence of men in nursing is in the military and monastic orders from the second millennium (Evans, 2004). Later, it was in Europe where the female aspects of care were first observed. The femininity of nursing began during the period of European industrialisation when women of low status began to carry out the tasks of nursing (Miers, 2000). In upper-class households,

private nurses were employed to deal with illness and appear to have been part of the servant class. Male nurses were not found to be prominent in assuming the caring role, because during industrialisation men mostly found labour-intensive employment in factories (Miers, 2000).

Subsequently, in South Africa nursing became largely a feminine profession (Marks, 2001). This gender stereotype rests on the view that there are psychological differences between the sexes and that women are particularly suitable for the caring role because they are generally nurturing and nursing, kind and gentle, selfless and subordinate – qualities required for a nursing career (Marks, 2001). With such stereotypes, most men do not aspire to venture into such female-concentrated occupations like nursing and only a few men undertake it (Williams, 1995). Hence, research on male nurses usually focuses on either the cultural factors that influenced them to take the profession (Lai et al, 2006) or not to take it (Schoonover-Shoffne, 2006). Some studies focus on attitudes and perceptions of men in nursing (Bartfay et al, 2010) including why they choose the profession (Tan-Kuick and Ng, 2010). In South Africa the focus of research on nursing has placed emphasis on the history thereof (Marks, 2001); and the role of black female herbalist's or 'granny' midwives in training other women as nurses and teaching them how to cater to their patients (Burns, 1996).

The feminisation of nursing cannot be discussed without considering masculinity. South African researchers have analysed a variety of topics such as men's relation to feminism (Meintjies, 1991); violence and the worker relationship in mines (Breckeridge, 1998); how manhood is negotiated during the transitional period (Walker, 2005); how women's engagement with norms of masculinity influence their agency in sexually coercive experiences (Stern et al, 2016) and the experiences of cisgender male and transgender sex workers and what the complexities their gender identities bring to understanding the issues of stigma and exclusion (Samudzi and Mannell, 2016).

However in a search of the literature little work in South Africa was found which specifically deals with masculinity in the context of men engaging in female-dominated occupations. The exception is Bhana and Moosa's (2016) work on the perceptions of a group of male pre-service teachers at a South African university for

choosing not to specialise in the teaching of young children. Therefore there is a need to expand research in the area of masculinity in relation to the men who engage in female concentrated occupations in the South Africa context.

1.3 Problem statement

Research has been done on men who engage in work in feminine-concentrated occupations (Williams, 1995; Kvande, 1998). The aim of such studies has been to understand the experiences of men working in such occupations. It is pointed out that those men in female-dominated occupations tend to move into such employment as ‘tokens’ (Bradley, 1993; Morgan, 1992). Research on men in women concentrated occupations has mainly been conducted in the northern, hemisphere, specifically in America, by focusing on the so called ‘glass escalator’ and the hidden advantages for men in the ‘female’ professions (Williams, 1992). Others have focused on masculinity at work and the experiences of men in female-dominated occupations (Simpson, 2004); or the experiences of men in caring professions (Simpson, 2009) and in Jamaica on the attitudes of patients towards being cared for by male nurses (Adeyemi-Adelanwa et al, 2016).

In Europe, research on men in gender-typical occupations has focused on the maintenance of masculinity for men who do 'women's work' (Lupton, 2000); men in non-traditional occupations in terms of their career entry, career orientation and experience of their roles (Simpson, 2005); men’s entry into female-centred occupations in terms of issues of masculinity and social class (Lupton, 2006); gender and ethnic differences in occupational positions and earnings among nurses and engineers in Norway; and the identical educational choices of male nurses and engineers and their unequal outcomes (Karlsen, 2012).

In Asia the focus of research on men in nursing in India has been on gender bias and discrimination in nursing education (Anthony, 2004); in Jordan research has paid attention to patients’ preferences for their nurses’ gender (Ahmad and Alasad 2007) and in China research has been conducted on the current status of career advantages and social demands of male nurses (Hongxia, 2010).

On the African continent research on men in feminine concentrated occupations has, focused on men doing ‘women's work’, masculinity and gender relations among street vendors in Maputo, Mozambique (Agadjanian, 2002) and in Ghana, the

involvement of men who do women's work, structural adjustment, unemployment and changing gender relations in the in formal economy (Overå, 2007) whereas there is a dearth of literature on men in gender atypical occupations in South Africa.

Instead in the South African context studies on masculine roles in the workplace have mainly paid attention to the effects of political transition from apartheid to democracy and how that disturbed the established gender order (Morrell, 2001; Walker, 2005); the causes and prevention of intimate partner violence (Jewkes, 2002); youth, fathers and masculinity (Morrell, 2005); young men and the construction of masculinity and its implications for HIV/AIDS, conflict, and violence (Barker and Ricardo, 2005) the importance of separating the experiences of contemporary masculinities particularly the gendered cultural politics through which they have been produced (Hunter, 2005); how first apartheid and then chronic unemployment have become entangled with ideas about femininity, masculinity, love, and sex to create an economy of exchange that perpetuates the transmission of HIV/AIDS (Hunter, 2010); and hegemonic masculinities/masculinity in South Africa in terms of culture, power and gender politics (Morrell, Jewkes and Lindegger, 2012).

As shown above, the research conducted on men in female concentrated occupations, mainly in other parts of the world, have focused on the issues of choice to the maintenance of gender identity in these feminine occupations, and what influences them to enter such occupations. In South Africa, despite a wide range of topics studied in relation to masculinity, there is a dearth of literature on the issue of men in gender-concentrated occupations. It is therefore the aim of this study to fill this gap in lack of understanding of how South African men experience their workplace masculine gender identity in the context of engaging in work which is supposedly feminine.

1.4 Aims and objectives

Little is known about the gendered structures of the nursing profession and how men negotiate a masculine identity within these gender structures especially in South Africa. It is therefore the aim of this study to contribute to this gap in understanding. The current study achieved this aim by employing a qualitative paradigm, and carrying out 15 in-depth interviews with male nurses, of a particular hospital in the Johannesburg area. Owing to the qualitative nature of the study, and the fact that,

the only 15 male nurses interviewed from this study were from one hospital in Johannesburg, South Africa, the results obtained in this study cannot be generalised. The main objective of this study is answering the question of how male nurses experience their gender identities in the workplace.

Therefore the aims of the study are to discuss data on:

- The involvement of men in the nursing profession;
- The feminine nature of the nursing profession and the demise of men from the profession;
- The current role of men in the nursing profession and the meaning and application of the concepts of masculinity and post-structuralism.
- The issue of maintaining a masculine identity in the context of engaging in work which is supposedly feminine, such as nursing from a South African perspective and
- The opinions and perceptions of male nurses in South Africa, Johannesburg on how they experience their masculine gender identity in the workplace.

1.5 Research questions

The main research question posed by the study is:

How do male nurses experience their gender identities in the workplace?

This research question will be aided by the following three sub-questions:

1. How do male nurses understand their own gender identities in the workplace?
2. How do male nurses reflect on gendered interactions with female healthcare workers in the workplace?
3. To what extent is hegemonic masculinity an identity source for male nurses?

The results obtained from this study will be discussed in relation to existing literature on post-structuralist interpretations of gender processes.

1.6 Significance of the study

The significance of this study is that it fills the gap in lack of understanding on how male nurses understand and resolve the contradiction of being a man and working in a female-dominated occupation by using post-structural interpretations of gender processes in the South African context. Theoretically this study proves that hegemonic masculinity is useful in understanding the gender processes at work, specifically in the context of men engaging in feminine occupations, similarly this study shows that, it is useful to adopt a post-structural perspective in the interpretation of such gender processes.

The practical contribution of this study is that, it highlights the fact that people in the nursing profession need to advance their understanding on the rich contribution made by male nurses to the nursing profession both in the classroom and at a societal level; this would help break the stereotype of women being better suited for nursing, and the view that male nurses as gay, effeminate, homosexual or sisters. If this stereotype would break, then there will be no need for male nurses to resort to configuring, misconfiguring and reconfiguring their masculine gender identity in the workplace.

In relation to policy, the recruitment of men to the nursing profession would decrease both the unemployment rate and shortage of nurses and contribute to an increase in these skills in South Africa. However, for this to take place, policy makers need to realise that the shortage of male nurses is due to the fact that males nurses and men who wish to enter into nursing lack male nursing role models whom they can aspire to emulate, but such figures can be found in studies such as this one. Policy makers therefore should encourage studies on male nurses, and focus on how they experience work, such studies ought to paint a picture that it is respectable to be, or want to be a male and a nurse, thereby decreasing the skills shortage and unemployment in South Africa.

1.7 Methodology

As Chapter 3 will show this study employs qualitative methods to collect and analyse data. The researcher conducted 15 in-depth interviews, with 15 male Black nurses at a hospital in Johannesburg, South Africa. The participants of this study were recruited using purposive and snowballing methods, data was collected through the

conduction of in-depth interviews, and the collected data was analysed using deductive and inductive thematic analysis. All ethical procedures were considered and adhered to in-order for this study to take place.

1.8 Report outline

Following this chapter which introduced the study; its background; problem statement; aims and objectives; research questions and the significance of the study, Chapter 2 will provide a literature review of the study. In this chapter, the presence of men in nursing will be highlighted in relation to hegemonic masculinity. This highlights that, men in feminine occupations employ a variety of strategies to portray it. Lastly this chapter illustrates the usefulness of post-structural interpretations of gender processes in studying masculinities.

Chapter 3 will illustrate how qualitative research methods were employed by the researcher to gather and interpret data. In addition, this chapter will also discuss the ethical considerations for the study. Thereafter the findings of the study will be presented in chapter 4, whereas chapter 5 will discuss these findings, before chapter 6 concludes the study.

Chapter 2: Literature review

2.1 Introduction

The themes presented in this literature review are concerned with understanding how male nurses experience their gender identity in the workplace. The argument will be presented that male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. It is important to review literature on the role played by men in the establishment of the nursing profession. As such, this literature review is divided into two sections.

The first section of the literature review will seek to present themes that relate to the history of the nursing profession in relation to the presence of men in, and disappearance of men from, the profession since its establishment globally and locally. It is important to review this literature because this history will show the changing roles and societal perception of male nurses thereby indicating the social construction gender and work. This will later (Chapter 5) demonstrate how contemporary gender relations influence the experiences of male nurses in a women-dominated workplace. After highlighting the establishment of the profession from a historical perspective, the second section of this literature review will discuss the concepts of hegemonic, marginalised, complicit and subordinate masculinities and post structuralism. Thereafter, these concepts will be used to examine the data obtained from the in-depth interviews the researcher had with the 15 male nurses. It is through the literature and fieldwork findings that this research report understands the situationality and context of male nurse's experiences. Hence it argues that male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. It is to men in women-dominated occupation that this literature review begins.

2.2 Men in Feminine Occupations

The following authors have studied the entry of men into gender atypical occupations (Williams, 1995; Evans, 1997; Meadus 2000; Cross and Bagilhole, 2002; Simpson, 2004; Lupton, 2006 and O'Connor, 2015). Their studies have explored the influences and experiences of men's entry into pre-school teaching, clerical work, nursing and

flight attendants (Simpson, 2004). Furthermore, the focus has been on how the minority status of men in these occupations is a [dis]advantage for the men and how the men [re]negotiate their masculinities in the workplace (Evans, 1997).

Studies on male nurses have also indicated that male nurse's do gender by conforming to dominant gender norms, as well as undo gender by resisting these norms (McDonald, 2013). Whereas some studies have investigated patient's views of being cared for by a male nurse, pointing out that patients generally had a negative attitude towards male nurses but had a positive view if they were cared for by a male nurse (Adeyemi-Adelanwa, 2016). Other studies on male nurses found that, contradictions and difficulties for men in nursing with identifying with the profession exist. Furthermore, because little encouragement is given to men to join the profession, for those men who have chosen to nurse, an attempt to distance themselves from traditional motivations for choosing nursing, such as caring and vocationalism, has been made (O'Connor, 2015). Some studies have provided the reasons why men chose nursing, barriers they experienced, strategies to improve recruitment/retention, recommendations to others, and career satisfaction (Twomey and Meadus, 2016).

2.2.1 Public perception as a catalyst for the paucity of men in female dominated occupations

In relation to the entry of men in gender atypical occupations, Meadus (2000: 5) identified factors which deterred the recruitment of men into the nursing profession, in Canada. He cites public perception as one of the factors that deter the entry of men into the profession. Meadus (2000: 6) argued that: "one major barrier that may deter men from entering the profession is nursing's traditional image. Nursing's image perpetuates cultural understandings and societal attitudes about occupations appropriate for men and women. As such, nursing remains stereotyped as a female occupation. After all, gender-role socialisation patterns in society provide examples of ways in which boys and girls are exposed to different role models and different messages about what is appropriate to each gender. Society has presented men with strong stereotypical boundaries concerning masculine or feminine behaviour. Men who choose nursing as a career risk challenging traditional gender-defined roles and stereotypes."

Political, social and economic systems play a huge role in enhancing these stereotypes. The stereotypes often result in discrimination against men for choosing careers which are not masculine. Males face a lot more criticism than females for entering in gender atypical occupations such as nursing. Additionally, because engaging in such occupations is often seen as a step down in status, some men shy away from pursuing gender atypical occupations (Meadus, 2000: 6-7). Additionally, Meadus (2000: 7) believes that this is because it is difficult to accept men in caring, gentle and considerate roles. Men's desire to enter nursing challenges society's stereotypical role of nursing. Meadus (2000: 7) cites a phenomenological study by Paterson et al (1996) which found that men can be as caring as women and can play the nursing role the same way women do. In addition, those men that decide to enter nursing do so for the same reasons their women counterparts do; that is, the desire to care for others.

These characteristics are not inherent in the biological or the social nature of the sexes but are culturally constructed to highlight the socially acceptable activities associated with being a male or female. Since gender and politics have contributed to how the responsibility of caring rests on women, this preference has contributed to how labour is divided across gender lines, implying that occupations are socially and culturally defined across gender constructs (Meadus, 2000: 7). Since a person's identity is directly linked to their gender/sex role in society, it is challenging to rethink the concept of masculinity. As such, men who aspire to enter into female dominated occupations receive less favourable appraisals by society than their female counterparts in male dominated occupations. These stereotypes also contribute to the paucity of men in the nursing profession.

Men that do pursue a career in gender atypical occupations, such as nursing, find that they have to constantly explain why they chose such a career. As much as there are socially constructed stereotypes that certain careers such as nursing are better suited for females, this study will show that these socially constructed stereotypes follow male nurses into the workplace and manifest there. Furthermore, this study will also highlight how male nurses result to configuring, misconfiguring and reconfiguring a male nurse masculine gender identity in order to find a socially acceptable way of being a man and being a nurse.

In-order to gain a fuller understanding of the process of configuration, misconfiguration and reconfiguration of male nurses' workplace masculine gender identity, it is important to understand the history of the occupation. Within this history, males are present and then suddenly disappear from the occupation due to societal changes taking place throughout history. The next section of this literature review will illustrate how, with the evolution of humans, the role of a nurse was developed. It is important to review this literature because it will assist with understanding how the re-entry of man in modern day nursing results in the male nurses attempting to portray hegemonic masculinity as their gender identity simultaneously being configured, misconfigured and reconfigured.

2.3 The historical periods of history in relation to nursing

2.3.1 The primitive times

The primitive times are characterised by the non-existence of writing all over the world. However, as time progressed, people who could not write lived alongside those that had some form of written language (Mellish, 1990: 4). Some scholars contend that, history only started when writing was discovered, therefore making the start of history about 3000 years before Christian Era (BCE) in Mesopotamia (Starbuck, 2003: 143). Human beings during 2500 BCE emerged from cage dwellers to clothed and sheltered beings. During this period, humans were living, giving birth and dying. This is the time when the primitive mother, as we think of her today, should have existed, her role was to give birth, nurture, protect and look after her child when he/she had an illness or was injured (Bulliet et al, 2014: 8). The role of the man in this society was to hunt for food, it was then the role of the woman to look after him and other family members if they caught an illness or experienced injury. For example, if a man was burned by fire, or injured by opposing tribes, it was the responsibility of the woman to nurse him during his illness or injury (Mellish, 1990).

Around 8000 or 7000 BCE, societies became more settled and some form of social organisation began to emerge as man started domesticating animals; building houses and huts; towns and villages started to emerge and tribal leaders were elected (Mellish, 1990: 5). For Baly (1973: 3), nursing was responding to the changing social needs of the time. During the same time, because the mother breastfed and prepared food for the family, she was more aware of foods and

substances which caused illnesses (Sharma and Sharma, 1997: 267). Additionally, during this period, ‘wise-women’ emerged. Wise women were women of particular tribes whose responsibility was to collect natural substances, such as plants, roots, seeds, nuts, and trees for healing purposes (Mellish, 1990: 6 and Ehrenreich and English, 2010: 25). Following the experimental remedies developed by the wise women by trial and error, people were able to offer needed explanations for many other strange phenomenon’s’ of the time such as incomprehensible illnesses, and natural disasters (Ehrenreich and English, 2010: 25-26).

During this period humans also turned to gods, evil spirits, demon possession and supernatural beings to explain the evils of the world in one form or another which visited people, members of their family, tribes or nations (Hollenbach, 1981). This resulted in the formation of the role of the witchdoctor, shaman or medicine man, who was believed to possess supernatural powers, which he could use for good and bad, and he was thought to be capable of weaving spells that could heal people as well as making them ill. The medicine man was responsible for the provision of medication just as modern day nurses are (Haggard, 2012).

The services provided by the ‘witchdoctors’ are similar to those provided by present traditional healers in certain parts of the world. They both employed medical practices by wearing charms to scare off evil spirits, and they attempt to pass off diseases or evil spirits to animals and inanimate objects. In fact, in present day Southern Africa, traditional healers still play an important role, to the extent that, patients in western hospitals accepting western medication arrive at these hospitals with charms on them. It was only until the late 3500 BCE that this religion started to play a role in healing of the sick (Mellish, 1990).

In Babylonian society, about 2500 BCE until 560 BCE, evidence exists which suggest that, the people of this society believed, diseases were caused by demons and it was the job of priests-physicians to interpret the actions of demons and to call on the Gods to alleviate suffering of the afflicted. Nurses are not mentioned as a separate category, but there is mention of temple attendants who were responsible for assisting the physicians in taking care of the patients (Mellish, 1990: 13). However, the idea of demon possession or a visitation of wrathful Gods as a cause of disease was discarded in late 460 BCE. The reason commonly cited for this was

the arrival of Hippocrates in ancient Greek who is dubbed as the ‘Father of Medicine’. He was responsible for the development the world’s first known medical school, which adhered to a common medical doctrine (Mellish, 1990: 21). Hippocrates believed that, in order to successfully, medically treat a patient it was important to look at the patient’s environment, health history and conduct a complete physical examination.

Both men and women carried out the nursing role. During this period, Aphrodite and Artemis were regarded as goddesses of fertility. Aphrodite was the goddess who spread life and joy (Mead, 1968). Thus, making a separation between the roles of priest-physician from that of the midwife, attendants of the sick worked hand in hand with physicians, they were pupils of the physicians who were left in-charge to carry out instructions, administer treatment and watch the condition of the person being treated. The assumption can be passed that they were men because these pupils had to be admitted to the mysteries of the art, and women in ancient Greece were forbidden in mysteries of any art (Mellish, 1990: 21). In 250 BCE in India, the first known school of nursing in history was formed. In this nursing school only men were accepted as students, because they were considered "pure" enough to take care of the sick (Tranbarger, 2007: 43).

The development of nursing as illustrated above, from the history of Wiseman, witchdoctors and attendants and nurses in India shows how the nursing role was associated, firstly with females as Wisewomen and then with males, as Wisemen, witchdoctors, attendants and nurses in India, thus highlighting the instability of gender association with the nursing profession. This was long before the advancement of the world’s two major religions, Christianity and Islam. The section below will illustrate how these two major religions viewed nursing in relation to gender and how for the world’s major religion of Christianity that has changed over time.

2.3.2 Religion and nursing

The advancement of Christianity and Islam was accompanied by the teachings of Christ (Christianity), which encouraged charitable ethos, such as taking care of the sick and the poor. The emergence of Christianity saw a rise in sick people flocking to the church in order to receive care. Many bishops responded to this by building

separate wings in the church to accommodate them. Originally, it was the responsibility of the deacons and deaconesses to care for these people. This was the birth of Christian hospitals (O'Lynn, 2007: 10). As time progressed, congregational members were replaced by monks and nuns, to play the nursing role. Between 527 and 565 Christian Era (CE), during the rise of the Roman Emperor Justinian, authority was given to bishops to oversee the management of all hospitals. Consequently, there was a rise in shelters, hospitals and religious orders that were geared towards caring for the sick and poor (O'Lynn, 2007: 10). To date, two men Ephrem and Basil, who were later characterised as saints (St), are respected for their work in launching nursing care for the sick.

In Islam, Rufaidah Al-Islamiah is a woman who is respected for launching nursing care for the sick (El-Haddad 2006: 288). In fact, El-Haddad (2006: 288) contends that in Islam, historically, it was the role of women to nurse, care for and nurture the sick and wounded as part of their formal social role as sisters, daughters, wives and mothers. It was no different for women in pre-Islamic and early Islamic eras, except that those women mostly nursed members of their families and/or direct communities. Furthermore, El-Haddad (2006: 288) contends that little is known about nursing in the Gulf region until the emergence of Islam and the arrival of Rufaidah Al-Islamiah.

El-Haddad (2006: 288) states that Rufaidah acquired the title when the Prophet Mohammad went with his followers to fight the first battle against their enemies. Rufaidah and a group of Muslim women participated in this battle by providing moral support to soldiers and by looking after their wounded. After they won the battle and went back to Medina, Rufaidah decided to continue to provide her services to sick people in her community and erected her tent near the Prophet’s mosque. Rufaidah believed that nursing is an art needed by people during the days of peace and war. After her death, many more Muslim women decided to continue her role by nursing sick people during peacetime and by accompanying Muslims into war and looking after their wounded.

This was not the case with Christianity, as St Ephrem worked as a deacon in the region of Edessa (modern day turkey) in 350 CE. During this period the region experienced a series of plagues. He was responsible for buying 300 beds, from

funds which he collected from the ‘rich’; thereafter, he placed the beds on porches and passageways to take care of the sick, many of which he took care of himself (O'Lynn, 2007: 10). St Basil in 370 CE became a bishop in Caesarea (located in modern day Turkey). Like St Ephrem, he showed a keen interest in caring of the sick, so much so that he often criticised the rich for their lack of interest in Christian Charity. In addition, St Basil, using the church’s resources, built beautiful church buildings in the suburbs that were used to house travellers, who cared for the sick, and provided training for the unskilled. In his buildings he built a place to take care of people who suffered from leprosy. The care that the leper’s received was so great that one of his hospitals became known as the premiere hospital for lepers (Mackintosh, 1996: 232 and O'Lynn, 2007: 10).

To assist him, St Basil hired many workers. The workers included male nurses known as nosocomi, who were men responsible for looking for sick people in the community and bringing them into the hospital. As time progressed, St Basil enlisted the help of a group of men known as the Parabolani, whose tasks were similar to that of modern day employees of home health agencies. In addition to their transportation services, the Parabolani provided an excellent service, especially during the numerous plagues experienced in Europe and the Middle-East (Mellish, 1990 and O’Lynn, 2007). However, the services of the Parabolani only lasted up until the period of 324 CE.

The period of 324 CE until 1453 CE, is known as the Byzantine period. During this period the institutional care of the sick expanded, especially in the eastern Mediterranean region. The motivation for this was the Christian belief in charitable ethos and the social structure of the region after the Roman capital was moved to Constantinople in the 4th century. A very important development of this period in relation to nursing was the establishment of facilities that were aimed at caring for the elderly called gerocomeia (Greek for elderly care). Emperors were the founders of these ancient nursing homes, and they were often built next to monasteries (Mellish, 1990 and O’Lynn, 2007). A very important gerocomeia built around this period was built during the time of Emperor John II Comnenus. The gerocomeia was equipped to care for 24 patients, who received care from six male nurses. If a patient fell ill, a physician would be notified and the patient would be transferred to a proper

hospital to receive medical attention (O'Lynn, 2007: 12). The rise in Byzantine hospitals was accompanied by a rise in the number of working nurses.

As the number of working nurses soared, many lay people were accepted into nursing and, consequently, they replaced the nuns and monks who were responsible for caring for the sick. According to Bullough and Bullough (1993) cited in O'Lynn, (2007: 12) the process was completed in the 6th century. For O'Lynn, this is when nursing become a specialised occupation, most of the nurses of this period were men, even though women still maintained the role of the midwife both at home and in the hospitals, some gained enough knowledge to play the role of midwife, healer and physician for women. It was only by the 13th century that some hospitals were entirely staffed by male nurses (2007: 12).

Both female and male nurses in Byzantine were eligible for wages as they were able to accompany the Byzantine guilds. However, little information exists on whether or not these nurses received any formal education; the facts that are known for certain are that, in order to qualify as a guard formal training was necessary, as well as apprenticeship training (O'Lynn, 2007: 12). Perhaps the nurses also received the same training because they had to accompany the guards. However, the hospitals in the western Mediterranean region were not the only place where lay people were employed as nurses. Men and women who were associated with Christian religious orders were also used as nurses. The arrangement of setting up hospitals near religious institutions was also observed in England and elsewhere (O'Lynn, 2007: 12).

The history of nursing presented above from an Islamic and Christian view illustrates the contradicting views of how these two religions and possibly many other religions globally might have viewed nursing in relation to gender. For Christians, nursing was assigned to men then assigned to women; thereafter, it was assigned to women and again to men. Whereas in Islam, nursing was the duty of a woman as an extension of her role of sister, daughter, wife and mother. However, the fact remains that men were present in the early establishment of nursing. Many modern day male nurses, such as the participants of this study, are not made aware of this history of men such as those described above in the profession and, as such, lack male role models

when choosing to enter nursing. They may well feel that they are the new pioneers, stepping off into foreign territory.

2.3.3 The rise of male nurses

The period of 1500 to 1800 BC is necessary to review because in Mellish's (1990: 55) words, "it was, however, a time of significant changes and may perhaps have been the time when modern man, as the 20th century regards him, was born." This was a period when man was travelling and making new discoveries. In addition, this was a time when many Christian pilgrims were traveling to the Holy Land, hostels were present to nurse, shelter and feed the pilgrims. The existence of these hostels can be traced as far back as 603 CE. The pilgrims were initially welcomed in the Holy land because of the commerce they bought with them. However, with the political and military struggles experienced in the eastern Mediterranean region, the number of pilgrims visiting the region fluctuated. As the century was coming to an end it was common practice for the pilgrims to get robbed and they were required to bribe thugs to gain access to the Holy Land (Evans, 2004).

In 1050, the caliph of Egypt took over Jerusalem and he awarded the rich Italian merchants a project to build a compound with hospitals, a convent, monastery and a church in Jerusalem. One hospital was St Mary Magdalene, built to care for female patients and another was St John, built to care for male patients. St John is rumoured to have been named after St John the Baptist, as he was the benefactor of the hospital and he was also the patron of the Knights Hospitallers of St John of Jerusalem (Evans, 2004: 322).

St John gained a good reputation for caring for poor and sick pilgrims. The servants of the hospital, the nurses, were made of a group of men who were associated with the monastery located in the same geographical setting. In Bullough and Bullough's (1993) opinion, women in this society played little or no role in nursing patients in the hospital; however, in the home setting this was not the case. In addition, it is highly unlikely that the patients receiving hospital care at this time were women as female religious orders were not put into place until the 17th century. The care given to patients at this hospital was of high quality, so much so, that some pilgrims choose to stay behind and joined the nurses in caring for the sick (O'Lynn. 2007: 14).

At the beginning of the millennium, many Christians were under the impression that the world was ending and they embarked on a journey to the Holy Land; consequently, crimes against the travellers increased. This was also a troublesome period for the region as there was infighting between the European kingdoms and nobles. It is because of this and other reasons that Pope Urban II arranged the First Crusade during the concluding years of the 11th century. The Hospitallers cared for many of the wounded soldiers at their hospital. After Jerusalem was successfully occupied in 1099, Godfrey of Bouillon, the first ruler of the Kingdom of Jerusalem, rewarded the Hospitallers with parcels of land. Because of this, the Hospitallers amassed great wealth (O'Lynn, 2007).

The Hospitallers used the newly accumulated wealth to build more hospitals, under the supervision of their leader, Brother Gerard; seven hospitals were built around the Mediterranean ports in less than 12 years. As the number of patients receiving care in these hospitals grew, so did the payments of gratitude given to the Hospitallers (Evans, 2004: 322). This enabled Brother Gerard to expand his mission and to build new hospitals in Europe and Jerusalem (O'Lynn. 2007: 14). The military role of the Hospitallers had not yet developed.

Their role was unique at the time, as they were only allowed to follow religious vocation and be active in the world. That is, their role was not only limited to the monastery, they were allowed to play other roles outside of the monastery. The lay brothers were men who were former soldiers and who took a vow of obedience, chastity and charity. Brother Gerard instructed some of the lay brothers to keep their arms, especially those who were responsible for escorting pilgrims travelling through dangerous routes in Jerusalem (Mellish, 1990 and O'Lynn, 2007).

The Hospitallers were changed from a secular to a religious order in 1113, when Brother Gerard's request was granted. His request was that the Vatican should incorporate the Hospitallers under the orders of Pope Paschal II. The request was granted giving the Hospitallers permission to elect officials without the interference of the Vatican (O'Lynn, 2007: 15). The Hospitallers assumed a white, eight pointed cross as their symbol in honour of the eight Beatitudes. O'Lynn (2007: 15) contends that, the hospitals of the Hospitallers were well-known for providing care that "was of a quality that had not been seen in other hospitals." The sick received excellent care.

As soon as the sick entered the hospital they were cleaned, in addition, they were given fresh gowns, robes and boots to wear in the hospital.

The sick were also given beds and fed fresh meat three times a week (Sire, 1994). In this hospital, four physicians were assigned to the hospital and nine brothers were assigned to each aisle of the hospital who played the nurse type role. It is noteworthy that the Hospitallers did not only provide care for Christians, but also for Muslim citizens and solders (O'Lynn, 2007: 16-17). Surrounding Muslim nations recaptured the Holy Land from the Hospitallers and other alliances like them in the 12th and 13 Century. Ultimately, the Hospitallers lost control of Jerusalem in 1188, the Muslim army allowed for the hospital to remain for 12 months in-order for the Hospitallers to provide nursing care to the sick and give them enough time to heal.

The Hospitallers consequently fled to Cyprus, but also fled to Rhodes in 1310. Again, in Rhodes, they were defeated by the growing Muslim population. In 1523, the Turks chased the Hospitallers from Rhodes and they fled to Malta in 1530 where they built hospitals which continued to serve both men and women; here too they provided nursing care for the sick (O'Lynn, 2007: 17). O'Lynn (2007: 18) states that, in 1798 the Hospitallers were chased out of Malta by napoleon and fled to Rome where they ceased to exist. However, since 1940 they slowly started to re-emerge and they operated in hospitals and ran a number of ambulances in Europe. Most recently, the Hospitallers have been operating and have responded to international relief organisations such as AmeriCares (AmeriCares. 2003).

Nursing during this period was male dominated. The history presented above shows the role played by men in the organisation of nursing. Hospitals are also one of the major institutions that nursing emerged from as a separate occupation, specifically for men. Over time, the status of nursing declined and, when nursing was reformed due to social changes happening at the time, the nursing occupation had no or limited space for the males who helped organise the occupation. The reasons for this will be discussed below.

2.3.4 The decline in the status of nursing

The nursing profession experienced a decline in knowledge base, values and status in many Western countries during the period of 1517 – 1648. The main reason cited for this was the closure of monasteries and convents because of the troubles

experienced by the Protestant Reformation. This is because many hospitals were run by different religious orders, as the nuns and monks were chased out of northern European countries, they took their nursing knowledge and texts with them (Donahue, 1996).

Consequently, hospitals, such as those previously run by the Hospitallers were left in the hands of secular organisations that lacked the basic knowledge and discipline required to keep a hospital functioning. As a result, many questionable characters that had little or no nursing training were recruited to take care of the sick as nurses. Additionally, with the decrease in the number of hospitals, which were run by religious orders, the number of written accounts of male nurses and their experiences also dropped (O'Lynn, 2007: 22).

The other reasons cited by O'Lynn (2007) for the causation of this decline was because of the increase of women entering the Catholic religious life in many Catholic countries, and those women were mainly directed toward serving in the hospital. Even though Evans (2004) contends that men continued to serve the nursing role in this era, their role was limited to providing physical strength needed to subdue mentally ill patients (Mackintosh, 1997). Furthermore, some larger and well-respected hospitals requested nuns as nurses (O'Lynn 2007: 22).

O'Lynn (2007: 22) argues that, some male nursing orders ceased to exist because of the numerous "disruptions in donor support, political infighting, military pursuits and the banning of activities by governments such as those of the French Revolution and Napoleonic France." In relation to war, men were still responsible for nursing the sick throughout the time, they continued to work as nurses in instances where female nurses were unable to carry out the nursing role, such as during wars or during the colonisation of America (Mackintosh, 1997).

Even though some authors (Baly, 1986; Mackintosh, 1997; Miers, 2000; Marks, 2001 and Evans, 2004) have recognised Florence Nightingale, for pioneering the feminisation of the nursing profession, the authors were not mindful of the three social changes that were taking place before Nightingale's arrival and contribution to the reduction of male nurses. O'Lynn (2007: 23-24) cites three important social events that contributed to the reduction of male nurses. Firstly, during the Renaissance period the waning of monasteries and male nursing orders led to a rise

in convents and female nursing orders. Secondly, nursing evolved into an ill-disciplined and poor quality occupation because of the rise in secular hospitals. Consequently, the status, respect and pay of nurses decreased. In fact, the nursing occupation's status plummeted to the point where many hired nurses were social misfits, alcoholics, prisoners, prostitutes or ne'er-do-wells' who were forced into the nursing services (Miers, 2000 and O'Lynn, 2007).

Lastly, the Industrial Revolution saw a growth in a number of factories being built across Europe and North America, which also saw a rise in the extraction of natural resources that were required for the production of factory goods. In these factories, intense physical labour and many days spent away from home were required from the factory workers. These requirements were not consistent with the female social roles of this time. Therefore, men rushed to work in factories since such jobs did not require any formal education and they paid higher wages than farm labour and basic labour.

During this period, there was a decline of men in nursing because of the above mentioned factors and because there were more favourable, high paying jobs in other sectors. Men's involvement in nursing was therefore only in circumstances where women would not be able to carry out the nursing role, such as during wars, or subduing mentally ill patients (Mackintosh, 1997 and Evans, 2004). Due to the social changes taking place during this time, it become socially acceptable for a man to be engaged in a profession which was contingent with his masculine gender identity, such as being a factory worker or working in the military as a soldier. Therefore, there was a disappearance of men from the profession, and the professionalisation of nursing as a feminine occupation occurred, as is illustrated below.

2.3.5 The feminisation and professionalisation of nursing

Evans (2004: 323) states that, Nightingale and others were able to officially feminise nursing. Nightingale, through the establishment of her school in the 19th century, was able to re-introduce nursing as a woman's occupation. She was able to do so by establishing an apprentice type education model, where it was deemed 'natural' for women to work in hospitals, under the supervision of male physicians without receiving any form of education. Her encouragement of women into nursing resulted

in the promotion of patriarchal Victorian family structure, and the doctor-nurse profession resembled the Victorian husband-wife-child relationship (Porter, 1992: 511). Where the male physicians were regarded as the dominant ones who assumed the role of the father, and female nurses were regarded as the women and patients as children. This completed the institutional family and reflected the social values of the time, where labour was divided in accordance with gender (Evans, 2004: 323). Furthermore, Evans (2004: 323) argued that the idea of male nurses was consequently not compatible with prevailing, institutional, family ideology of this time. Nursing and nursing education was restructured and this restructuring was aided by the division of labour which took place during a time when the Victorian gender separatist ideologies of gender were at their highest peak.

For O'Lynn (2007: 24) nursing become a respectable occupation for females when upper-class women were recruited and trained as nurses. By doing so, Nightingale managed to secure respectable employment for Victorian women. Thus, nursing was turned into a respectable profession for women. The formation of nurse's homes or residences to house women, nursing students and nurses, caused a further isolation of women from men and was a catalyst for excluding men from the nursing profession (Evans, 2004 and O'Lynn, 2007). O'Lynn (2007: 25) argued that the asylums in England were the only group able to resist the introduction of trained nurses in their sex-segregated facilities. Mackintosh (1997: 233) supports this argument by stating that, "the asylums with their strict sexual segregation of patients and staff proved more difficult to infiltrate. Male attendants were not prepared to allow general trained female nurses to take over the asylums." The formation of the Medico-Psychological Association in 1879 by medical superintendents was a way of training and certifying male attendants who played the nursing role.

However they did not succeed as they could not match up to the standards and social respectability set by the trained nurses who usually came from a higher social class than men. As a result, the asylums assumed a psychiatric focused care, since men were forbidden from receiving a formal nursing education; they were demoted to the duties of orderlies (Mackintosh, 1997: 234 and O'Lynn, 2007: 25). In other parts of the world, such as England, men still played the nursing role in the military as private duty nurses. Evidence to support this claim is the deployment of over 800 male nurses who served in the Anglo-Boer war.

This is a very important period of nursing to review because it shows how nursing changed to a feminine occupation. As a result, men did not feature in the early years of the formation of the occupation, resulting in modern day male nurses not having a male figure to look up to where, women have Nightingale. Therefore, as will be illustrated by this study in the chapters to follow, male nurses have to find their own ways of constructing an identity of the male nurse with the absence of male role models. The feminisation of nursing were taking place during the period of colonisation to put this study into context, the following section of this literature review will focus on the nursing profession in South Africa before, during and after colonisation (Mellish, 1990 and O'Lynn, 2007: 25-26).

2.4 Nursing in South Africa

Dolamo and Olubiyi (2013) contended that, when it comes to nursing in South Africa, nursing developed through three key periods; that is, pre-colonial, colonial and the post-colonial periods. However, in pre-colonial South Africa, not much is known about nursing; except for the fact that in much of pre-colonial Africa, the nursing-type roles by the indigenous Black population were and are still served by traditional healers (Mellish and Paton, 2005: 52). These traditional healers are usually Black, elderly women who play the herbalist role and act as midwives in their communities. In these communities, the elderly women, are responsible for training younger women to become 'nurses' (Burns, 1996). Similarly, in pre-colonial Nigeria the role of women was to take care of the sick, cook, prepare firewood and to water the earth (Ezegbe and Akubue, 2012: 28). It is during the period of colonisation that the above-mentioned nursing type roles were incorporated with professional nursing in South Africa.

The introduction of nursing in South Africa was a result of the desired transition to western forms of medicine and health care that was deeply embedded within a broader, moral and ideological project of 'civilising the natives' and that was contingent with the abolishment of 'superstitious' and 'ignorant' traditional beliefs of the natives by the White settlers (Marks, 1994). In colonial South Africa, Sister Henrietta Stockdale, was responsible for establishing the first nursing school in Kimberly in the 1800s, which only admitted White female students. She was not only first to establish modern, professional training standards for White South African

women, but she also provided the profession with its founding charter (Marks, 1994 and Dolamo and Olubiyi, 2013).

According to Searle et al (2009) the independent states of Botswana, Lesotho, Swaziland, Zimbabwe, Zambia, Malawi and South Africa all have British influence on the development of nursing and midwifery. The Cape colony hospital body enacted the rule of requiring all trained registered nurses and midwives appointed to posts under their control to be registered so that standards of education and training the and level of competence, responsibility and accountability, could be verified and disciplinary control exercised legally. Most of these nurses were White females, who came to South Africa through the religious orders (Searle et al, 2009).

In Mellish's (1990: 108) opinion, the first religious order aimed at the introduction of nursing to South Africa was the Roman Catholic nuns Assumption order in 1847. Headed by Sister Marie Gertrude of the Blessed Sacrament, who first arrived in Port Elizabeth heading for Grahamstown, these nuns arrived during the Frontier War and they provided nursing services to the sick and attended to people who were wounded during the war. In 1867, an additional order of sisters arrived in South Africa and stayed for 25 years, caring for sick and poor people in the Port Elizabeth area (Mellish, 1990: 108). The establishment of hospitals only started in 1877. In 1877, another order of nuns arrived in South Africa. The Dominican sisters arrived in King Williams Town as a teaching order; however this soon changed, as they become nurses in order to fulfil the health needs of the time. This order soon spread across Rhodesia, and hospitals were established across the colony (Mellish, 1990: 108). Formal nursing education in South Africa only began after the establishment of these hospitals.

The Sisters of the Holy Family of Bordeaux was stationed at the General Hospital in Johannesburg, headed by Mother St Adele, who played an important role in the establishment of three-year training course for nurses at Johannesburg Hospital. After completing the course, the students would receive a certificate (Mellish, 1990: 108). The Holy Family Sisters remained in Johannesburg until 1915. In 1915, the Holy Family Sisters withdrew from Johannesburg General Hospital to go and run their own hospitals and, as a result, many secular nurses were employed in the hospitals, most of which were from Great Britain (Mellish, 1990: 108).

These sisters played an important role in the provision of mission nursing. With the spread of mission work throughout the Southern Africa region, the sick would seek help from the Sisters; this resulted in gathering children in one place, who would possibly become ill. Huts were initially built to house the sick, but ultimately hospitals were built to house both the sick and nursing nuns (Mellish, 1990). The formation of the first Anglican Women's Order took place in England in 1845; subsequently, the nursing order was formed in St Johns House in 1848. This order was the first order to introduce hospital training for nurses and religious sisters in England; they introduced a two-year nursing training course in hospitals across the London area (Mellish, 1990).

The students paid for training and a course in midwifery was also introduced which the students could enrol for. In 1861, the sisterhood took over the running of St John's House and they sent some of their nurses to South Africa, Cape Town at Somerset Hospital (Mellish, 1990: 109). Nursing education was introduced in South Africa upon their arrival. Mellish (1990) argued that, from 1810 through the 1870s, nursing services were provided predominantly by religious sisterhoods, such as the Roman Catholic Sisterhood and the Anglican sisterhood. These sisterhoods were accompanied by a very particular philosophy modelled on Victorian notions of femininity and Christian duty. This later contributed to the elite social status associated with mission-educated nursing for young Black women (Marks, 1994). However, these young Black women faced discrimination, from within their own community and from the colonial community.

The first hospital for Black people in South Africa was established in 1856, after the appointment of Dr JP Fitzgerald as a hospital superintendent of the Hospitals in British Kaffraria. Firstly, he opened a clinic specifically for the Black population in King Williams's town. The first people employed to work at the hospital were interpreters and hospital attendants and were all men; these attendants served the nursing role (Mellish, 1990). Furthermore, Mellish (1990: 114) argues that, this was because Dr Fitzgerald required assistants, who could speak, write and read in English. In addition, the male dominated tribal life meant that women had little chance of receiving any education available at that time.

However, in the early 1900's Black women started receiving nursing education, because they had no formal education they could not be trained under the Nightingale model. Lovedale Hospital was the first hospital in South Africa to prepare the first Black auxiliary nurses with hospital certificates, and the first Black professional nurse in South Africa, Cecilia Makiwane, was formally registered in 1908 (Mellish, 1990: 115). African women in colonial times only became accepted as nurses after they had won a battle of discrimination from the White medical community, the missionary community, White settler state hierarchy and from within their own home communities. By the 1920's, because Black women were able to receive formal education, it was deemed acceptable for Black educated Christian women to pursue nursing as a legitimate career (Walker, 1990: 252-255). Other factors contributed to African women winning this battle of discrimination.

The legitimisation of Black female nurses took place because of White racial fears of female White nurses attending to Black sick patients; this was the result of Black men and women finding their ways to urban hospitals (Burns, 1996: 701). This required intervention from the government. Therefore, the government devised a plan aimed at training and hiring Black women as nurses. However, Burns (1996: 702) posited that, the plan left an empty space for the training of male nurses in industrial areas where women were prohibited and a place where only African patients required treatment. Subsequently, for much of the 20th century, men received training as nurses to work in the Black mine hospitals (Marks, 2001: 1). Thereafter, a decline of men in nursing in South Africa was experienced (Burns, 1996).

2.4.1 Establishment of the South African Nursing Association (SANC) and the South African Nursing Council

After the Union of South Africa was established in 1910, the four provincial medical councils existed until 1928, before the South African Nursing Council (SANC) replaced them. The SANC was the sole body in South Africa responsible for the registration of nurses at a national level, and it allowed for two nurses to be elected to the Medical Council (Mellish, 1990: 126).

Dolamo and Olubiyi (2013: 18) argued that, in colonial South Africa, it was the South African Medical and Dental Council (SAMDC) which initially controlled each

province. The SAMDC provided regulatory guidelines and norms for the training of nurses which was followed in all the provinces. “When all the provinces were united (Union of South Africa), the South African Nursing Council (SANC) came into existence in 1944 in terms of the Nursing Act 45 1944. This was 300 years after the first licensing of midwives in South Africa and 53 years after nurses were first included in the professional register (Searle et al, 2009).”

For Dolamo and Olubiyi (2013: 18) the purpose of passing the act was for the provision of regulatory body responsible for controlling the nursing and midwifery profession by nurses. SANC had the same powers and functions as SAMDC. It is only in 1978 that other races besides Whites (Blacks/Africans, Coloureds and Indians) were recognised and represented in SANC. Thereafter, in 1819 the formal training of midwives began. In the same year, qualified nurses could be admitted to a register which was maintained under the South African Pharmacy Act 34 of 1891 (Dolamo and Olubiyi, 2013: 18). In terms of gender, the following important events took place in South African nursing in 1899; firstly, nurses for the mentally ill were included in the registration for the first time, and male attendants received statutory recognition under Act 21 of 1899 (Dolamo and Olubiyi, 2013: 18).

Currently, in South Africa, nursing education institutions such as universities, universities of technology, nursing colleges, nursing schools, etc. and the SANC (2009) are bound to change in relation to the South African Qualifications Act (SAQA) of 1995. According to section 31 (1) of the Nursing Act, 2005 (Act No. 33 of 2005) categories of professional nurse, midwife, staff nurse, auxiliary nurse and auxiliary midwife are provided for registration after completion and fulfilment of the prescribed education and training (Searle et al, 2009).

The facts presented above illustrate that in colonial South Africa nursing was introduced through the religious orders as mainly a feminine occupation. During the establishment of the occupation, males were not included. Even with the inclusion of other races, there is no mention of male involvement in nursing, thus highlighting the feminine nature of nursing in South African. The next section of this literature review will discuss the concept of masculinities and post-structuralism, as these themes play an integral role in analysing the data obtained from the 15 male nurses interviewed for this study.

2.5 Gender as a configuration of social practice

Connell (2001: 34) posits that, gender is a way in which social practice is ordered. That is the way in which life is constructed in relation to the reproductive arena; which is constructed by the bodily structures and processes of human reproduction. In this arena, sexual arousal and intercourse, childbirth and infant care, sex and similarity are included (Connell, 2001: 34). For Connell there is a difference between the reproduction arena and the biological base.

Connell (2001: 34) refers to it as a reproductive arena and not a biological base because gender is a historical process involving the body, not a fixed set of biological determinants. That is, "gender is a social practice that constantly refers to bodies and what bodies do, it is not a social practice reduced to the body (Connell, 2001: 34)." Therefore, gender exists exactly to the range that biology does not determine the social. Gender has a point of transition whereby historical processes are succeeded by biological evolution as a form of change. Gender is a scandal, an outage, from the essentialist point of view, socio-biologist are always looking for means to destroy it. By trying to prove that, human social arrangements are a reaction of evolutionary laws.

Social practice is both original and imaginative, but it is not undeveloped. It responds to different situations and is produced within fixed structures of social relations. Gender relations, and how people and groups are organised through the social arena, makes up one major structure of all documented societies (Connell, 2001). Practice that relates to this structure, generated as people and group's battle with their historical situations does not exist in isolated acts. Actions are configured in larger units, when masculinity and femininity is spoken of; it is a reference of the configurations of gender practice. Since configuration of gender is a social practice, it suggests that, because society undergoes changes all the time, misconfiguration and reconfiguration of gender as a social practice can also take place, as a result of these changes in society. For example, as this study will illustrate in chapter 5, because of male nurses' presence in nursing their gender identity goes through the process of configuration, misconfiguration and reconfiguration. That is, configuration, as explained by Connell (2001), whereby the embodiment of an appropriate gender identity occurs; misconfiguration occurs in instances where gender identity is destabilised and reconfiguration occurs in instances whereby new configurations of

gender identity take place, because the concept of masculinity cannot be discussed in isolation of gender. The subsequent section of this review will attempt to provide definitions of masculinity.

2.6 Towards a definition of masculinity

The concept of masculinity has been studied by many social scientists. For example, psychologists, such as Frosh (1994) (Frosh et al, 2002); historians, such as Morrell (2001) and anthropologists, such as Gilmore (1990, cited in Langa, 2012) have all engaged on the debate of what constitutes masculinity. In addition, sociologists, such as Connell (1995, 2000, 2001and 2005) and Kimmell (2004), have engaged in this debate and provided further understanding of the concept from a sociological point of view. It is undoubtedly a contested concept.

The works of Connell (2001) and Kimmell (2004) attempted to define what constitutes masculinity. They went on to define the concept as, the gender identity that could be used to describe males. Additionally, Connell (1995) argued that, masculinity was constructed from the social life, implying that, masculinity was developed from gender socialisation. Furthermore, Connell (2001: 31) states that, “the concept of masculinity is inherently a rational concept, that is, masculinity cannot exist except in contrast with femininity.”

Connell (2001) argues that the definitions of masculinity have taken people’s cultural position for granted; however, they have followed a range of techniques so that they can personify the type of a person who is masculine. Connell (2001: 31) identified four main strategies that have been followed, which are essentialist, positivist, normative and semiotic approaches.

The essentialist definitions of masculinity for Connell (2001: 31) “pick a feature that defines the core of the masculine,” in doing so, they base men’s lives on it. Connell (2001: 31) states that essentialists focus too much on the essence of masculinity, such as risk-taking, responsibility, irresponsibility, aggression, etc. The weakness in the essentialist approach is that, the choice of the essence is illogical, in a sense that, the universal basis of masculinity only speaks to the character of the individual than about anything else (2001: 31).

The positivists, who are only concerned with finding the facts, provide a simplistic definition of masculinity: that is what men really are. The problem with this definition of masculinity is that it cuts out the tradition of referring to some women as masculine and some men as feminine, and some actions as being masculine or feminine, irrespective of who displays them (Connell, 2001: 32).

Normative definitions of masculinity place emphasis on what men should be. Here masculinity is treated as a social norm for the behaviour of men. The problem with the normative definition is that few men can live up to the image of what an 'ideal' man should be. Therefore, if this ideal image is not met, does it mean that all the other men who were unable to meet it are un-masculine? This definition does a poor job of providing an account of masculinity in relation to personality (Connell, 2001: 33).

The semiotic approach in defining masculinity places emphasis on symbolic differences in which masculine and feminine places are compared. In this sense, masculinity is defined as not femininity (Connell, 2001: 33). The insight drawn from post-structuralism is that, knowledge and understanding, especially about gender, cannot be ended, completed or concluded. It changes inevitably without individuals being aware of it.

Furthermore, Connell (2001: 33) argues that, the semiotic approach follows a method of structural linguistics, where elements of speech are defined by how different they are from one another. This is the definition of masculinity that the current study will employ, as it is in Connell's (2001: 33) opinion, the definition which is most used in post-structural accounts of gender. That is, it produces more than a mere abstract distinction of femininity and masculinity, of the kind found in the male/female scales. Its usefulness and applicability to the current study will be discussed below. Thereafter, this review will discuss the concepts of hegemonic masculinity.

2.6.1 Post-structural accounts of gender

Whitehead (2002; 207) argues that poststructuralists believe that there is no individual that can exist in separation of discourse. Poststructuralists speak of privileged knowledge and ways of thinking about the world. Therefore, even though an individual is a discursive subject, it cannot be a neutral one. For taking up

discourses as ‘practice of self-signification’, acts of performativity (Butler 1993, 1999). These acts posit not only a series of identities on the subject; they set to locate that subject within associated regimes of power/knowledge. Through the sometimes ritualistic repetition of normalised codes, identity emerges from abstraction into the social world, thus enabling the subject (man, woman) to take their place in society (Whitehead, 2002: 207 and Gardiner, 2005: 45).

Whitehead (2002: 207) provides an example, of a pregnant woman who goes for an ultrasound and discovers the sex of her unborn foetus. He states that the foetus is subject to a process of identity work. That is, it is not much about the sex of the unborn baby being revealed, but it is about the child being positioned in a discursive power regime as soon as the word male or female is pronounced upon it. From the moment of birth, at least, the sexed child is being rendered unto a gender, although one that is largely conditional upon the prevailing discourses circulating the cultural and social spaces in which the child is born (Whitehead, 2002: 208).

Such knowledge and truths, as they surround the growing child, are not fixed and secure; they are under constant movement, particularly in the postmodern age when all that appeared solid, increasingly appears contingent. However, the child with all discursive subjects must emerge in the world and take up his/her place as an individual. He/she must take up identity/identities, but cannot do so with absolute choice; they must take up ways of being that are readily available, indeed, which instruct their very sense of self as being a sexual-gendered person. For those subjects rendered male, the discourses most likely to be placed at their disposal are masculine in their signification. In this way, a masculine subject emerges into the world. As we assume the male/boy (discursive subject) to be masculine, so the discursive subject assumes themselves to be masculine (Whitehead, 2002 and Gardiner, 2005: 45). It is during this point of assumption, and the circulatory arrangement that configures it, that the masculine subject is ushered into existence (Gardiner, 2005: 45).

Whitehead (2002: 208) suggests that it is the inconsistent ‘persistence and instability’ (Butler, 1990) of this arrangement that is at the heart of gender power and being. The masculine subject has materialised from what was described, prior to the scan in the above given example, as an ‘it’, an apolitical, neutral, disembodied presence.

At the moment the ‘it’ is gazed upon, so a set of knowledge, codes and protocols are placed upon it, bringing forth a sex-gendered being. From that moment onwards dominant cultural knowledge and truths come into play, not least concerning, how to live and perform as a heterosexual male. To be sure, the masculine subject has the capacity to reconstruct it in numerous forms and, as most parents know, it is impossible to predict the adult from the child. Nevertheless, without undertaking the physical and legal transformation of gender reassignment, the discursive subject remains, fundamentally, male/man, a masculine subject (Whitehead, 2002: 208).

Post-structural accounts of gender will help this study to explore the changing nature of masculinity, how it is dis-configured before male nurses come in the workplace and configured, misconfigured and re-configured in the workplace. Furthermore, post-structural accounts will assist this study in understanding how masculinity is experienced at a personal level and how multiple masculinities exist in relation to the dominant ones.

2.6.2 From masculinity to masculinities

An argument in gender studies emerged by Connell (2000) when she proposed that because masculinity is experienced differently in different contexts races, cultures, classes and ethnic groups, scholars should refer to masculinities as opposed to masculinity, because masculinity is not a single entity. Her proposal faced much criticism; for example, Connell, 2001 argued that, “there is a real difficulty in defining masculinity or masculinities” since these terms are used in inconsistent ways by different authors. Whitehead (2002) advances Connells argument on multiple masculinities.

For Whitehead (2002: 33), functionalism, gender role theory and Freudian and Jungian theories speak of dualism that reinforces what Connell refers to as the “gender order”. Whitehead (2002: 33) further argues that, women and men should not be seen as political categories, and notions of fixed or final gender roles are implausible. He states that it is no longer acceptable, because of the recognition of the multiplicity, historicity and dynamism of gender representations, to talk of masculinity in the singular.

Instead, Whitehead (2002: 33-34) states that because it is evident that masculinities are plural and multiple; they are different in different spaces; times and context; are

entrenched in cultural and social moment and are, therefore, without a doubt entangled with other powerful and influential variables like ethnicity, age and class. However, when claiming to speak of boys and men, masculinities are very useful because they seem to have an ideological element that seems to be embedded in given truths.

Connell and Messerschmidt (2005; 2001: 38) argued that because there was a common recognition of the interplay between gender, race and class, multiple masculinities become commonly recognisable: Black as well as White, working-class as well as middle-class masculinities. Connell argued that, as much as this was welcomed, it risked the oversimplification of masculinities, such as think that there is a Black masculinity or there is a white working masculinity.

Connell and Messerschmidt (2005; 2001: 38) warned of the importance of recognising that multiple masculinities exist as the first step. They stressed that the next very important step after making this recognition should be to examine the relations between the different masculinities, as well as unpack the setting of class and race and examine the gender relations operating within them. They contend that there are, after all, Black gay men and effeminate factory hands, not to mention middle class rapists and cross dressing bourgeoisie.

Connell and Messerschmidt's (2005; 2001: 38) argument is that in-order to keep the analysis active it is necessary to focus on the gender relations among men, they further contend that hegemonic masculinity is not a fixed character type, always and everywhere the same, it is rather the form of masculinity that occupied the hegemonic position in a given pattern of gender relations, a position always constable.

Focusing on relations offers a sense of realism, identifying multiple masculinities risks taking them for alternative lifestyles, or as a matter of consumer choice. Therefore, applying a rational approach makes it easier to recognise the hard compulsions under which gender configurations are formed. After providing this guideline, Connell and Messerschmidt (2005; 2001: 38- 39) identify the main patterns of masculinities, which will be discussed below.

2.6.3 Hegemonic masculinity

Connell developed the concept of 'hegemonic masculinity' to discuss the domination of men in all spheres of life against other men and women (Connell, 2001: 832). However, in reality, hegemonic masculinity could only be displayed by a minority of men because the hegemonic ideal of masculinity is aspirational and most men cannot achieve it. Even though it might not be achievable to all men, it is nonetheless practiced by all men, as men, even gay men, aspire to align themselves in relation to it. For example, a man who is engaged in a feminine occupation might display this form of masculinity.

In addition, hegemonic masculinity ensured that, men would ascend other men and women in all spheres of life and culture, institutions and persuasion could aid this ascendency (Connell, 2001). The formation of the concept of 'hegemonic masculinity' was defined by the norms of the patriarchal gender system, implying that, it could change over time. The concept could change to less harmful and less oppressive forms of masculinities (Connell, 2001: 39). Hegemonic masculinity was used by Connell (2001: 39) to refer to men who are successful and dignified in all of society. For example, a major league wealthy soccer player is the hegemonic form of masculinity in contemporary society.

Hegemonic masculinity can be viewed as a process operating from both larger sociological and individual psychosocial perspectives. Hegemonic masculinity can take place in sexual relationships between men and women, and women's understandings of hegemonic masculinity could affect their perceptions, responses and agency in sexually coercive experiences (Stern, Buikema and Cooper, 2015). At an organisational level, hegemonic masculinity can take place in an academic setting where hegemonic careerist masculinity reflects the persistence of an underlying system of male privileging in the changing landscape of higher education (O'Connor, O'Hagan and Brannen, 2015).

In organisational studies, the concept of hegemonic masculinity proved its usefulness in studying the gendered nature of bureaucracies and workplaces. Furthermore, qualitative work outlined the institutionalisation of hegemonic masculinities in different organisations; for example, the concept proved successful in understanding how masculinity was constructed within the US Navy. Barrett

(1996) found that definitions of hegemonic masculinity were rationally constructed through associations of difference in the navy. For instance, aviators would tend to draw upon themes of autonomy and risk taking; surface warfare officers would draw upon themes of perseverance and endurance and supply officers would draw upon themes of technical rationality. Further, these masculinities depended on various contrasting definitions of femininity (Barrett, 1996).

Similarly, Simpson (2004) used the concept to understand how men who are involved in gender atypical occupations, such as: librarianship; cabin crew; nurses and primary school teachers. In looking at the experience of work within the organisation and the implications it had on their gender identity, the concept was useful in understanding how these men adopted a variety of strategies to re-establish a masculinity that has been undermined by the 'feminine' nature of their work. These included re-labelling, status enhancement and distancing from the feminine (Simpson, 2004).

Away from the workplace, hegemonic masculinity proved useful in exploring the implications of sexual and violent practices among disenfranchised young men in Southern Africa. Green (2009) found that in Maputo, Mozambique, unemployed young men based their authority on their bodily powers as opposed to their social status and economic powers. Similarly, the same study found that young men from the city's growing middle class enacted hegemonic masculinities in relationships to female partners, by means of financial powers and adherence to a 'breadwinner' ideology, poor young men reacted to a situation of unemployment and poverty by enacting masculinities that are subordinate.

Similar to the studies cited above, the concept of hegemonic masculinity will be used by the current study for the purposes of analysing masculinities within the context of men working as nurses. The analysis of masculinities will be used entirely within the framework of men working as nurses and Connell's theory will simply be used as an analytical tool for understanding society. However, Connell (2001: 81) cautioned that it is in its application that the concept gains its value. That is, there is not a fixed hegemonic form of masculinity. Connell used the terms marginalised, complicit and subordinate masculinities to map out other forms of relations for masculinities that relate to hegemonic positions.

2.6.4 Other masculinities

2.6.4.1 Marginalised masculinities

Marginalised masculinities are demonstrated by working class men in relation to the bourgeoisie notions of hegemonic masculinity (Connell, 2001: 41-42). Marginalised men are those for whom their status (ethnic, physical, mental) prevents them from aspiring to hegemonic masculinity (Levy 2007:254). According to Holligan (2015: 635), hegemonic masculinities dominate and use marginalised masculinities. For example, due to the structure of class, working-class masculinities are essentially marginalised.

Connell and Messerschmidt (2005, 847) argued that 'protest masculinities' are 'associated with marginalised groups'. Protest types are patterns of masculinity constructed in local working-class settings and through cultural modelling. However, they lack the economic resources and institutional authority of regional hegemonic masculinities. Barber (2015) provides an example of marginalised masculinities, by illustrating how London born Vietnamese men in London are marginalised in relation to other men because of their supposed lack of masculine qualities, those determined by more hegemonic Black and White masculinities. Barber (2015) found that the London born Vietnamese men were even more marginalised by experiences of cultural invisibility and Oriental stigmatisation.

2.6.4.2 Complicit masculinities

Complicit masculinities give up parts of the hegemonic position through personal negotiation with institutions, spouses or others (Connell, 2001: 40-41). In addition, this form of masculinity realises the patriarchal dividend, without tensions of being frontline troops of patriarchy. In other words, complicit masculinities are those masculinities which are not dominant, but support dominant masculinities (Connell, 2001). This would include participating in aspects of masculinities that conform to dominant masculine norms in hopes of receiving rewards for being like the dominant group, while recognising, perhaps at some level, that you will never be primarily in the dominant sphere. Complicit masculinities are more widely available to men as a group because potentially all men can benefit from hegemony whether directly or indirectly.

For example, Walker and Eller's (2015) analysis of gay men's dating profiles of a dating website, which revealed that the gay men on the website increased the benefits for themselves and other men by reinforcing masculinity's dominance and its difference from women and femininity. Therefore, the subordination of femininity to masculinity, in this instance, served as a benefit to all men who are complicit in the structure of hegemonic masculinity.

2.6.4.3 Subordinate masculinities

Finally, subordinate masculinities are masculinities that Connell (2001: 39-40) demonstrated not only with gay men but also with other men who are culturally stigmatised for being inferior in one way or the other. Subordinated masculinities refer to experiences that are not only marginalised, but also subjugated, meaning that these types of masculinities are viewed as being legitimately not what men do (Connell, 2001). For example, men who are physically weak, emotional, gay or being too emotional or expressive embody this type of masculinity. Hegemonic masculinity is able to sustain its dominance by rejecting this kind of masculinity.

For example, subordinate masculinities could be used to refer to how historically the way for males to achieve hegemonic masculinity is by supporting their families and engaging in a professional career. Because some, typically younger, males do not have access to as many opportunities to achieve a dominant masculine identity through family or work, they maintain subordinate social statuses (Kelley and Gruenewald, 2014).

2.6.5 Some criticisms of the concept of hegemonic masculinity

Connell and Messerschmidt (2005: 836) acknowledge that the concept faced much constructive criticism, which they tried to address in-order to show that it was worth retaining. Firstly, the concept was criticised for being a blurred concept. Due to the fact that it was attached to contradictions, for example, Donaldson (1993) was cited in Hearn (2004: 56) arguing that it was difficult to identify what exactly hegemonic masculinity was, because little exists according to hegemonic masculinity that could be viewed as counter hegemonic masculinity. He further elaborated his point by asking if men's greater involvement in fathering or parenting could be considered an indication or intensification of hegemonic masculinity. Hearn (2004: 56) argued that for Donaldson (1993) the conceptualisation of hegemonic masculinity, economic

class, was neglected and simultaneously extremely important, politically and analytically. Therefore, for Donaldson (1993) it was unclear what really constituted as hegemonic masculinity.

In response to Donaldson (1993) and Hearn (2004), Connell and Messerschmidt (2005: 838) argued that, even though they agree with the critics, there are ambiguities in the usage of the concept. It would be best to withdraw any usage of the concept of hegemonic masculinity as a fixed, trans-historical model. For Connell and Messerschmidt (2005: 838) employing this usage goes against the historicity of gender and ignores the huge efforts taking place in the social world in relation to trying to locate the definition of masculinity.

For Whitehead (2002: 58), hegemonic masculinity as a concept did a poor job of incorporating the teachings and resistances that encompassed everyday social interaction. In addition, he believed that the concept did a poor job of enhancing the importance of the concept of masculinity in the contemporary world. Whitehead (2002) further posited that the concept of hegemonic masculinity limited the need of empirically engaging in debates that could move the concept of masculinity onwards. Therefore, it is implied that the concept of hegemonic masculinity was responsible for stagnating intellectual debates about the concept of masculinity.

In response to Whitehead (2002), Connell and Messerschmidt (2005: 836) argued that the concept is not essentialist in nature and the fact that research on masculinities in the humanities and social sciences has flourished over the past 20 years proves this. In addition, Connell and Messerschmidt (2005: 836) cite Halberstam (1998) and Messerschmidt (2004) to refute the claim that the concept is essentialist because they have employed it to study “masculinities enacted by people with female bodies.” This proves that masculinity is neither fixed nor rooted in the body or personality characteristics of individuals. “Masculinities are configurations of practice that are accomplished in social action and, therefore, can differ according to the gender relations in a particular social setting” (Connell and Messerschmidt, 2005: 836).

2.6.6 Applying the concept of hegemonic masculinity to the debates about male nurses

2.6.6.1 (Dis)Advantages of the minority status of male nurses

Evans (1997) identified the following (dis)advantages of the minority status of men in nursing. He discovered that the minority status of men in nursing provided them with a tokenistic status in Canada. Evans (1997) uses Kanter's (1977) definition of tokens as "people who differ from the majority group members in ascribed characteristics sex or race, which carry with them a set of assumptions about culture, status and behaviour. In the context of patriarchal culture, men's greater status and power in relation to women affords them situational dominance, with the result that small numbers of men in the female-dominated nursing profession are given a special and privileged minority status."

Evans (1997: 227) found that the minority status of men gave them an advantage in a sense that they are afforded a power and prestigious status because they mainly occupied elite areas of specialty and administrative positions. This is especially true for the current study and for the South African nursing profession, as most powerful positions in the nursing trade unions and nursing student organisations are occupied by men (Evans, 1997). In addition, male nurses choose to specialise in areas such as orthopaedics or trauma. A re-occurring disadvantage in literature experienced by male nurses is the issue of being - stereotyped by society as effeminate, homosexual or as gay. This stereotype originates from the beliefs from society about masculinity, as opposed to originating from objective judgements about men's sexual lifestyles (Williams, 1995; and Evans, 1997: 228).

Evans (1997) believes that the driving force behind this stereotype is the view perpetuated by Nightingale that nursing is an extension of women's work as nursing came naturally to them, thus leading to the feminisation of the nursing occupation. Men who choose to enter into the nursing profession are stigmatised from being different to other men. However, male nurses in a bid to display their masculinity, lean more towards fields in the nursing profession which are seen as masculine such as specialising in fields of nursing seen to be more consistent with the masculine sex role in order to eliminate the sex role conflict that denounce them as deviant or isolate them from other men (Evans, 1997: 228).

Men therefore specialise in areas such as psychiatry which is more compatible with men's physical strength; anaesthesiology, because of its association with technical knowhow and autonomy; and intensive emergency care which is associated with technical skill and cool-headedness (Evans, 1997: 228). These specialities help men to display stereotypical masculine behaviours. In addition, the male identity is strengthened in these fields of nursing by their lack of association with feminine nursing characteristics, such as the need to touch, feed, bath and deliver bedside care for patients (Evans, 1997).

Evans (1997: 229) identifies social distancing as an advantage and disadvantage. It is advantageous for male nurses because he argues that the nursing profession is structured in a manner that benefits men. That is, all the top jobs in the nursing profession emphasise leadership skills, technical competence, and an unconditional dedication to work qualities typically associated with the male sex role (Williams, 1995). Qualities which are associated with the female sex role, such as attention to detail and being emotional, are discarded and not desired for leadership roles in nursing - and are a barrier for women's career progression in nursing. For male nurses, it is important to distance themselves from feminine traits which are regarded as anti-leadership. In doing so they maintain a masculine gender prestige, they do so by distancing themselves from women colleagues and socialising more with male physicians (Williams, 1995).

Lupton (2006) found that men who were engaged in feminine occupations benefited from their minority status in a sense that they progressed faster than women to senior positions. In addition, Lupton (2006) also found that men get better remuneration than the women in these positions. Further, Evans (1997) states that these men had different experiences of their masculine identities in the such as a common trend of men working in female dominated occupations to over-emphasise their masculinity in a bid to distance themselves from their female colleagues, as a way of legitimising their working in a women's job.

For example, male nurses dress differently from their female counterparts. Male nurses never wear the traditional nursing cap. Therefore, clothing differences are a constant symbolic reaffirmation of sex differences that emphasise the masculinity of male nurses (Williams, 1991: 4). In addition, Williams (1995) found that men in

feminine concentrated occupations were more inclined to move into fields of speciality and into fast paced ‘prestigious’ areas of these occupations. For example, in nursing, men were mostly found in paediatric, gynaecological and obstetric nursing. For Williams (1995: 12) this creates the glass escalator effect where men are on an “invisible up and may have to struggle to remain in the lower (i.e. “feminine”) levels of the profession”.

On the contrary, Cross and Bagilhole (2002) found a majority of men in non-traditional occupations tried to maintain a traditional masculine identity in the workplace. By colonising some feminine skills and abilities they could become a more ‘complete man’. Furthermore, male nurses often excluded themselves from their female colleagues as a means of fulfilling their socialisation needs. This practice is commonly referred to as social distancing. This happens when the male nurses socially distance themselves from their female colleagues because they feel that female colleagues just do not talk the same language, they complain that topics discussed by women, such as babies or periods, are just of no interest to them (Evans, 1997).

Instead, male nurses prefer to be in the company of male colleagues such as physicians and discuss topics mutually enjoyed by both parties; topics such as sports and fast cars. This strategy provides significant advantages for the male nurses and aids their prospects for career advancement (Evans, 1997: 229). However, a strategy of social distancing can also be an advantage for the male nurses in a sense that male nurses are viewed by the male physicians as more competent (Evans, 1997: 229). This attitude is often reflected in the physician’s evaluations of the male nurses and plays an in-direct but significant role in determining the male nurse’s position in the hospital. The physicians prefer male nurses over female nurses and, sometimes, this leads to promotions within the field, as the male nurses have good evaluations and come highly recommended by certain physicians.

Similarly, male nurses aligning themselves with male physicians can be a disadvantage as it might lead to male nurses being dissatisfied with nursing because it has low pay and is of a lower status (Evans, 1997: 229). However, these studies reveal little about the motives of men entering into gender-atypical occupations.

2.6.6.2 Men in nursing as 'finders, seekers and settlers'

Simpson (2004) explored the motivations and aspirations of men-nurses, pre-school teachers and flight attendants. She did so by analysing the token status experiences and the implications it could yield on their gender identities. In doing so, she identified a typology of men in non-traditional occupations as 'finders, seekers and settlers'.

Simpson (2004: 25) states that, "the finders did not originally state a preference for the occupation but found it because of availability or convenience during the period of job search. Seekers, by contrast, actively chose the occupation. In a departure from Williams and Villemez's (1993) work, a third group of 'settlers' has also been identified. Like seekers, their occupational choice tended to involve a career change but this was often from a traditionally 'masculine' field - after which they 'settled' in their new career."

The current study advances on Simpson's (2004) typology of finders, seekers and settlers and makes an addition to this typology by adding on a third component to this typology of those intending to leave the profession. This added component of the typology is better explained in chapter 4. From the discussion of the disadvantages and advantages of the minority status of male nurses and of men in nursing as 'finders, seekers and settlers' it is apparent that male nurses' masculine gender identity undergoes the process of configuration, misconfiguration and reconfiguration as they try to find strategies of being a man and being a nurse. The next section of this literature review will discuss the concept of masculinity in South Africa. This will assist in analysing the male nurses' reports on how they experience their masculine gender identity in a feminine dominated occupation.

2.7 Masculinities in the South African context

In South Africa, for Morrell et al (2012) hegemonic masculinity can be used to explain the natural form of male power. He identified three masculinities present in the South African setting which include White masculinity which represented White political and economic dominance of the White ruling class; African masculinity that was based in the rural area and was maintained by native institutions such as customary law, communal land occupation and chiefship and with the advancement

of urbanisation and the development of African townships Black masculinity (Morrell et al, 2012: 12-13).

Similarly, Hunter (2005) provides accounts of masculinities in South Africa both from a pre and a post-apartheid context. He argues that for much of the 19th century South African society, especially the Zulu culture, manliness was characterised by bravery and fighting. In this society men that owned cattle, were able to have many wives; in fact, the more wives the man had, the more labour he was able to control and, ultimately, the richer and more respected he would be (Hunter, 2005: 142-143).

Hunter (2005) notes that women in this society mainly played the role of caregivers and child bearers. For the purposes of growing the clan, the man's role was to provide for his wives. The introduction of Christianity and the notion of the women's body as the temple promoted the idea of single monogamous codes in the 1940's and 1950's (Hunter, 2005: 145). Still, some men during this period were promiscuous. Promiscuity was present between men and women, but more acceptable for men as women who were promiscuous were looked down upon.

South African migrant labour in the 1950's increased as there was the discovery of gold and diamonds which led to many rural men migrating from their homesteads to growing industries, mostly found in urban towns such as Johannesburg and Durban. Women also began to migrate as they moved to urban areas to work as domestic workers, or brew beer. The introduction of waged labour introduced new powers and expectations for African men; they assumed the new role of the breadwinner and were responsible for supporting the family (Hunter, 2005: 144).

Morrell (2001: 14) illustrates how the mines were a key site of transitional masculinities in the early twentieth century and states that "miners came to tell a story about themselves which made claims about their masculine capacities …this reflected their subordination in a workplace owned and controlled by capitalists and supervisors..." (Morrell, 2001: 14). The most recent Marikana mine tragedy in South Africa still reflects the significance of mining and 'the mines' in relations between men, and, the politics of economics in shaping masculinities.

In the era of democracy, Morrell (2005) identified another form of masculinity; he termed this as 'heroic masculinity' which was exemplified by the late Nelson

Mandela. In Morell's (2005) opinion, this is the most powerful masculinity found in present day South Africa; this form of masculinity is one that embraces tolerance, harmony, domestic responsibility, empathy, equality and self-examination. Nevertheless, what is also rising in the country is a more violent form of masculinity, illustrated in high incidents of rape and violent crime that, Morrell (2001) argues, can be understood as a social attempt by men to deal with loss of status (such a huge number of males not being able to afford to pay for brides-worth) and power and unemployment. For Morell (2005), the high rates of unemployment have resulted in South African men adopting a new form of strategies to cope with these challenges such as the consumption of alcohol and abuse of women.

Hunter (2005: 369) contends that, "from the 1970s, however, technological developments, slow growth, population rises, and, since 1994, tariff reductions, prompted a dramatic increase in unemployment and a greater casualization of work." This led to some men not being able to exhibit a dominant form of masculinity, such as, becoming a breadwinner, which usually resulted in having multiple sexual partners, in-order to compensate for not being able to exhibit this dominant form of masculinity. Therefore, this implies that men in South Africa perform the role of being a man differently. Therefore, there is no uniform masculinity which can be attached to how men experience being men in the South African context.

A study conducted by Langa and Kiguwa (2013) illustrated this. It found new ways in which young South African men imaged and reimaged new forms of masculinities in the post-apartheid, South African era through service delivery protest. This was a result of the societal expectations of men to aspire to power and status. The protesters were disgruntled about the fact that, the Black elite men who drove flashy expensive cars had money and, as a result, were able to attract many girlfriends, while they were unable to do the same because of their poor economic status. The protesters then resulted in using violence as a way of dealing with their emasculation and disempowerment (Langa and Kiguwa, 2013: 20).

As illustrated above, in South Africa masculinities have been studied. However, these studies have paid attention to race, culture and politics and, in doing so, have shown how South African masculinities are unstable, from pre-colonial to colonial and post-colonial South African masculinities; they have been changed, challenged

and reformed. However, what has remained constant with the changes taking place has been the use of physical strength through violence by men to dominate over others. As this study will illustrate, male nurses also use physical strength as a means of domination over others. As such, this review of literature will assist this study in using the characteristics of what makes a man in South Africa, as mentioned above, to compare and analyse against male nurses' reports of how they experience their gender identity in the workplace.

2.8 Conclusion

The main aim of this report is to understand how male nurses experience their gender identities in a women-dominated workplace. In order to understand these experiences, this chapter reviewed literature in two ways. The first section of the literature review offered discussions on the history of the nursing profession in relation to presence and disappearance of men in the profession since its establishment globally and locally. It was important to review this literature because this history showed the role played by men in the organisation of the nursing profession. Section two of this literature review showed that multiple and contextual strategies exist in which male nurses attempt to portray a hegemonic masculine gender identity. Some of these strategies will be presented and discussed in chapter 4. Chapter 5 will argue that male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace.

Chapter 3: Research and methodology

3.1 Introduction

The aim of this chapter is to discuss the methods the researcher employed in collecting data for this study. This chapter will discuss how a qualitative paradigm was used in order to collect data; the discussion will highlight how the researcher conducted 15 in-depth interviews, with 15 male Black nurses at a hospital in Johannesburg, South Africa. This chapter will also discuss how the male nurses of this study were recruited using purposive and snowballing methods. It also aims to highlight how data was collected through the conduction of in-depth interviews. The process of data analysis and how using deductive and inductive thematic analysis was appropriate for this study will also be discussed. Thereafter, a discussion will follow on the ethical procedures considered and adhered to in-order for this study to take place, a discussion on reflexivity limitations will follow before concluding the chapter.

3.2 Research design

Research design, according to Burns and Grove (2003: 19), is a plan of ensuring that a study will be conducted in a manner that issues that might influence or interfere with validity of the findings are addressed. Research design is the plan in which the researcher will set out about answering the research question and sub-questions. This study aimed to uncover how male nurses shape their gender identities in the workplace. The qualitative approach was identified as an appropriate method of collecting data.

For Ritchie et al (2003: 2) three approaches exist in defining qualitative research design. There is the theoretical approach, which is concerned with capturing the core of qualitative research design by recognising its key characteristic's. Denzin and Lincoln (2000: 3) use this approach in defining qualitative research. They state that qualitative research is a situated activity that puts the observer in the world. It is made out of interpretive, material practices that help make this world visible. These practices assist in turning the world into a series of representations which include field notes, interviews, conversations, recordings and memos to the observer.

Qualitative research for Denzin and Lincoln (2000: 3), involves an "interpretive, naturalistic approach to the world." Meaning that, in qualitative research, the

researcher studies people in their natural settings, in an attempt to make sense of, or to interpret, phenomena in relation to the meanings people bring to them. The second approach for Ritchie et al (2003: 2) is to identify qualitative research for what it is not. For example, Straus and Corbin (1997) define qualitative research is in this manner when they state that qualitative research is research which produces its findings by not employing statistical procedures and quantification.

The third approach is concerned with combining both the theoretical and practical definitions of qualitative research. In following this approach, qualitative research can be defined as research aimed at providing an in-depth knowledge of the social world of the participants of the research by learning about their lived experiences, social circumstances, perspectives and histories (Ritchie et al, 2003: 2). For this study, the qualitative paradigm was employed because of the nature of the research question posed, since the aim of the study was to understand how male nurses experienced their gender identities in the workplace. The researcher immediately became aware of the fact that an emic perspective had to be employed in order to answer this research question. That is, the researcher needed to understand the perspectives of male nurses by infiltrating their frames of meaning.

In order for this to happen, the researcher had to view the social life of male nurses in the workplace in terms of processes as opposed to static terms, the researcher had to provide a rounded perspective within an explained context and needed to sustain an empathic position whereby he needed to use his personal insight, while taking a non-judgemental stance, all of which the quantitative paradigm would have not been able to provide (Denzin and Lincoln, 2000 and Ritchie et al, 2003). Furthermore, the qualitative paradigm was selected because it became obvious to the researcher that the research strategy needed to be flexible since the study being conducted was a naturalistic inquiry in the real world of the nursing profession as opposed to a manipulated, experimental setting or the classification and categorisation of events and observable phenomena related to human beings as is the case with quantitative enquiry (Braun and Clarke 2008).

The qualitative paradigm therefore was chosen because it offers a way of understanding the construction of meanings that are socially constructed, and how these meanings differ from one place to another (Creswell, 1998; and Ritchie et al,

2003: 3). The researcher also chose the qualitative paradigm, because of the nature of data this paradigm generates. Data is generated from qualitative inquiry using methods which are flexible and sensitive to the social context in which the data is being produced, this was done by making use of methods that involve close contact between the researcher and the male nurses, and the researcher was the primary instrument of generating the data. The nature of the methods used was in-depth individual interviews (Bless and Higson-Smith, 2000: 38).

The qualitative paradigm was also chosen because of the nature of the analysis of data. The analysis of the data accrued from the in-depth interviews was based on building analysis and explanations which reflect the complexity, detail and context of the data. Furthermore, the data was analysed by identifying the emergent categories and theories as opposed to imposing pre-existing categories and ideas (Corbin and Strauss, 2015). By employing a qualitative analysis, this study was able to respect the distinctiveness of each case and, simultaneously, conduct a cross-case analysis. In doing so, the researcher was able to come up with explanations at the level of meaning as opposed to the cause, as the case would be with quantitative inquiry (Dey, 1993; Strauss and Corbin, 1997; Creswell, 1998; Ritchie et al, 2003 and Corbin and Strauss, 2015).

As will be illustrated in this chapter and chapter 4, the nature of the output of the qualitative paradigm allowed for the researcher to produce “detailed descriptions and rounded understandings,” which were created on, or offered an interpretation of, the perspectives of male nurses, in relation to how they experience their working environment (Ritchie et al, 2003: 4). This allowed the researcher to map out meanings, process and contexts, and to answer the research question; consider the influence of the researcher’s perspectives; to select the small scale, sample size for the study purposively on the basis of a strict criteria; to employ data collection methods which involved close contact between the researcher and participants, which were interactive and developmental, and allowed for the exploration of emergent issues; to extract data which was very detailed, information rich as well as extensive; to employ analysis which was open to emergent concepts and ideas which have produced detailed descriptions and classifications, identified patterns of association, or typologies and explanations and, lastly, to produce output which

focused on interpretation social meaning through mapping and re-representing the working environment of the male nurses.

By choosing the qualitative paradigm, the researcher is aware that the knowledge produced from the study would not be generalizable to other settings; for example, other hospitals in South Africa (Babbie, 2004: 27). In addition, it was apparent that the researcher would not be able to make quantitative predictions about the experiences of male nurses, because explicit hypotheses could not have been generated from the start of the research. Consequently, the researcher was not guided by any formulated hypotheses. The researcher was also aware of the fact that by employing a qualitative approach and introducing systematic procedures for coding, in Hodkinson's (2008) opinion, personal biases and idiosyncrasies would be brought to the research which could not be eliminated.

Another shortfall of employing the qualitative paradigm was that, because the method was imposed for the purposes of producing theory, there was a dismissal of direct validity and the importation of the male nurses' own accounts (Thomas and James, 2006). Nonetheless, the qualitative research paradigm was chosen because the advantages outweigh the disadvantages and, as such, it has been proved to be very influential and it has had a major contribution to the applied method of inquiry in social research (Thomas and James 2006). A discussion on the population of the study will follow in the subsequent section.

3.3 Participants

According to Nursing Act (2005: Section 31: 1) "a professional nurse is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice." Similarly, the Nursing Act (2005: Section 31: 2) states that, "a midwife is a person who is qualified and competent to independently practise midwifery in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice." Nursing Act (2005: Section 31: 3) a staff nurse is identified as "a person educated to practise basic nursing in the manner and to the level prescribed." Lastly, the Nursing Act (2005: Section 31: 4) stipulates that, "an auxiliary nurse or an auxiliary midwife is a person educated to provide elementary nursing care in the manner and to the level

prescribed." In essence, auxiliary nurses act as aids to the staff nurses and midwives.

In addition, the Nursing Act (2005) stipulates that in order for one to qualify as a professional nurse, midwife, staff nurse and auxiliary nurse or an auxiliary midwife they would have to abide by the prescribed conditions of the act and pay a subscription fee, in order to be issued a license to practice in any one of the above-mentioned categories of nursing. The population of this study consisted of professional male nurses, midwives, staff nurses and auxiliary nurses or auxiliary midwifes. By population, this study refers to the total number of all individuals who have certain characteristics and are of interest to a researcher (Coleman, 2005). Since this study was concerned with the gender identity of male nurses, the target population of this study is male midwives or staff nurses in Johannesburg, Gauteng, South Africa.

Coleman (2005) posits that, a sample is the population which the researcher is interested in, the population which the researcher will get the required results from. Therefore, the sample of this study was 15 Black male nurses in Johannesburg, South Africa. The nurses were selected from an accredited hospital in Johannesburg, South Africa. The hospital's professional and support staff exceeds 4000 people.

Table 1

Participant ID	Age	Field of nursing	Experience (in years in the current field of nursing)
Participant 1	41	Paediatric	3 years
Participant 2	42	Trauma	2 years
Participant 3	28	Orthopaedic	2 years
Participant 4	31	Paediatric	3 years
Participant 5	33	Orthopaedic	4 years
Participant 6	29	Paediatric	2 years
Participant 7	42	Orthopaedic	2 years
Participant 8	37	Midwifery	2 years
Participant 9	26	Trauma	2 years

Participant 10	26	Orthopaedic	2 years
Participant 11	28	Trauma	3 years
Participant 12	33	Trauma	5 years
Participant 13	50	Oncology	8 years
Participant 14	36	Paediatric	4 years
Participant 15	44	Trauma	2 years

Table 1 illustrates the composition of the 15 male nurses, who participated in this study, in relation to their age, nursing field and experience in their current field of nursing. The sample of this study consisted of 15 Black male nurses between the ages of 26-50 because, according to SANC (2014), many registered male nurses in South Africa fall within the age range of 25-65 and most male nurses in South Africa fall within this race range. Furthermore, all the male nurses who participated in this study were Black males because the researcher employed purposive and snowballing sampling techniques. In addition Black male nurses were selected because they make up approximately 81.7 percent of the nursing population (SANC, 2014). The following section of this chapter will discuss how the male nurses of the current study were located, by discussing the sampling method employed by the researcher.

3.4 Sampling method

Ritchie et al (2003: 19) posit that it is a general feature of any type of research, qualitative or quantitative, to select and design samples for the study. It does not matter whether or not the study involves very small populations or single case studies; decisions need to be made about people, settings or actions. For example, even in ethnographic field studies, sampling is still required because the researcher cannot observe and record everything that occurs. Numerous sampling strategies exist; it is the aim of this section to discuss the methods used for designing and selecting samples for this study.

When sampling techniques for social research are described, a key difference is recognised between probability and non-probability samples (Keyton, 2010: 19; and Ritchie et al, 2003: 19). Even-though probability sampling is considered to be the most rigorous approach in sampling for statistical research, it is highly inappropriate

to use probability sampling for qualitative research such as this one (Burns, 2000 and Ritchie et al, 2003: 19). For a study of this nature, a non-probability sampling technique can be and was used to select the population of the study. In a non-probability sample, units are purposively selected to reveal particular features of a sampled population. The aim is not to be statistically representative, as the chances of an element being selected is not known, instead, the characteristics of the population are used as the source of selection (Ritchie et al, 2003: 78).

For this study, the criterion of selecting participants for purposive sampling was based on the sample units of the study which were chosen because they have particular features or characteristics; such as, they were registered male nurses in any category of nursing between the ages of 25-65 and had been employed in their current field of nursing for a minimum of two years. These particular features or characteristics enabled the researcher to conduct a detailed exploration of how male nurses experience their gender identities in the workplace.

In essence, purposive sampling is exactly as the name suggests. Members of a sample are chosen with the 'purpose of representing a location or type in relation to key criterion (Ritchie et al, 2003: 79). "This has two principal aims. The first is to ensure that all the key constituencies of relevance to the subject matter are covered. The second is to ensure that, within each of the key criteria, some diversity is included so that the impact of the characteristic concerned can be explored" (Ritchie et al, 2003: 79). For example, this study, even though it only studied Black male nurses in a particular hospital, included Black male nurses of different age groups in order to ensure that any different perspectives between age groups were explored. Numerous approaches to purposive sampling were designed to yield different types of sample composition, depending on the aims of the study and its coverage.

For this study, a homogenous sample was used. Keyton (2010) describes this sample as one chosen to paint a detailed picture of a particular phenomenon; for example, Black male nurses of different ages, experiencing being men, and working in a feminine occupation in different ways. This allows for a detailed investigation into the social processes of the nursing profession. In addition, this study also made use of a snowballing sampling method; this was used in conjunction with the non-probability purposive sampling. The snowballing is used to refer to an approach

which involves asking people who have already been interviewed to identify other people they know who fit the selection criteria (Corbin and Strauss, 2015). For this study, snowballing was used as follows: male nurses who were identified using non-probability sampling and interviewed were asked to identity colleagues who would be suitable to participate in the study. On three occasions the researcher was told to go to certain wards and ask for certain individuals to participate in the study. Furthermore, these individuals, after participating, would refer the researcher to other male nurses within the same ward or outside the ward, within the same hospital.

Ritchie et al (2003: 94) state that snowballing is a useful approach for small and dispersed populations, where the key selection criteria are characteristics that might not be widely disclosed by individuals; for example, talking about the experience of Black male nurses in the workplace, in relation to their gender identities. The above sampling techniques may have certain limitations. Firstly, interviewees who are selected by responding to requests for help in this case through a mutual acquaintance with the researcher may be more aware of and reflexive about the significance of gender at work or may have more 'issues' in relation to their non-traditional occupational choice than other men in these occupations (Simpson, 2004). Secondly, relying on personal contacts may lead to a sample that is not wholly representative. However, Simpson (2004) employed such techniques in researching men in non-traditional occupations, making their utility acceptable, regardless of the above uncertainties. The following section of this chapter will discuss the procedure which the researcher went through to collect the data.

3.5 Procedure

Ritchie et al (2003: 19) posit that it is a general feature of any type of research, qualitative or quantitative, to select and design samples for the study. It does not matter whether or not the study involves very small populations or single case studies; decisions need to be made about people, settings or actions. For example, even in ethnographic field studies, sampling is still required because the researcher cannot observe and record everything that occurs. Numerous sampling strategies exist; it is the aim of this section to discuss the methods used for designing and selecting samples for this study.

When sampling techniques for social research are described, a key difference is recognised between probability and non-probability samples (Keyton, 2010: 19; and Ritchie et al, 2003: 19). Even-though probability sampling is considered to be the most rigorous approach in sampling for statistical research, it is highly inappropriate to use probability sampling for qualitative research such as this one (Burns, 2000 and Ritchie et al, 2003: 19). For a study of this nature, a non-probability sampling technique can be and was used to select the population of the study. In a non-probability sample, units are purposively selected to reveal particular features of a sampled population. The aim is not to be statistically representative, as the chances of an element being selected is not known, instead, the characteristics of the population are used as the source of selection (Ritchie et al, 2003: 78).

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3.6 Data collection method

Cresswell (2003: 18) stated that in qualitative research design, data could be collected using in-depth interviews, which are ideal for collecting data on individuals’ personal perspectives. The in-depth interview is a qualitative method of analysis which proceeds as a confidential and secure conversation between an interviewer and a respondent. By means of a thorough composed interview guide, which was

approved by the participants, the researcher ensured that the conversation covered the topics that are crucial to ask for the purpose and issues of the study.

There are a few limitations and pitfalls, in using this data collection method, such as, using it is prone to bias, that is there was a possibility that male nurses would have offered answers which they thought the researcher was looking for Cresswell (2003). However, the researcher took the necessary steps to ensure that this was not the case by ensuring that the manner in which the in-depth interviews were conducted eliminated the possibility of the researcher appearing superior or condescending to the male nurses. The researcher made sure of this by only using familiar words; questions were posed indirectly and informatively to the participants; the researcher remained detached and objective throughout the conduction of the interviews; the researcher avoided questions and question structures that encouraged 'yes' or 'no' answers; the researcher probed until all relevant details, emotions and attitudes were revealed and, lastly, the researcher provided an atmosphere that encouraged the respondent to speak freely, yet kept the conservation focused on the issue(s) being researched.

Another shortfall in using this method of collecting data is that this method was time consuming because of time needed to conduct the interviews; transcribe them and analyse the results (Cresswell, 2003). The researcher overcame this by planning well ahead of time, for the transcription and analysis of the data. Due to the fact that the data was collected from a small sample of 15 male nurses of a particular hospital in the Johannesburg area, the findings of this study are not generalizable. However, this method of in-depth interviews collected rich data on the experiences of male nurses.

The method of the in-depth interview was appropriate because this study aimed to gain insight into male nurse’s impressions of their gender identity in the workplace. This method was the right one to use for this proposed study because the primary objective was to find out how male nurses negotiate their masculinity, and the interview was able to produce very precise and specific answers as well as a complete and varied knowledge about the male nurses’ experiences, opinions and motives which, for example, a group interview or the quantitative methods could not have produced.

In addition, Cresswell (2003: 18) argued that the method of the in-depth interview is also appropriate if your subject and issue are in the nature of something controversial, sensitive or tabooed. The topic was a sensitive topic, because society as illustrated in the literature review in chapter 2, considers nursing to be a feminine occupation. Keyton (2010) posited that, one of the advantages of the in-depth interview is that there is time for the respondent, in peace, to further develop and give reasons for his or her individual point of views without being influenced by the opinions of other respondents.

The data was collected from the in-depth interviews with an audio recorder and the participants, if they agreed to be interviewed, signed a consent form giving the interviewer permission for the recording to take place (see Appendix B) that would later be transcribed for analysis. The next section of this chapter will discuss how the collected data was analysed before discussing the ethical considerations.

3.7 Data analysis

Data analysis is the process where the researcher is required to make sense of the data, break it down, study its contents, explore its importance and understand its meanings (Marshall, 1996; Lacey and Luff, 2001; Taylor-Powell and Renner, 2003 and Bailey, 2007). The researcher decided that the best method to analyse data for this study was thematic analysis. Thematic analysis essentially involves transcribing the tape-recorded interviews into readable text. Thereafter, the researcher reads and re-reads the transcribed data in their entirety, reflecting on the interviews as a whole. Following this, the researcher summarises the interviews, with the idea in mind that, more than one theme might exist for one set of interviews (Bailey, 2007; Corbin and Strauss, 2015).

This method of analysis involves, coding, which is described by Babbie (2004: 318) as “the process whereby raw data are transformed into standardised form suitable for machine processing and analysis.” Similarly, Bailey (2007: 127) describes “coding as, the process of organising large amounts of data into smaller segments that, when needed, can be retrieved easily.” There are two methods of coding, that is, initial or open coding and focused or axial coding (Bailey, 2007; Corbin and Strauss, 2015). Initial or open coding is the process whereby the researcher breaks several pages of text into more controllable themes that can be grouped together

and used during later stages of data analysis (Bailey, 2007; Corbin and Strauss, 2015).

For this study, the question asked by the researcher of “can you describe for me how it is like being a guy and being a nurse,” and participant 3’s response of “it’s hectic hey. Especially when it comes to midwifery, it’s hectic,” the participant’s response has two codes: one that midwifery is a very demanding (mentally, physically and emotionally) type of nursing; and the other code, that midwifery is hard for a male nurse because culturally, historically and socially the process of giving birth is a gender role mostly associated with women (Bulliet et al, 2014: 8). Focused or axial coding is a process whereby the researcher combines the initially coded data into larger categories that incorporate multiple codes (Bailey, 2007 and Corbin and Strauss 2015). Again for this study, from the above given example, the theme that might have been labelled from the initial coding as ‘midwifery a very demanding field of nursing’ and as ‘midwifery a very disturbing field of nursing for male nurses,’ could be put together into one theme called ‘challenged masculinities.’ Themes of this study were developed in two ways by deductive thematic analysis, and inductive thematic analysis. The theme of challenged masculinities, in this example, was derived from using deductive and inductive thematic analysis.

Since an explanation has already been provided on how themes are produced through the process of coding, this part of the chapter will describe what a theme is. A theme, according to Braun and Clarke (2008: 82), is something that “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set.” Such as challenged masculinities in the context of studying how male nurses experience their gendered identity in the workplace. Themes or patterns within data can be identified in one of two main ways in thematic analysis.

An inductive thematic analysis approach occurs when identified themes are strongly linked to the data themselves (Brent and Clarke, 2008: 83); for example, challenged masculinities in nursing because of midwifery. The deductive thematic analysis approach occurs when emergent themes are generated using predetermined themes from literature (Brent and Clarke, 2008: 83). Such challenged masculinities are

derived from the literature (Connell, 2001). Therefore, this study employed both inductive and deductive data thematic analysis.

While using thematic analysis, the researcher recognised that in the initial phases of data analysis he was unable to analyse the data. This was because, as Braun and Clarke (2008: 94) explained, thematic analysis is not just a collection of extracts threaded together with little or no logical narrative; nor is it a selection of extracts with analytic comment that simply summaries their content. The extracts in thematic analysis are indicative of the analytic points the researcher made about the data and should be used to support an analysis that goes beyond their specific content, to make sense of the data, and tell the reader what it does or might mean.

Another pitfall was that, in the initial phases of data analysis, there seemed to be a discrepancy between the data and the analytic claims that were made about it. This resulted in claims made not being supported by the data. The researcher employed Braun and Clarke's (2008: 94) advice and made sure that his interpretations and analytic points were consistent with the data extracts.

Lastly, in relation to shortfalls associated with thematic data analysis experienced by the researcher, in the initial stages data analysis, it became apparent that there was a mismatch between theory and the analytic claims the researcher was making. In-order to overcome this shortfall, the researcher had to make sure that the interpretations of the data were consistent with the theoretical framework (Braun and Clarke, 2008: 95). That is, the researcher had to ensure that the themes identified in chapter 4 were in line with hegemonic masculinity's post-structural interpretations of gender.

3.8 Ethical considerations

Permission to carry out the study was granted by the University of the Witwatersrand Sociology Department, in Johannesburg under the supervision of Doctor Rajohane Matshedisho, with protocol number H15/06/29. The study was carried out as pre-requisite for the partial fulfilment of the researcher's MA (Economic/Industrial Sociology) degree studies. Participants who were recruited to participate in this study were given a consent form to sign which guaranteed their confidentiality and security of information; details of who will have access to personal information and the purpose[s] for which participant information will be used, including whether

participants would be potentially identifiable in any published material; a statement that participation in the research was completely voluntary, that participants were at liberty to withdraw at any time without prejudice or negative consequences, that non-participation would not affect an individual's rights/access to other services/care; the contact details of the investigators and supervisor should the participant require further information; the contact details of the University of the Witwatersrand, should participants wish to make a complaint on ethical grounds .

Thereafter, the researcher proceeded in interviewing male nurses from a Hospital in Johannesburg, Gauteng South Africa. If a participant[s] agreed to participate in the study, the researcher would arrange a meeting with the participant[s] at a public space, for example, a shopping mall, or in a restaurant that would be mutually agreed by both parties. The respondents were not asked questions that can obstruct the hospitals privacy and confidentiality and put the hospital and the male nurses at risk. The name of the hospital and that of the participants was not used in the study.

3.9 Reflexivity

"Reflexivity is commonly viewed as the process of a continual internal dialogue and critical self-evaluation of researcher's positionality, as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015: 220). Reflexive researchers are therefore conscious of the impact of their personal values and life experiences might have on the research process.

The researcher was aware of how his race and gender might have an influence on the participants. Being a South African Black male, in his mid-twenties, meant there was the possibility of the participants not battling to disclose accurate and honest accounts of being a nurse, and the impact it might yield on their masculine gender identity, because they would easily relate with the researcher, as they were the same age, gender and race. There was a high possibility that the participants, would over relate with the researcher because of the above-mentioned similarities. The researcher was aware of the negative impact; this might yield on the research, and therefore was extremely cautious of this possible issue and attempted to minimise its impact on the accuracy of the data collected.

The researcher did so by, avoiding imposing his worldviews or assumptions during the data collection phase of the conduction of the study. For the purposes of ensuring that an open atmosphere was created, the researcher attempted to engage with the participants in open, calm, relaxed and informal settings. This conveyed to the participants that the researcher was interested in their lives and their work related experiences without him imposing his preconceived views on them. In doing so, the researcher successfully created an open, non-judgemental and encouraging atmosphere.

By inviting or requesting an interview with the male nurses outside their workstation in the hospital, for example, meeting the researcher in the cafeteria, the researcher noticed that the participants were more open and able to discuss work-related issues freely. Thereby, a quick rapport developed between the researcher and the male nurses. In relation to talking to a male researcher, the participants found comfort in expressing issues of masculinity to another male. The participants expressed their preference of talking with a male researcher when one participant reported to the researcher that:

“You see at least with you, you understand, because its guy to guy, women just don’t get these things.”

The above participant’s quoted report is indicative of the fact that he felt comfortable talking to another male who would understand his experiences based on the fact that he is also a male, as opposed to talking to a female researcher where maybe the need to present himself as an ideal masculine man would have risen and negatively impacted the quality of data collected.

Another participant said that he was:

“Just happy that finally someone wants to hear our story.”

Implying that, for him it would not have mattered whether the researcher was male or female, Black or White; what mattered for him was that there was a person willing to listen to him. Therefore, the gender of the researcher was not an issue for the participants. In relation to the researcher’s race, of being Black, the issue that the participants would view themselves as marginalised was a concern the researcher battled with. For example, another participant reported that:

“You know us Black people back then we had not many choices, our parents didn’t go to school, so we couldn’t afford to go to Wits like you Blacks of these days.”

The above report from the participant is indicative of the issue of feeling marginalised; however, after telling the researcher this, he was able to trace how he came into the profession and was able to open up freely about his experiences of being a male nurse, indicating that he was able to develop rapport with the researcher and the researcher was not in any way judgemental towards him. However, the younger participants expressed some shock that the research was being conducted by someone of a similar age, race and gender as them. For instance, a participant explained that:

“It’s a good thing that a young man like you is doing this. I never thought in my life I would be interviewed for research by someone like you.”

After the interview he explained that he intends on doing research in the near future and asked the researcher how he can go about it, irrespective of participants’ feelings of being marginalised and expressing shock, the researcher was able to overcome this by maintaining a neutral stance and refraining from colluding with the participants.

3.10 Limitations

Even though the qualitative paradigm was identified as the best means of collecting data for this study, by choosing the qualitative paradigm the researcher is aware that the knowledge produced from the study would not be generalizable to other settings, for example, other hospitals in South Africa, and therefore the findings of this study are limited to one hospital in the Johannesburg area (Babbie, 2004: 27). Given the qualitative nature of this study, it was apparent that the researcher would not be able to make quantitative predictions about the experiences of male nurses, because explicit hypotheses could not have been generated from the start of the research; the researcher was, consequently, not guided by any formulated hypotheses (Babbie, 20014).

The researcher was also aware of the fact that, by employing a qualitative approach and introducing systematic procedures for coding, he would bring in personal biases and idiosyncrasies to the research which could not be eliminated (Hodkinson, 2008).

Another shortfall of employing the qualitative paradigm was that, because the method was imposed for the purposes of producing theory, there was a dismissal of direct validity and the importation of the male nurses own accounts (Thomas and James, 2006).

In relation to interviews, because they can produce a lot of data in a short amount of time, the shortfall of employing the method of the in-depth interview is that it is time consuming; scheduling the interview, conducting the interview, and inputting notes for analysis takes time (Simpson, 2004). This study was limited by time constraints, given that this is a Masters Research report which combined course work and a research report, there was limited time to conduct a full research study.

Another shortfall which Simpson (2004) cautioned about was that, in in-depth interviews, interviewing men on their gender identity, the issue of homosexuality might arise as some respondents might bring up how they identify themselves as homosexual, some of whom might be willing to offer insights into the importance of sexual orientation. However, because of the sensitivity of this issue, the significance of sexual orientation for the way men manage masculinity in a female dominated environment was not explored in any systematic way and was only discussed if it was raised, unprompted, by interviewees.

3.11 Conclusion

This chapter discussed the methods the researcher employed in collecting data for the current study: this chapter discussed how the study made use of a qualitative paradigm in order to collect data, the discussion highlighted how the researcher conducted 15-indepth interviews, with 15 male Black nurses at a hospital in Johannesburg, Gauteng, South Africa; this chapter also discussed how the male nurses of this study were recruited using purposive and snowballing methods. It was also the aim of this chapter to highlight how data was collected through the conduction of in-depth interviews. This chapter discussed the process data analysis and how using deductive and inductive thematic analysis was used for this. Thereafter, a discussion took place regarding ethical procedures considered and adhered to, in-order for this study to take place, then a discussion on reflexivity and lastly limitations of the study followed.

In conclusion, in order to ensure the validity of the findings of this study two sampling and data analysis methods and were used. The subsequent chapter of this study will present the findings and discussion of the data collected using the above mentioned methods.

Chapter 4: Research findings

4.1 Introduction

This study sought to investigate and argue that male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. Chapter 1 explained the purpose and the outline of the study. Chapter 2 presented and critically discussed the literature relevant to the research question. Chapter 3 listed and explained the methods used to collect the data. This chapter presents the data gathered from the 15 male nurses, referred to as the male nurse participants of a particular hospital in Johannesburg who took part in this study. Furthermore, the data presented in this chapter will help the researcher to answer research sub-question two asking, 'how do male nurses understand their own gender identities in the workplace?'

This chapter is divided in 10 sub-sections, these are: specialisation, social distancing, colonisation of female traits, feminisation of the male, which was demonstrated with the theme of the "labelling male nurses as gays and "sisters," incidental exclusion, the midwifery experience, female doctors, (dis)advantages of being a male nurse and male nurses ideal and non-ideal man. These 10 themes represent themes identified by the researcher after the data was reviewed and demonstrate the constant configuration, misconfiguration and reconfiguration of male nurses' masculine gender identity.

4.2 Themes

4.2.1 Specialisation

Evans (1997) argued that for male nurses specialising in fields of nursing such as trauma helps them to display stereotypical masculine behaviours. This was also the case for the current study. This theme of specialisation is useful for this study, as it helps to suggest how male nurses configure, misconfigure and reconfigure their gender identity in chapter five. When a participant was asked by the researcher why he chose to work in the trauma ward? The participant explained that he chose trauma because:

> "In trauma you experience eh a lot of things at the same time because let's say for example, trauma we generalise, there is oncology, there is like eh maybe let's say

somebody just experienced eh a very bad accident ya so you have to be eish… But it's also an advantage to gain more experience, because you get to experience everything. That's why I have an interest in trauma, because I just want to get the whole knowledge at the same time."

Another participant explained that his choice was based on the fact that according to him:

"otho's[1] is basically for males, the workload is for males, basically you do a whole lot of lifting, and you work with your hands mostly."

With pride another participant explained how for him he chose this field of nursing because:

"I get to help both young and old patients battling with pain from different kinds of bone fractures caused by bullets, falling, car accidents it's fast and unpredictable. This is an experience where I can't get in other fields such as medical or midwifery"

Whereas this participant said that his choice to work in the orthopaedic ward was due to, his desire of:

"Working in the trauma ward, where you have to stitch people's heads that you know have been in accidents, yeah you it's an interesting part which made me look forward to specialising in it."

Evans (1997) claimed that male nurses distance themselves from fields of nursing which do not help them display a masculine gender identity, fields of nursing which emphasise feminine characteristics such as the need to touch, feed, bath and deliver bedside care for patients, was affirmed in this study. The following quote of a participant responding to the question which field of nursing he would not like to work in? His explanation was that:

"I wouldn't wanna do medical nursing hey, yoh! That part of nursing is for the ladies, you see what they do there, they have to cater for patients every need, like bathing, taking them to the toilet there is too much care involved there. That's why I prefer theatre nursing, or rather remaining in Orth's."

[1] A nursing specialty focused on the prevention and treatment of musculoskeletal disorders.

As for a male nurse working in a nursing field which is associated with typically feminine nursing characteristics, such as midwifery, when asked how he found working in this field of nursing, his answer was directed towards his duties in his current field of nursing as a result, his explanation leaned more towards issues of male strength in midwifery:

> "sometimes you know, they make me do things which only a man can do, like lifting heavy equipment, or if a doctor is not around, and a woman is giving me birth and I am on call assisting with the birth, the women think I am a doctor and they calm down and trust me, because in their minds it's a doctor whose helping them and not a nurse."

After further probing by the researcher in order to find out why he chose to specialise in this field of nursing the participant replied:

> "Because when I was getting training I saw that there were not a lot of us here in the delivery ward. I thought I would be able get promotions easier since there were not many guys, working here."

4.2.2 Social distancing

Evans (1997: 229) identifies social distancing as a process which occurs when male nurses prefer to socially distance themselves from their female colleagues, in order to fulfil their socialisation needs. As a result, male nurses prefer to associate themselves with other male nurses or male medical doctors. As will be demonstrated in Chapter 5, social distancing seems to play a role in male nurses, workplace gender identity formation. This type of behaviour was reflected in the current study by the following participants report relating to how he thinks his female colleagues viewed him:

> "There is not much of a difference you notice at school, but when you come here, you notice the difference. Like most of our sisters who are in-charge of us they think, that most of the guys who are here are not here because they wanted to be here, they think it's just a job for them. So they think that you are just doing this for now, and then you will leave. So they think that all we want here is to do the nursing course get a little bit of experience and finish and go work in the mines, and do occupational therapy there is a lot more money there than here. So sometimes it's

like there is a bit of tension between us and them. Because of this I mainly get along with male doctors and other male nurses."

Evans (1997) argued that for male nurses social distancing is an advantage because the nursing profession is structured in a manner that benefits men. That is, all the top jobs in the nursing profession emphasise leadership skills, technical competence, and an unconditional dedication to work qualities typically associated with the male sex role (Williams, 1995). The expectation of males to take up leadership positions was reflected in the following quote:

"We are mistaken for doctors most of the time hey, patients always think we are doctors, sometimes they even think the female doctors are the nurses. And some female nurses will act out and start to show that you are just a nurse."

However it is not just the male nurses who socially distance themselves from female colleagues, this behaviour of social distancing is also reflected in the patient's behaviour when dealing with nurses. Some patients have a gender preference when receiving care that is they prefer to be treated by male nurse. As will be illustrated by the following report quote:

"Some women patients don't wanna be treated by female nurses because women naturally just don't like each other. They are jealous of each other so they will be busy giving other attitude instead of trusting one each other. And there is the general belief that men know more than women."

Williams (1995) argued that, for male nurses it is important to distance themselves from feminine traits which are regarded as anti-leadership. For example, the following quote of a participant's response to the question of why he chose to specialise in trauma orthopaedics illustrates this:

"I cannot work in the labour ward because when he was receiving training and had to serve in the ward; women who were giving birth would ask me do you know how I am feeling?"

For him professionally distancing himself from a ward where he is constantly interacting with woman patients, who are giving birth, helps him to maintain a masculine gender identity. His next response justified his stance:

> "The patient doesn't feel comfortable because you don't know how they feel, you don't know what they experiencing and you will never experience what they are experiencing. That's why for me I would never work there. I prefer to work somewhere where I can use my strength or knowledge to the maximum."

4.2.3 Colonisation of female skills

Cross and Bagilhole (2002) argued that men who choose to enter into the gender atypical occupations are stigmatised from being different to other men found that a majority of men in non-traditional occupations tried to maintain a traditional masculine identity in the workplace, by trying to colonising some feminine skills and abilities so that they could be more 'complete man.' Here the researcher suggest tension between being a man, and being a nurse, this theme as will be discussed in chapter five, demonstrates how male nurses overcome the contradiction of being a man and being a nurse. This was reflected in the following participant's response to the question of what are some of your duties in your current nursing field.

> "Sometimes you have to use your strength, you have to pick up patients, so I am there as a man."

In addition, male nurses colonise feminine skills by emphasising their knowledge of health issues, outside the workplace as a way of displaying a masculine gender identity, for example, this participant said that:

> "As a male nurse, I have realised that people out there don't know a lot of things, like when I am traveling to go home in the taxi, when they talk certain things, and how men cannot take care of themselves in terms of their health. You realise that there is still more education out there needed on men and health. I sometimes have to get in there and educate them, such as telling them you cannot drink like this, you drink too much at the end of the day the drinking is affecting your body you understand?"

He finds himself offering advice to his fellow passenger's advice such as:

> "You cannot always eat i-*skopo*[2] or whatever out are eating in the street, it's not healthy for you. Because when they get sick they come here and are force to eat those things."

[2] South African township slang for cooked cattle head

For him other men's masculinity(ies) are questioned when they come into the hospital seeking assistance:

> "When the guy gets sick he doesn't want to speak to the female nurses, he wants to speak to the male nurse. And most of the times in the wards, the guys don't want to speak to the female nurses when maybe they have sexual problems. Sometimes we end up having to pass the message to the sisters in charge, because they are shy to speak to them about these things."

This gives male nurses a sense of superiority as was displayed by this participant, when he stated that:

> "Most of the things patients prefer to ask, male nurses, they won't bother to ask female nurses."

For another participant, decolonising female traits and advancing male strength is a way in which he maintains a masculine gender identity he achieves this by:

> "Sometimes they actually ask you, hey now we need the man's strength. And well I am ok with that, I don't have a problem I never question that, because I will always be a man, it doesn't mean that because I am now a nurse I am less of a man understand. I know that I have more strength than them. In fact the female nurses they learn that in class, that we are not the same. They learn that we have more strength than them. And even our make is not the same, we have more strength more power, we are more powerful than them. When it comes, when it comes physique we are superior. And even our make-up is not the same the way God made us we are not the same. And we can't change that unfortunately, we can give women everything, we not gonna change what God made us them to be."

For some male nurses they decolonise feminine traits by being assertive and refusing to do work which is not part of their job description. This assertiveness can be viewed as a catalyst of helping these men separate themselves from other nurses who do these tasks and thereby colonising some traits of nursing which do not fit well into their gender identity as a male nurse, this behaviour was reflected in a participant's response to the question of how do you relate to your female colleagues? His response was:

> "Like when they tell you to buy lunch. That's not my job hey, and I say no I can't do that she feels like I am being rude."

4.2.4 Feminisation of the male

Feminisation of male nurses is illustrated by the stereotypes male nurses face by mere fact of that they are male in a feminine occupation, the professional set up of nursing requires them to perform task which society would ideally associate with women. These stereotypes suggest that, because of the male nurse's presence in a feminine dominated occupation, society expects them to become feminised; it seems because of this feminisation process that male nurses tend to configure, misconfigure and reconfigure their masculine gender identity as they attempt to portray hegemonic masculinity, as will be illustrated in chapter five.

4.2.4.1 Male nurses as "gay" "sisters"

Males face a lot of criticism for entering in gender atypical occupations such as nursing, because engaging in such occupations is often seen as a step down in status, some men shy away from pursuing gender atypical occupations (Meadus, 2000: 6-7). Those that do pursue a career in these gender atypical occupations such as nursing, find that they have to constantly explain themselves as to why they chose such a career. As this participant explained:

> "You find that, people will ask you, so why did you chose nursing? Especially male patients and you know deep down all they want to know is, are you gay or not?"

A re-occurring disadvantage in literature experienced by male nurses is the issue of being - stereotyped by society as effeminate, homosexuals or as gay. For Williams (1995) and Evans (1997) this stereotype originates from the beliefs from society about masculinity, as opposed to originating from objective judgements about these men's sexual lifestyles. Male nurses are well aware of this stereotype and have developed strategies of dealing with it, for example, the following two reports from two participants illustrate this:

> "I used to think that maybe men would think of you being less of a man if you are doing, if you are in a female dominated occupation. But now, I realise that there many of us here, and we are still men. You know even if they could be people who

could label us as "*moffies*"[3]. But, I haven't come across such people. But I know the perception of people when they are ignorant."

"You know what I heard, most people when they are talking about male nurses? They just think male nurses are gays, you know. People that are homosexuals they think a male nurse is someone who thinks like a female person."

Meadus (2000: 7) believes that this is because; it is difficult to accept men in caring, gentle and considerate roles. Men's desire to enter nursing challenges, society's stereotypical role of nursing. Since it this difficulty exist, male nurses find that the nursing profession does not have a gender appropriate way of addressing them, such as, female nurses are referred to as "sisters" and male nurses from biblical times were referred to as saints. Modern day nurses do not have a gender appropriate way of being addressed. This can cause frustration for male nurses as it is uncomfortable for the male nurses; the subsequent interview transcript from a participant illustrates this:

"Yes but also in that regard, it's uncomfortable for us [male nurses] to be called *sisters* because some of the patients they call us sisters and even the other nurses they call us *sisters*. I think the nursing council, SANC, should come up with a proper title for us eh male nurses."

In addition, because a person's identity is directly linked to their gender/sex role in society, it is challenging to rethink the concept of masculinity. As such, men who aspire to enter into female dominate; occupations receive less favourable appraisals by society than their female counterparts in male dominated occupations do. These stereotypes were experienced by a participant who stated that:

"Some people think that we are gays; to them being in this uniform is a crime for a guy. And the funny thing is, some of them don't even a job themselves."

For him, even though his choice to be a nurse is sometimes questioned by society, he does not mind it, because some of the people who pass the negative comments, for him should not be passing such comments as they do not have a job themselves. Therefore they cannot relate or understand his career choice. However male nurses

[3] A South African slang word meaning a guy who dresses and acts like a girl. It does not necessarily refer to a gay man, but rather to those who display female tendencies i.e. drag queens and cross-dressers etc.

find strategies of to dealing with these kinds of stereotypes such as for this participant:

> "I feel that people in the hospital are more understanding than those outside, who look at you like yoh! You are a nurse. When I started out I used to take off my uniform before going home so that I couldn't answer those are you a nurse or a doctor questions, and when I say I am a nurse getting those very weird looks. But as time went on, I got used to it. I wear this uniform everywhere now."

4.2.5 Incidental exclusion

Incidental exclusion of male nurses refers how because there is paucity of males in the nursing profession, male nurses are not provided with amenities such as, separate toilets or urinals from the female nurses, because in South Africa, nursing was initially established as a feminine occupation; as a result, many hospitals were built around this principle (Mellish, 1990). Male nurses interviewed in this study expressed their unhappiness of this lack of service provision. Consequently male nurse's today feel discriminated against because in some hospital's they do not have access to toilets. This was reflected in the following conversation between the researcher and a participant:

> "Participant: Well it wasn't easy at first, because us guys are very few in the profession, it comes with its disadvantages sometimes. Well because not everything is catered for.
>
> Researcher: For guys?
>
> Participant: Yes! not everything like for instance you go into a ward, where you'll find that there is a toilet for "stuff". Meaning "stuff" referring to females."
>
> Researcher: So you guy's sometimes don't have access to toilets in the wards?
>
> Participant: Yes, sometimes like you have to use public toilets, because their always public toilets nearby. But you end up going into those toilets, because I think from the onset I don't know if they didn't anticipate guys to be coming into the profession as they are coming in right now."

Another participant expressed his unhappiness of the toilet situation as he put it:

> "The toilet situation is very challenging, because in this hospital most of the toilets are for female nurses and there are just few for male nurses. Of which there are used

> also by the doctors so we struggle a lot if for example, here in block one and block two, when you wanna go to toilet, you have to use some lifts while there is toilets around. So it's really challenging the toilets and even in the wards, when you are a male nurse. The female... male patient will be like more open to you as male nurse."

The situation of not having access to toilets in the wards, for the previous participant's re-enforces to them a sense of their minority status in the profession. Irrespective of this, some male nurses take this constraint of not having access to toilets, and being left to figure out alternatives as an opportunity to display their masculine gender identity. That was the case for the following participant:

> "You see in the ward I am in, there are no toilets for male's nurses, but am a man, so I have to go to another ward to help myself. A man always makes a plan, and I am used to it now, so it doesn't bother me."

Three participants stated that toilets were present in the wards; however they did not shed light as to whether these toilets were strictly for males or females. Whereas another participant shed light on this matter by stating that:

> "You know there is a staff toilet in the ward, it says staff. And it has a picture of a female. So we have to use patient's toilets."

4.2.6 The midwifery experience for the male nurse

Male nurses are required by SANC (2005) as part of their nursing curriculum to practice a field of nursing which male nurses, consider as no place for a man. Midwifery is a nursing field where nurses have to assist with the birth process. For some male nurse's, involvement in midwifery impacts can or their masculine gender identity. This was reflected in the following interview transcripts from the following participant's. Working in midwifery for this participant was:

> "I did midwifery and no it's not uncomfortable, but it depends from person to person even females I was doing it with said they felt uncomfortable with midwifery."

Whereas for this participant working in midwifery was the opposite:

> "It's hectic hey, midwifery was hectic. I don't know why they made it compulsory because it was hard hey… sometimes ethics come along because there are some things you feel as a male nurse you cannot do. Watching a woman give birth is not easy hey"

Again similar views were expressed by another participant:

> "As a guy participating in the birth process it's difficult, it's challenging. I think that part of nursing is better suited for women."

However for some male nurses, involvement in midwifery was just part of the course and a great learning experience:

> "Midwifery I gained experience, it was helpful experience, like let's say if some-one goes in labour in this shop. I would be able to step in and assist them. Of which I couldn't be able to do if I didn't take up nursing."

4.2.7 Female doctors

As Evans (1997) argued male nurses prefer the company of other male medical professionals such as medical male doctors, because they feel that, female colleagues just do not talk the same language as them. This can be because ideally males are not supposed to receive orders from females, but the professional set up of nursing, male nurses receive work related orders from female superiors, resulting in the relationship between the male nurses and female doctors "tense" and "challenging,". this theme by illustrating the relationship between male nurses and female doctors, helps to answer the research sub-question of 'how do male nurses reflect on gendered interactions with female healthcare workers in the workplace?' as some participant put it:

> "From my experience, with male doctors, it's like he is a guy and I am a guy whenever when there is like time, he will like show you things, even the approach is quite different between female and male doctors. Whereas with female doctors, some are different some they don't even give you the attention and they just need you to do whatever they want you to do. They don't even greet you. But well people are different. We cannot blame the profession for that."

Another participant expressed the same kind of views in relation to socialising with female colleagues:

> "The male doctors, they are really... They like us. Male nurses it's that thing of you are a guy and I am a guy…. As with the female doctors, there is no openness, with them like you know even... With the approach you cannot just approach them openly, because they really show like they are not interested, in whatever."

For another participant after he explained that he is just a general nurse in the orthopaedic ward. He believes that:

> "When he came into nursing he would choose to work with only males."

However, he explained that, his experience of being treated differently by female bosses was due to:

> "The sister who was in charge of us in my previous ward hates my kind of people and our language. She made the job difficult for me by making my job bad, by treating me badly in front of everyone."

Whereas some participants said they did not experience any difference in how they were treated. For example:

> "Maybe they hide that, because I have never seen anybody treating me differently, they treat me the same as they treat other female nurses."

As another participant explained:

> "I am very lucky I am loved in this ward, the female doctors the sisters, they all love me."

By stating that he is lucky for being liked suggests that consequences exist for those who are not "lucky" or "loved" like he is. Furthermore he we went on to provide an example of an incident whereby a male nurse colleague of his was challenging a female doctor and:

> "They put him in his place."

4.2.8 Seekers, finders, settlers and those intending to leave

Like Simpson's (2004) study the current study identified a typology of male nurses as 'finders, seekers and settlers'. This typology can be used to explain the presence of these males in nursing. Furthermore, for the current study, a third category of those intending to leave the current position in the occupation or the occupation was also identified; this category was assigned the theme of "those intending to leave."

For Simpson (2004: 25) finders did not originally state a preference for the occupation but found it because of availability or convenience during the period of job search. For example, this participant was a finder:

> "Then I just felt like ah you know what I am going to keep on applying for nursing. Because it's on government side maybe one day I will get an opportunity. Then I only got it when I lost my job and it was something to fall back on."

Another participant was a seeker, as he actively chose the occupation, driven by the desire to help those in need:

> "Ya so I came to nursing, motivated by her passing and also the passion for helping people who can't help themselves."

Whereas this participant was identified as a settler, moving from being a masculine occupation to becoming a nurse:

> "I worked in the army before coming to nursing, I served in the army for 2 years, then I left because I wanted to be a doctor and I saw that I would not get that chance in the army, after that I saw this advert about nursing, and then I applied."

Another category of those intending to leave the occupation was identified, this category was assigned to male nurses who wanted to leave the occupation all together or intended to stay in the health profession but at a higher level than they their current position in nursing. For example, a participant stated that he is considering leaving because:

> "I am considering leaving the hospital environment… I would like to join the unions and work there, a friend of mine works there."

Whereas this participant stated that he would like to:

> "Go back home to Limpopo, and change things there, the nurses there don't take their jobs seriously, I would like to change things by becoming an inspector or maybe open my own nursing school."

Another participant explained his plans, which differed to nursing:

> "I applied for the nGap[4] position at the University of [redacted] that's my plan now to become a lecturer and do research in the field of nursing."

Whereas this participant wanted to remain in nursing but was:

[4] The New Generation of Academics Programme (nGAP) involves the recruitment of highly capable scholars as new academics, against carefully designed and balanced equity considerations and in light of the disciplinary areas of greatest need.
[5] The name of the university is withheld for anonymity

> "Considering to go overseas and do nursing of the elderly for a few years to make some money. I am saving money for that because it's expensive to go that side you know…"

For some they desired to remain in the profession, but at a higher rank:

> "I have fallen in-love with endocrinology, so I have decided that, next year I should go back to school and study something closely related to endocrinology."

4.2.9 (Dis)advantages

The minority status of male nurses serves as an advantage in some instances and a disadvantage in other instances as will be illustrated by the following reports from male nurses interviewed. For example, for this participant, being a male nurse serve as an advantage when he is talking to the opposite sex:

> "I would in my nursing uniform approach a girl and ask her out. I would gain points for that."

For another participant being a male nurse is an advantage because he receives inconsequential transgressions from his female superiors:

> "With male nurses we are treated as eggs you know, different from female nurses like with other female's neh, the sisters don't treat them fairly. For example, when they are late, the sisters are like you are late! They get shouted at, but us male nurses; if you are late they just look at you it's that thing *shimani*[6] you know."

This participant also experienced the same kind of treatment as a male nurse:

> "All the attention comes to you. You don't feel like you don't belong there or you are an outsider. Because they are trying not to make you feel like you don't belong there or you are an outsider."

The advantage of being a male nurse for some male nurses was that they were able to help other guys, who did not feel comfortable receiving help from female nurses as explained:

> "Male patients who prefer to be treated by male nurses like your traditional guys they don't feel comfortable being treated by a female, like sometimes you have to bath

[6] Indigenous term for guy

them you see or you have to insert a catheter on them so, you have to touch his penis, and traditional man they don't like that. So if I am here then I can go and help."

In relation to being able to help other guys this participant stated that as a male nurse he is able to:

"We motivate each other, by discussing the challenges we face as male nurse… We really wanna change this profession because, even up to today, it is still perceived as a female dominated occupation. We even encourage, other males who wanna be nurses… like if we are together they ask us how is it being a male nurse… is it scary with the blood and all that? So we just try to moderate that kind of fear, we tell them you can also do it. And then some show some interest."

Another advantage for the male nurse was that, they are liked by the male doctors for example this was that:

"The male doctors, they are really… They like us. Male nurses it's that thing of you are a guy and I am a guy…"

The disadvantage of the male nurse's minority status in the hospital setting included, not being liked by female doctors as this participant explained:

"With the female doctors… they really show like they are not interested."

Besides the treatment they received from female doctors, remuneration was also an identified disadvantage of being a male nurse for example this participant complained that:

"Ayi the money sucks man…"

Whereas for another participant the issue of patients preferring that they receive treatment from him was a disadvantage in a sense that:

"You sometimes find that, you are attending patients which were not supposed to be attended by you, and your workload increases. Sometimes you do the job of two nurses when just because you are the only guy in the ward."

Performing tasks outside the job description of a nurse was an identified disadvantage of being a male nurse by:

> "You find that you are delegated to do certain tasks yeah, but you end up leaving those tasks, doing other physical work like you know labour. Lifting heavy things and patients. Even if it's not for patients like let's say there is some equipment of which has to be removed from the ward yeah they call you. Like to assist with those equipment and you leave the tasks."

Whereas for another participant the disadvantage of being a male nurse was the minority status of male nurses in the nursing profession:

> "We are not being equalised in the field, it's still a female dominated occupation, more men should come into the field so that we can feel comfortable when there is many of us here."

The disadvantage for another participant was that he felt that he had limited knowledge:

> "The disadvantage that I realised of being a nurse is that, we don't have much knowledge, we depend too much on the doctors to give us orders on what to do."

Bathing patients was a disadvantage for another participant:

> "Sometimes we have to bath patients, young, old, men or women that thing man it's not nice for a guy. But you get used to it and you have to do it because it's your job."

4.2.10 Hobbies

The stereotype that exist, that, male nurses are gay or effeminate suggests that they engage in activities which only females engage in, however this was not the case as this section of the findings chapter seeks to dismiss or affirm this stereotype by reporting on the hobbies male nurses, said they engaged in away from work, the characteristics that they think makes an ideal man and a none manly man.

Concerning hobbies this is what some of the participants said they did when they were not working:

> "In my spare time basically it's either play-station, going out or going to the gym."

> "Usually with my friends enjoying soccer or having a drink, but I like to go out with my wife visit family and friends. But most of the time I like to be a lot in the house and spend quality time with my wife."

"I enjoy watching soccer; I am a big pirates[7] fan. So if am not here its either I am at home watching soccer or sometimes I go to the stadium with at the stadium with friends. But if am not doing that then I like to go to church with my family or seat with them and just relax."

4.2.10.1 Ideal man

When it came to identifying their ideal men male nurses made reference to friends, family, heroes and colleagues as examples. The following five quotations illustrate what an ideal man for the male nurses was:

"This guy I went to nursing school with, he is now a senior member of DENOSA[8], he taught me that, in life you have to work hard in order to achieve your goals. That guy is my friend he inspires me to be a better man."

"Someone people can look up to and a person who takes care of their family. And in South Africa, a man who doesn't beat the wife."

"A person who treat others the way he would like to be treated."

"Someone who's going to be there for their family, support them love them unconditionally."

"My father in law, he suffered too much before he got to where he is right now. So he is now a business man he is a good guy, a guy who can be able to eat pap[9] with tea when he has millions in the bank. And then when you ask him why you do this he will just tell you that, I remember those days, when I used to eat pap with water or pap with tea without bread. He is a very humble guy. He treats everyone the same he respects everyone he doesn't care even if you come across this guy you can't see that this guy is rich."

4.2.10.2 None manly men

The following are the male nurse's responses to the question of do you think there man out there who are not mainly?

The following four quotations are the nurse's response to this question.

"Men who rape and run away from their responsibility."

[7] A South African football club
[8] A trade union in South Africa that describes itself as "a voluntary organisation for South African nurses and midwifery professionals."
[9] A traditional porridge/polenta made from ground maize and a staple food of Southern Africans.

"Ok you do get some guys that you would not actually say this is a real man. Somebody let's say, ok example, you get people that we admit at the hospital, some of them are there and they will be like… you know I… Don't have anywhere to go I want somebody to take responsibility of me, so as a man you need to learn to be independent and responsible for yourself."

"Have got kids who they don't support. Guys who rape or rob people. That's not being a man."

"Some guys are gays… that's being unmanly isn't it?"

4.3 Conclusion

This chapter has demonstrated that male nurses of a particular hospital in South Africa, Johannesburg have numerous ways in which they display their masculine gender identity as was described by the literature (Williams, 1995; Barret, 1996; Evans, 1997; Mackintosh, 1997; Meadus, 2000; Connell, 2001 and Simpson, 2004). In addition, this chapter has also answered the research sub question of, 'how do male nurses reflect on gendered interactions with female healthcare workers in the workplace?' this interaction as illustrated above was found to be tense and a challenging interaction, this is because within the nursing occupation, male nurses are expected to receive work related orders from female doctors or superiors which destabilise the gender identity of male nurses, because ideally men are expected to give orders to women, which is not the case in nursing. Male nurses therefore resort to wide range of strategies to deal with this, such as socially distancing themselves from female doctors, or colonising feminine traits of the occupation in order to reconstruct their masculine gender identity.

The next chapter will use this data to argue that male nurse's tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. It will also demonstrate how the instability and situationality of male nurse's gender identity is reflected by the constant configuration, misconfiguration and reconfiguration. Chapter 6 will present the summary and recommendations of the study.

Chapter 5: Discussion

5.1 Introduction

According to Oliver (2014: 181), the purpose of the discussion chapter is to state the researcher's interpretations and opinions and to explain the implications of the findings. The main objective of the discussion chapter is to answer the research questions posed in the introduction, explain how the results support the answers and how the answers fit in with existing knowledge on the topic. The discussion chapter is considered the heart of the study (Oliver, 2014). The purpose of this study was to answer the research question, 'how do male nurses experience their gender identity in the workplace?' The question was to be answered using three research sub-questions:

1. How do male nurses understand their own gender identities in the workplace?

2. How do male nurses reflect on gendered interactions with female healthcare workers in the workplace? And

3. To what extent is hegemonic masculinity an identity source for male nurses?

Chapter 4 answered the research sub-question two. Data collected from the 15 male nurses showed how male nurses experienced their gender identity in the workplace, revealing the following themes: specialisation, social distancing, and feminisation of the male, incidental exclusion and colonisation of female skills. This chapter will use these themes to show how male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. Thereafter, these themes will be used to demonstrate how the instability and situationality of male nurse's gender identity is reflected by the constant configuration, misconfiguration and reconfiguration.

Before the researcher answers the research question and-sub questions one and three, it is important to remind the reader what the concepts of configuration, misconfiguration and reconfiguration mean as they play an integral part in explaining the argument of the study. Configuration refers to a social process whereby male nurses come to embody an appropriate masculine gender identity (Connell, 2001). Misconfiguration refers to instances or situations in which male nurses' gender identity is destabilised by the experiences of working in a women dominated space.

Reconfiguration refers to ways and instances in which male nurse's masculine gender identity is reorganised and settled.

5.2 Specialisation

Specialisation refers to the choices regarding which fields of nursing male nurses will choose to work in once they become nurses. As Evans (1997) reported, male nurses choose to specialise in nursing fields such as trauma which allows them to display stereotypical masculine behaviours. As the male nurses interviewed for this study reported, most of them worked in the trauma or orthopaedic wards. In order for the male nurses to specialise in these wards, they need to have specialty knowledge.

As pointed out by Hunter (2005) and Morrell (2005), modern day South African men used their physical strength and possess specialty knowledge to maintain their hegemony over other men and women. If a man does not possess specialty knowledge, which can allow him to gain employment to occupy a hegemonic position over women and other men, as was reported by Hunter (2005). It is common for South African men to use their physical strength in the form of violence against women as a form of domination. Male nurses, interviewed for this study, reported that their domination over other nurses was displayed by specialising in nursing field's contingent to their masculine gender identity. This specialisation, takes place because male nurses are aware of the underlying tension between their gender identity and career choice because, socially, men are not expected to be in a caring profession and, historically, nursing has been considered as a feminine occupation (Williams, 1995; Evans, 1997; Meadus 2000; Cross and Bagilhole, 2002; Simpson, 2004; Lupton, 2006 and O'Connor, 2015). In order to settle this tension, and to maintain their masculine identities, male nurses chose to specialise in trauma, orthopaedic or oncology nursing, thereby a configuration process takes place.

The choice is not automatic but rather ideological and experiential. The destabilisation of male nurses' gender identity occurs when they study midwifery, which is a compulsory part of their nursing training SANC (2005). However, specialising in midwifery is considered by the male nurses and society as a role best suited for females. Male nurses who participated in this study explained how midwifery was a challenging and uncomfortable experience, as assisting in childbirth was contrary to masculine tasks. The midwifery experience thus exposes the

process of misconfiguration taking place, whereby male nurse's masculine gender identity is destabilised.

Male nurse's reaction to midwifery is that it is just not meant for men. Therefore, it seems that by choosing not to specialise in midwifery is a way of reconfiguring their masculine gender identity. Once they qualified as nurses, after they have experienced midwifery, they opted to specialise in trauma or orthopaedic nursing. In such fields of nursing, male nurses are able to perform tasks contingent with masculine gender identity, such as lifting heavy patients, operating machines and working in these wards requires them to maintain a certain level of cool headedness. Specialisation is thus a way of male nurses portraying hegemonic masculinity. By specialising, they are able to display masculine qualities expected of them from society and, in doing so, are able to dominate other male and female nurses in nursing.

5.3 Social distancing

Social distancing refers to a process which occurs when male nurses prefer to socially distance themselves from their female colleagues in order to fulfil their socialisation needs (Evans, 1997). This distancing is created because of the gender structures in the nursing profession known by society and the male nurses during their nursing training. That is, in nursing male nurses are expected to receive and execute work related orders from their female superiors, ideally society does not expect a man to be executing orders received from a woman. However, because this is a professional environment and male nurses are expected to behave professionally, they execute the orders but report that their relationship with female superiors is a tense relationship in which the female superiors just do not get the male nurses. This shows the underlying social tension which exists between male nurses and female superiors because of their presence in nursing. Male nurses resolve this tension by socially distancing themselves from the female superiors and keeping their relationship with them strictly profession, thereby the configuration process takes place.

Their choice to socially distance themselves from female superiors is because of the social construct that men are supposed to be dominant over women. In situations where women are dominant over men, the gender identity of the men becomes

destabilised. Such is the case with male nurses in situations where they have to execute orders from their female doctors and superiors. This is an instance of destabilisation of male nurse's gender identity because the ability of the female doctors and superiors to give out orders to the male nurses for execution suggests, the subordination of the male nurses, because they have less intellectual capital and occupy a lower professional rank than the female superiors; therefore, this is an instance of process of misconfiguration taking place.

Male nurses resolve this destabilisation of their gender identity by socially distancing themselves from their female superiors and doctors. That is, male nurses prefer to socially align themselves with male doctors and nurses as a means of reconfiguration. As reported by the male nurses interviewed for this study, they enjoyed being in the company of male doctors and nurses, because they claimed that they learned a lot from each other. The fact that male doctors and female doctors possess the same kind of health knowledge and male nurses only feel like they can only get the knowledge they require from male doctors illustrates an instance of reorganisation of their gender identity, because it illustrates how male nurses would rather be subordinated by male doctors than female doctors, thereby allowing the male doctors to occupy the hegemonic position, and the male nurses also displaying a form of hegemony by affording the socialisation 'privilege' only to male doctors and colleagues, which benefits them in the long run as they get good reviews from the male doctors which allows them to progress in their career (Evan, 1997). Therefore, social distancing as reconfiguration allows male nurses to display a hegemonic masculine gender identity, by the subordinating female superiors and doctors.

5.4 Feminisation of the male

Historically, nursing has been viewed by society as feminine occupation, men who decide to become nurses are susceptible to facing gender stereotypes of being viewed by society as gay, effeminate, homosexuals or sisters because of the tension between their career choice and gender identity. As reported by male nurses interviewed in this study, these stereotypes came from patients, colleagues and society. Male nurses therefore denounced the stereotypes of being referred to as gays, effeminate, homosexuals or sisters by stating that, amongst other things, people who pass such comments do not have a job themselves. As stated by Hunter

(2005) and Morrell (2005), another way in which a modern South African man displays his masculine gender identity is his ability to provide, by securing employment. Furthermore, male nurses also state that because they received nursing training they possess knowledge which other people do not possess, which they use to help people in need of health related help. In doing so, male nurses are able to display their masculine gender identity by having a job and possessing knowledge which other people do not have, in this manner, the configuration process takes place by the male nurses through denouncing feminisation of the male.

As much as they denounce these stereotypes, the fact remains that male nurses still get referred to by colleagues and society by gender inappropriate terms such as “moffies”. This results in the destabilisation of their gender identity, because being referred to by such terms suggests the marginalisation of male nurses because of their career choice. Being marginalised is a quality which is not contingent with the masculine gender identity; therefore, the feminisation of the male nurses illustrates the misconfiguration process taking place.

Male nurses resort to shaming the people who pass such derogatory comments, and portray an image of not being bothered by them. As explained above, male nurses state that the people who pass these comments do not have jobs themselves, therefore they are able to display a masculine gender identity because of their employment status even if the employment is in a feminine dominated occupation. Furthermore, male nurses also state that it does not bother them when derogatory comments are used to refer to them, in doing so they are able to portray a masculine gender identity, one in which a man rises against all odds, such as being referred to by people by something he is not, and continuing to carry on his tasks irrespective of this. Thus, instances of male nurses denouncing stereotypes of being referred to by gender inappropriate terms, and portraying an image of not being bothered by such is both an instance of the reconfiguration process taking place, and portrayal of hegemonic masculinity.

5.5 Incidental exclusion

Incidental exclusion refers to the tension which exists between male nurses gender identity because nursing is considered as a feminine occupation and, given the fact that men are a minority numerically, means that hospitals in Johannesburg, where

the current study was carried out, were built on this premise (Mellish, 1990). As such certain amenities such as toilets for male nurses were overlooked, and not provided. However, over time, as more men get involved in nursing, it would be expected that this situation would change. However, as reported by the male nurses of this study, this was not the case, when they reported difficulty in finding toilets in their respective wards, and resulted in them having to go to other wards to use the toilets from those wards.

The fact that the male nurse's do not have access to toilets in certain wards implies that there is a long tradition with male nurses of not raising the issue with hospital management, or that they have raised it and management has overlooked the issue. The reason for this would include, given their gender identity, complaining about the lack of toilets is something not expected of a man, as society expects a man to not complain, or that the person who is in charge of providing toilets is female and, because of the social distance between male nurses and female superiors, the issue cannot be raised. In addition, management can be aware of this it can be an oversight on their part, or they choose to do nothing about it because of the male nurses' numerical minority status in the wards, and the hospital cannot go out of its way to provide toilet's for a minority group, resulting in the minority finding strategies of overcoming this challenge, thereby maintaining a masculine gender identity and illustrating how the configuration process takes place.

Male nurses (in)ability to voice their apprehensions about the incidental exclusion they experience in nursing is another way in which their gender identity is destabilised. The lack of provision of toilets in certain nursing wards whether it was an oversight or deliberate from management for the male nurses was described as a challenging situation which is not easy to overcome. This implies that, again, the lack of toilets reinforces to the male nurses their minority status as well as their subordination by the dominant group in the nursing field, thus destabilising their masculine gender identity because a man is not expected to be dominated by other groups but, as illustrated above, the lack of provision of toilets re-enforces this subordination, and in doing so illustrates the process of misconfiguration taking place.

The experience of the (in)ability to voice their apprehensions about the incidental exclusion for male nurses is a way in which they reconfigure their destabilised masculine identity. As some male nurses explained, they use the opportunity to make a plan, which is what society expects a man to do, “make a plan.” This implies that, not having toilets, looking for them and not complaining about it to management, is an instance of a new configuration taking place, where a man results in not voicing out his apprehensions about a certain situation, because such behaviour might seem like nagging and is not socially expected from a man.

Another way in which male nurses reorganise and settle their destabilised gender identity is by enjoying inconsequential transgressions; that is, given their gender identity of being male, and because society expects men to dominate in all spheres of life. Male nurses do not face any consequences for bad workplace behaviour, such as coming in late for work. Instead, their female superiors let them get away with such behaviour, and justify it by saying he is late, because it is something males typically do. As reported by a male nurse when he was describing the (dis)advantages of being a male nurse, female colleagues do not enjoy the same privilege of coming in late and not facing consequences for it. Therefore, the reconfiguration process is also illustrated by male inconsequential transgression enjoyed by the male nurses, which is also an instance of them portraying hegemonic masculinity.

5.6 Colonisation of feminine skills

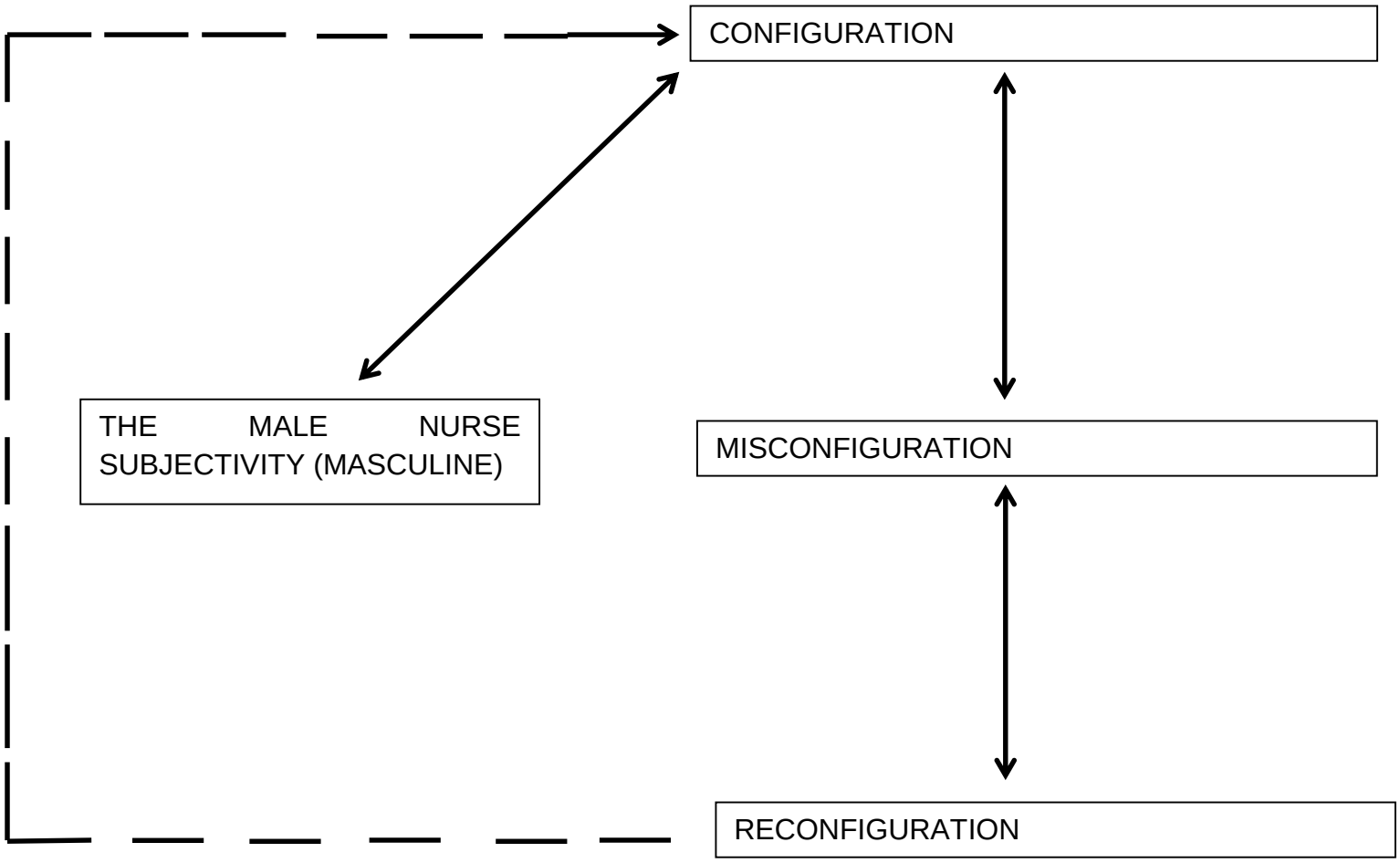
According to Cross and Bagilhole (2002) colonisation of feminine skills refers to the ability by men in feminine occupations to maintain a masculine gender identity by their ability to colonise feminine skills of the profession in order to seem like complete men. For the current study, the configuration process was illustrated in instances where male nurses colonised feminine skills. That is, when male nurses were asked what their daily activities as a nurse in the hospital were, their explanations were centred around masculine activities, such as using their physical strength. The strength and knowledge they offer is only possessed by them and, as such, allowing them to display a masculine gender identity.

However, nursing being considered a feminine occupation, means that nurses have to perform certain tasks, such as bathing, fixing wounds and providing constant care

to patients. Male nurse's, did not mention this as part of their daily activities. This implies that, they were afraid of being viewed as less of a man and, as a result, chose to not mention such tasks as part of their job description, which is stated in SANC (2005). The fact that they did not mention them also implies that it negatively affects their masculine gender identity, as if they mention that they bath and take care of patients, they will be viewed as less of men because of the fact that they have to carry out such tasks, thereby resulting in the destabilisation of their gender identity, in doing so illustrating the taking place of the misconfiguration process.

In relation to colonisation of feminine skills, restabilising takes place through specialisation, that is, male nurses specialise in nursing fields which are contingent with their masculine identity, so that when they have to describe what it is they do, they can easily focus solely on the masculine tasks they are required to do in order to execute their nursing duties. Another way in which male nurses restabilise their masculine gender identity is through their display of specialty knowledge, to peers and patients. Furthermore, they also restabilise their masculine gender identity by stating that, patients prefer to be treated by them instead of other nurses. In doing so male nurses are able to portray a masculine gender identity the kind where, they know more than most, are liked more than others and are the only ones who can do what they do because they possess strength which other do not possess, which is also a portrayal of hegemonic masculinity. The next section of this chapter will explain the above demonstrated argument, with the aid of the figure below.

Figure One



The figure above summarises the researcher's analysis and, as such, will be read from the box titled 'the male nurse subjectivity', which represents the male nurse before he becomes a nurse. That is, by virtue of him being a man he is constructed by society as such and, as a result of this, it is expected of him to be masculine and perform masculine related tasks. Moving with the arrow anti-clockwise towards the right is a box titled as 'configuration', this box represents the configuration of a male masculine gender identity within a feminine occupation as was explained above using the themes from chapter 4. This box represents both the everyday understanding of masculine identity and the underlying tension of being a male nurse in a women-dominated workplace.

Thereafter, just below configuration on the right, is 'misconfiguration' which refers to instances or situations which destabilise male nurses' gender identity. Again there is a connection between configuration and misconfiguration, as illustrated by the arrow

pointing at both the configuration and misconfiguration box. The arrow below the misconfiguration box illustrates the final process of the three configurations, which is 'reconfiguration'. Reconfiguration being the process in which there are ways and instances of "new" configurations taking place. These new configurations are a result of male nurses' attempts to reorganise and stabilise their masculine gender identity. These configurations can be explained using Connell's (2001) concept of hegemonic masculinity. That is, male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. As the concept of hegemonic masculinity states, it is the ascendency of men over other men in all spheres of life, this ascent, as was demonstrated above, is aided though culture, institutions and persuasion. For the current study, male nurses tended to portray hegemonic masculinity as explained by the themes of specialisation, social distancing, the midwifery experience, feminisation of the male, incidental exclusion and colonisation of feminine skills.

The dotted arrow from the reconfiguration box to the configuration box demonstrates how, for male nurses, this is a continuous contradictory process, happening in different situations and instances. Even though other masculinities exist in relation to hegemonic masculinity, such as complicit, subordinate, and marginalised masculinities, for purposes of this analysis and meeting the aims of this study the focus was only on hegemonic masculinity. The following section of this chapter will conclude the chapter before chapter 6 concludes the study and makes recommendations.

5.7 Conclusion

In conclusion, the following themes from chapter 4: specialisation, social distancing, and feminisation of the male, incidental exclusion and colonisation of female skills, were used to show how male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. Furthermore, this chapter also illustrated how male nurse's masculine gender identity is unstable and situational, as a result of their attempt of the portrayal of hegemonic masculinity. In doing so, it answers the research question of 'how do male nurses experience their gender identity in the workplace?'

Whereas, for the research sub-question one of, ‘how do male nurses understand their own gender identities in the workplace?’ this study found that male nurses understand their gender identities in the workplace by configuring a male nurse masculine identity. That is, because male nurses are men in a feminine occupation, they understood their workplace gender identity by configuring a workplace masculine male nurse gender identity. They do so by specialisation, social distancing, and backlashing against feminisation of the male, backlashing against incidental exclusion and colonisation of female skills. In relation to research sub-question three of ‘to what extent is hegemonic masculinity an identity source for male nurses?’ this study found that hegemonic masculinity is the main masculine gender identity source for male nurses. The following chapter of this study will conclude the study and offer recommendations on the topic.

Chapter 6: Conclusion and recommendations

6.1 Introduction

The aim of this chapter is to conclude the study and to provide recommendations for future study. The conclusion will proceed by providing a summary of each chapter to discuss whether the study achieved what it sought to do. Finally, the recommendations section of this chapter will conclude the study, which will be divided into the following two sections: practice and knowledgebase and future research.

Chapter 1 of this study provided the researcher's view of the problem, which described issues pertaining to the paucity of men in the nursing profession and provided a justification for the study. The main aim of the research was to find out 'how do male nurses experience their gender identities in the workplace?' To answer this question, three research sub-questions were created; these were, 'how do male nurses understand their own gender identities in the workplace', 'howdo male nurses reflect on gendered interactions with other healthcare workers in the workplace' and 'to what extent is hegemonic masculinity an identity source for male nurses?'

Chapter 1 included a statement of the problem and explained the objective of the study which was to find out how male nurses experience their gender identity in the workplace. The objective of the study was fulfilled with the following aims: to explain, from the literature review, the involvement of men in the nursing profession; the feminisation of the nursing profession and the demise of men from the profession; the current role of men in the nursing profession and the meaning and application of the concepts of masculinity and post-structuralism. This study also aimed to discuss data from the literature review regarding the issue of maintaining a masculine gender identity in the context of engaging in work which is supposedly feminine, such as nursing from a South African perspective. This study also aimed to, find out from the male nurses, the opinions and perceptions of how male nurses in South Africa, Johannesburg, experience their masculine gender identity in the workplace.

The significance of the study, to the current debates on the masculine gender identity of men in gender atypical occupations was explained in chapter 1. Theoretically, the study fills the gap in lack of understanding on how male nurses understand and resolve the contradiction of being a man and working in a female

dominated occupation by using post-structural interpretations of gender processes in the South African context. Furthermore, this study proves that hegemonic masculinity is a useful theoretical tool in understanding the gender processes at work, specifically in the context of men engaging in feminine occupations. Similarly this study shows that it is useful to adopt a post-structural perspective in interpreting such gender processes. Practically, this study highlights the fact that people need to advance their understanding on the rich contribution made by male nurses to the nursing profession, both in the classroom and at a societal level; this would break the stereotype of women being better suited for the nursing position, and the view of male nurses as gay, effeminate, homosexual or sisters.

In chapter 2 a literature review of the study was provided which was divided into two sections. The first section of the literature review presented themes that relate to the history of the nursing profession in relation to presence and disappearance of men in the profession since its establishment globally and locally. It was important to review this literature, because this history showed the role played by men in the organisation of the nursing profession. The second section of the review of literature discussed the concepts of masculinities, hegemonic, marginalised, complicit and subordinate masculinities and post structuralism, thereafter these concepts were used to examine the data obtained from the in-depth interviews the researcher had with the 15 male nurses.

Chapter 3 discussed the qualitative methodology the study employed in gathering data from 15 male nurses of a particular hospital in Johannesburg, entailing the: design; population; sampling; data collection and data analysis methods. This chapter also gave a reflection of the researcher's experience; entailing limitations the researcher encountered when collecting data and how these were overcome. This chapter also showed that ethical considerations were taken into account when the research was being conducted.

Chapter 4 presented the research findings and demonstrated the numerous ways in which male nurses experience their masculine gender identity as was described by the literature (Williams, 1995; Barret, 1996; Evans, 1997; Mackintosh, 1997; Meadus, 2000; Connell, 2001 and Simpson, 2004). In addition, this chapter also answered the research sub-question one of, 'howdo male nurses reflect on gendered

interactions with female healthcare workers in the workplace?' This interaction was found to be tense and a challenging interaction, this is because, within the nursing occupation, male nurses are expected to receive work related orders from female doctors or superiors which destabilises their gender identity, because ideally men are expected to give orders to women, which is not the case in nursing. Male nurses therefore resort to a wide range of strategies to deal with this, such as socially distancing themselves from female doctors, or colonising feminine traits of the occupation in order to reconfigure their masculine gender identity.

Chapter 5, using the data accumulated from chapter 4 in conjunction with the literature presented in chapter 2, showed how the study arrived at the conclusion that, male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. In doing so, answering the research question of, 'how do male nurses experience their gender identities in the workplace? And the research sub-questions one and three. Research sub-question one was answered by arguing that, because male nurses are men in a feminine occupation, they understood their workplace gender identity by configuring a workplace masculine male nurse gender identity. They do so by specialisation, social distancing, and backlashing against feminisation of the male, backlashing against incidental exclusion and colonisation of female skills. In relation to research sub-question three of 'to what extent is hegemonic masculinity an identity source for male nurses?' this study found that, hegemonic masculinity is the main masculine gender identity source for male nurses. The final section of this study will conclude the chapter and study by making recommendations.

6.2 Recommendations

6.2.1 Practice and knowledge base

The current stereotypes of male nurses as gays, effeminate, homosexuals and *sisters* reflects ignorance of the historical role of male nurses. This has resulted in male nurses developing lack of pride of their historical contributions to the profession.

Therefore, a recommendation would be made to advance people's understanding on this rich contribution made by male nurses to the nursing profession, both in the classroom and at a societal level. This could be done by encouraging studies such

as those of O'Lynn (2007) which solely focus on male nurses' contribution to the nursing profession and, in doing so, male nurses would be able to relate to other males who have contributed to the profession, perhaps universities or nursing colleges would offer a teaching units which solely focuses on the history of nursing with a component on male nurses.

In relation to the gender inappropriate term of male nurses being referred to by colleagues and patients as "sisters", a suggestion that the SANC develop a gender appropriate term for male nurses, a term such as "meneer"[10] would be better suited and more gender appropriate for male nurses. Furthermore, this study would recommend that SANC should put it in their constitution that hospitals should provide amenities, such as toilets, to all wards for nurses of all sexes and gender, this could be done by turning the available toilets into unisex toilets or building stuff toilets for the male nurses. The availability of such facilities would make male nurses' presence in the toilets acceptable.

In relation to the colonisation of female traits in the nursing profession, male nurses prefer to work in fields of nursing which require them to display a stereotypical, masculine gender identity, implying that there is a shortage of male nurses in other fields of nursing. Therefore, a recommendation is made that male nurses should learn from historical examples of their predecessors that nursing is a human profession not exclusive to either sex.

6.2.2 Future research

This study identified the process of configuration, misconfiguration and reconfiguration of male nurse's workplace masculine gender identity, the researcher would like to make the following three recommendations in relation to the process. Firstly, this study was only concerned with male nurses' masculine gender identity in the workplace, a recommendation would be made to future studies on the topic to investigate factors that influence men to take up a career in nursing. Focusing on these factors could shed more light on how male nurses experience their masculine gender identity even before enrolling in the profession. Comparisons could be made between how they experience their masculine gender identity away from the

[10] An Afrikaans name for 'sir', 'gentleman' or 'mister'. Sometimes male teachers in South African township schools are also colloquially addressed as 'meneer'.

workplace and within the workplace thereby providing a better understanding of masculinities in women-dominated workplaces.

Secondly, studies focusing on the current role of male nurses in the nursing profession, including what their daily activities and roles were as male nurses, would help to break the stereotype of only females being better suited for the nursing role. Studies such as this one and those by Williams (1995), Evans (1997), Cross and Bagilhole (2002) and O'Connor (2015) show that male nurses are not gay effeminate or homosexual. If an image of male nurses, is shown to the public, of being a man and being a nurse, then certainly these stereotypes would cease to exist. This can equally work so for (potential) male nurses as well as I have suggested above.

Finally, taking into account the findings on social distancing between male nurses and female doctors, the researcher would recommend that future studies focus on the relationship between male nurses and female doctors. By shining some light on this relationship, better conclusions would be made on the dynamics gender and authority in the workplace.

6.3 Conclusion

From the interviews with 15 male nurses in Johannesburg, this study has argued that male nurses tend to portray hegemonic masculinity as their gender identity is simultaneously being configured, misconfigured and reconfigured in the workplace. The literature review has demonstrated the historical changes in the role and societal perceptions of male nurses in South Arica and elsewhere. This study suggests that societal (including male nurses) ignorance of the history of male nurses renders the profession feminine and is partly responsible for the challenging gender identities of male nurses in the workplace. Part of the recommendations is to present nursing as a human profession rather than a 'naturally' women's profession.

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Appendices

Appendix A: Ethics Clearance

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Kalemba

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H15/06/29**
PROJECT TITLE	Men working in a women-dominated occupation: An exploratory study into the lives of male nurses in South Africa
INVESTIGATOR(S)	Mr J Kalemba
SCHOOL/DEPARTMENT	School of Sociology/
DATE CONSIDERED	19 June 2015
DECISION OF THE COMMITTEE	Approved unconditionally
EXPIRY DATE	02 July 2017
DATE 03 July 2015	**CHAIRPERSON** J. Knight (Professor J Knight)

cc: Supervisor : Dr R Matshedisho

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ _____/_____/_____
Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix B: Consent Form

Consent to participate in the research study

I,…….., will willingly participate in the study titled: ""It's uncomfortable for us to be called sisters." An exploratory study into the experiences of male nurses in a Johannesburg hospital, South Africa". As a participant I am aware of the following:

That I am free to withdraw from the study at any point during the conduction of the study without any punitive measures and pressure from management and the researcher. All the information supplied in this study will be treated as private and confidential.

Anonymity will be ensured, my identity will not be linked to any response during the audio-taping of the interview. The audio-tapes and transcriptions will be safe-guarded by the researcher and will be destroyed after five years of conducting the study.

Permission will be obtained from the executive management of the hospital where the study will be conducted, if the participant and the executive management of the hospital wish the findings of the study will be available to them.

Signature:…….

Date:……

Joshua Kalemba

Cell: [redacted]

Email: kalembajoshua4@gmail.com

Supervisor Doctor Rajohane Matshedisho

Tel: [redacted]

Email: Rajohane.Matshedisho@wits.ac.za

Appendix C: Audio-Recording Consent Form

Consent to be Audio-Recorded during an In-depth Interview

I,……..…..…., Will willingly participate in the study titled: ““It’s uncomfortable for us to be called sisters.” An exploratory study into the experiences of male nurses in a Johannesburg hospital, South Africa.”

I hereby give my permission to be audio-taped during the interview, which will be conducted by an experienced interviewer. I am aware that anonymity will ensured.

If the participant and the executive management of the hospital wish the findings of the study will be available to them.

Signature: ……..

Date:……..