NURSE EDUCATORS’ PERCEPTIONS OF
MALE NURSING STUDENTS IN THE CLINICAL SETTING

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Men have worked in the nursing profession throughout history, yet, the stereotypes and gender bias that male nurses experience still permeates society today. Indications of these may be responsible for the relatively minimal growth in the percentage of males choosing nursing as a career. Studies on nurse educators’ evaluative interactions and observations of male nursing students’ performance have not included those in a clinical setting, a critical component of nursing education. No research has provided insight into the nurse educators’ perceptions of male nursing students in these settings, although there is a plethora of literature focused on men in nursing. Thus, this study examined nurse educators’ perceptions of male nursing students in the clinical setting utilizing a multicase study design. Results of this study noted four prominent themes related to nurse educators’ perceptions: preconceived assumptions, the concept of caring, persisting gender stereotypes and the exploitation of physical strength. These findings indicate that nurse educators continue to perpetuate the lingering stereotypes and gender biases that have plagued males for decades. Implications for nursing education include engaging students in reciprocal dialogue, educating others about the differences in caring between genders, and critically reevaluating the curriculum in order to create a warm, fair, and educational environment that invites males into this profession.
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“If I have seen further, it is by standing on the shoulders of giants.”

Issac Newton

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CHAPTER I

INTRODUCTION

Providing holistic and individualized care to an increasingly diverse and expanding population has become a challenge and hardship for nurses today. The complexity of patients coupled with the ever-growing nursing shortage has put pressure on the healthcare system to increase and educate students who have an interest in nursing and healthcare. Despite this ongoing effort, the percentage of men in nursing has not substantially increased and efforts to increase the number of men who choose nursing as a profession have produced only moderate results. In addition, lingering gender stereotypes and societal perceptions of men in nursing have continued to permeate; thus further perpetuating the feminization of the nursing profession.

There is hope that the population of men in nursing will continue to increase because of the rising complexity of technology, the socioeconomic rewards of nursing related to stable salaries, and the present unemployment situation in today’s economy (Yu, 2008). Thus, nurse educators need to be aware of men’s contributions to the profession; hence, they need to be sensitive to the impact of gender bias and negative stereotypes and embrace the unique contributions that males can bring to the nursing profession. In addition, nursing faculty can be in a position to “revalue” the knowledge, ways of thinking, and acting that male students possess (Bourdieu & Wacquant, 1992).

Statement of Significance

In many industrialized countries of the world, gendering of occupations persists with a clear division between “men’s work” and “women’s work,” particularly within the
nursing profession (Williams, 1993). There is a paucity of research on the perceptions of men in nontraditional roles, including elementary school teachers, daycare workers, librarians, flight attendants, secretaries, elderly caregivers, and male nurses (J. Allen, 1993; Applegate & Kaye, 1993; Cooney & Bittner, 2001; DeCorse & Vogtle, 1997; Pringle, 1993; Sargent, 2005; Simpson, 2009, Skelton, 2003; Williams, 1993; Wood, 2012). However, there is little, if any, research exploring faculty perceptions of male nursing students in the clinical setting. Much of the research on the topic of males in nursing is outdated (dating back to the 1970s and 1980s), and the majority of the articles published originate outside of the United States. In addition, much of the research centers on male nurses’ perceptions of nursing in this female dominated profession.

Throughout the history of nursing, women’s accomplishments in the field have been overwhelmingly documented, leaving little acknowledgment of the male role despite their participation since the profession’s infancy (Mackintosh, 1997). According to O’Lynn (2013), much of the history of nursing during the past 100 years has been documented by women emphasizing their significance and accomplishments, often apportioning minimal credit to the contributions of males in the nursing profession.

Currently, the healthcare industry is one of the fastest growing in the United States, due in part, to the aging population. This has increased the demand for more long-term and skilled nursing facilities. As a result, the demand for registered nurses has increased as a predicted shortage of nurses continues to permeate. Thus, efforts are increasing to recruit and retain more nurses to meet the growing needs of our aging society (U.S. Census Bureau, 2013).
Despite the industry’s potential growth, the U.S. Census Bureau (2013) reported that in 2011, only 9% of all nurses were men compared to 1% in 1963; thus, there has been a relatively minimal increase in the past five decades. In addition, the percentage of men enrolled in basic Registered Nurse (RN) programs has only steadily increased from 12% in 1995, to 15% in 2012 (National League for Nursing [NLN], 2013). However, these percentages and numbers are small to moderate compared to the rate of growth of the healthcare industry (U.S. Census Bureau, 2013).

Nurse leaders and educators recognize that a key aspect is to increase efforts to recruit more males into the nursing profession (Anthony, 2004; Bell-Scriber, 2008; Meadus, 2000; Meadus & Twomey, 2007; O’Lynn, 2004; Porter-O’Grady, 1998; Perkins, Bennett, & Dorman, 1993; Villeneuve, 1994; Xu, 2008). However, stereotypical perceptions of males in nursing continue to perpetuate, possibly impeding the number of males pursuing nursing as a career. In addition, Brady and Sherrod (2003) reported that nursing faculty are often unaware of the gender-based barriers existing within schools of nursing, possibly contributing to the relatively low number of males in the nursing profession.

Diekelmann (2007) asserted that it is time that we, as nurse educators, revisit curricular and instructional models in an attempt to deal with the fundamental struggle of how best to build a new vision for nursing education and leadership. However, nursing faculty and leadership need to acknowledge the numerous societal and collegial perceptions of males in nursing. These lingering perceptions continue to create a highly
gender differentiated and predominantly feminine culture in nursing education (Anthony, 2004; Bartfay, Bartfay, Clow, & Wu, 2010; Cabaniss, 2011).

In addition to being mindful of the perceptions of male nurses, nurse educators need to continue to “search for the threads of social justice and human rights in our curricula” (Fitzpatrick, 2003, p. 65) and re-evaluate the implications of critical social theory within nursing education.

According to Kirkham and Browne (2006), social justice refers to the application of justice to social groups. They contended that justice entails fairness in determining inequality and discrimination within particular population groups. Although often associated with wealth, income, and other material resources, social justice also involves disparities in nonmaterial concepts such as rights, opportunities, and power. Frasier (2003) suggested that social justice requires both distribution so that all participants have a “voice” and recognition ensuring that equal respect and opportunity is available to achieve social respect. As a result, those in the minority would be an integral part of the decision-making processes.

D. G. Allen (2007) contended that one of the “delights” (p. 118) is the dimension of diversity that is inherent in today’s nursing student population. As a result, these students bring into the classroom different histories and ambitions that may be construed as marginal. Consequently, “any person’s slight deviation from the ‘norm’ is met with negative pressure” (Hall, 1999, p. 92); hence, a student may be unaware that his or her behavior is being shaped toward conforming to the norm (Foucault, 1995; Hall, 1999). Thus, the critical educator needs to be “committed to empowerment, community
building, and social action through rational dialogue that will allow students to understand how others experience power and oppression” (Ironside, 2001, pp. 76-77).

Nurse educators can refer to Habermas’s theory of communicative action to encourage individuals to speak freely and non-coerced. This theory acknowledges that power relations and current social structures either enable or inhibit an individual’s way of behaving (Kemmis, 2001). Utilizing Habermas’s theory asserts that “the vulnerabilities of all the humans in the school and clinical settings are acknowledged, which means that discourse is facilitated where all the voices are heard” (D. G. Allen, 2007, p. 136). Thus, communication is between “equal” individuals and problem solving becomes a dialogue leading to a mutual agreement. This process can facilitate empowerment for those who may feel their voices are constrained (Wilson-Thomas, 1995).

In an interview with Dr. Chad O’Lynn, a prominent and highly respected expert on the topic of men in nursing, I asked him what he felt nursing educators can do to warm the climate for male nursing students. Dr. O’Lynn suggested two areas on which to focus: First,

We as nursing educators need to be aware of potential biases and barriers that exist related to men in nursing. Secondly, educators need to help students work through these potential or real barriers in order to promote a more positive educational opportunity for “underrepresented” (in this case male nursing students) students. (telephone interview, January 29, 2014)
Perhaps if nurse leaders and educators address these perceptions and barriers, engage in reciprocal dialogue with students, and commit ourselves to an orientation of social justice, we, as educators, can help create a male-friendly atmosphere that may dissipate these perceptions and invite more males to enter into the nursing profession.

**Purpose of the Study**

Review of the literature and evaluation of current nursing curriculum have revealed that perceptions of male nurses and barriers to practice continue to permeate within society and the educational realm. However, I was unable to find any research focusing on nurse educators’ perceptions of male nurses or male nursing students. Hence, the purpose of this case study is to explore nurse educators’ perceptions of male nursing students in the clinical setting to better understand and be sensitive to various perceptions associated with male nurses in the female dominated profession of nursing.

**Research Questions**

Overarching research question: What are nurse educators’ perceptions of male nursing students in the clinical setting?

Qualitative research questions addressed:

1. What are selected clinical nurse educators’ perceptions of male nursing students?

2. How do selected nurse educators’ perceptions influence, if at all, their interactions with male nursing students?
Significance of the Term *Perception*

The word *perception*, a noun, evokes a variety of definitions and ideas. For example, Merriam-Webster (2004) listed several definitions including “a result of observation,” “a mental image,” “or physical sensation interpreted in the light of experience.” Merriam-Webster further added that perception involves “the ability to understand inner qualities or relationships, and/or the knowledge gained from the process of coming to know or understand something.” According to McDonald (2011), “*Perception* involves the way one sees the world” (p. 2). As a result, perception is a uniquely, multifaceted, never objective, individualized understanding; a personal manifestation of how each individual views his or her world influenced by many sociocultural elements.

Although dictionary definitions of the word perception exist, the influence of culture and habitus on our perceptions cannot be overlooked. According to Dewey (2013), cultural prejudices of race, nationality, class, gender, and sect are obvious influences on an individual’s personal and social relations. These influences are not determined by heredity alone; but rather are “embedded in traditions, institutions, customs, and the purposes and beliefs they both carry and inspire” (Dewey, 2013, p. 75). As a result, our perceptions support empirists’ claim that “we know the word most directly by looking or pointing at things rather than thinking about them” (Ryan, 2011, p. 8). Ultimately this may help explain unexamined or unwarranted beliefs about perceptions of males in female dominated professions.
Perception is also informed by Bourdieu’s (1984) concept of habitus. Bourdieu suggested that habitus explains aspects of social life that are “influenced by history, tradition, customs, and principles that people make explicit (Rhynas, 2005, p. 182). Subsequently, habitus is an exemplified reality often unquestioned and perpetuated as individuals imitate and incorporate behaviors into their lives. Thus, Ryan (2011) contended habits accumulate over years and are only disrupted when unexpected problems arise (p. 21). Habitus supports the notion that certain perceptions exist simply because “it is what it is.”

Bourdieu’s habitus can be applied to nursing practice and education. Rhynas (2005) cited the example of nursing students becoming socialized in the workplace. The students learn ways of interacting with peers, educators, and patients. These observations often become the basis for future interactions. In addition, students often bring their own personal notions and experiences to school, further shaping their responses and behaviors in the educational environment.

Bourdieu’s notion of habitus is similar to Foucault’s work in that “bodily intensity is not natural but involves the inscription of dominant social norms or the cultural arbitrary upon the body” (McNay, 2000, p. 36). Bourdieu explained this may help how certain social groupings “choose” to enter certain occupations according to stereotypical trajectories (Colley, James, & Tedder, 2002). In addition, Bourdieu’s theory takes into consideration the notion that particular groups possess “homogeneity of the habitus” (Bourdieu, 1990, p. 80). Thus, individuals often classify themselves via the hierarchical category of gender.
Dewey (1934) is careful to differentiate between *perception* and *recognition*. It is recognition that is responsible for classifying, labeling, or attaching a “name tag” to someone or something. He contended that recognition is an “act of perception cut short that lacks the richness of understanding.” Thus, it is only partial seeing and only the “beginning of an act of perception” (p. 54). Dewey (1934) maintained, “In *recognition*, we fall back, as upon a stereotype, upon some previously formed scheme” (p. 54).

According to Dewey (1934), *perception* goes beyond recognition and must “develop freely” (p. 54). He believed perception replaces recognition and involves a process that unfolds involving “cooperation of all funded ideas to complete the picture” (pp. 54-55). In addition, “perception is an act of the going-out of energy in order to receive” (p. 55); an intrusion of the world where “we must summon energy and pitch it at a responsive key in order to take in” (p. 55). Thus, “to perceive, a beholder must create his own experience” (p. 56).

The concepts of culture and habit and Dewey’s notion of perception versus recognition further expand the definition of perception and help explain the perpetuation of stereotypes regarding male nursing students. Perhaps if nursing faculty recognize the impact of habit and culture on perceptions, more males will choose to pursue a career in nursing. Confronting habit can produce doubt “that calls forth cognitive inquiry in order to determine what is wrong and what we should do about it (Ryan, 2011, p. 21).

**Theoretical Framework**

Theory is present in case study research as a means to help us “anticipate and make sense of events” (Merriam, 2009, p. 69). Hence, the research questions
extrapolated from my literature review are supported by the ideas of numerous curriculum theorists including William Pinar, James Henderson, John Dewey, and Nel Noddings. In addition, Social Role Theory is an integral theory in this study in that this theory attempts to explain how societies may develop and perpetuate gender stereotypes.

Pinar (2004) stated, “Curriculum theory is the interdisciplinary study of educational experience” (p. 2). However, he is careful to say that not all educational experiences or curriculum theories are necessarily interdisciplinary. In addition, curriculum theory has a responsibility to educational experiences and, thus, is critical to modern school “reform” (Pinar, 2004). As a result, nurse educators continue to work with other disciplines such as biology and chemistry to embrace ideas and newer technologies that support and encourage innovative nursing pedagogy.

Within the discipline of nursing, curriculum theory focuses on theory that originates in practice and has been “tested” and discussed with colleagues. This evolving theory is dynamic and developing into a “living theory” (Bevis, 1988, p. 69). As a result, living theory arises from readings, lectures, and discussions centers around nursing practice. Thus, a reciprocal relationship develops between theory and practice, each enlightening, provoking insight, and altering meanings for those involved. For example, Diekelmann (2007) contended that clinical educators focus on clinical knowledge coupled with clinical experiences that then informs curriculum. As a result, students and educators “come together” (p. 15) to give meaning to shared experiences. Thus, according to Bevis (1988), “as the theory evolves so the practice evolves. In this way, in the truly professional curriculum, each informs the other in the magical whole of praxis”
Hence, students and faculty work hand in hand, in nursing, to evaluate and improve the curriculum.

Pinar’s (2004) work emphasizes the significance of “subjectivity to teaching, to study, to the process of education” (p. 4). He advocated the concept of a “complicated conversation” (p. xiii) that he hopes provides educators as well as public school teachers the ability and intellectual freedoms to develop curriculum in which “academic knowledge, subjectivity, and society are inextricably linked” (p. 11). Therefore, nursing learning is facilitated through the open and respectful dialogue between nursing educators and student. Pinar’s hope is that someday education will no longer be academic businesses, but rather schools will be sites of education for creativity and interdisciplinary intellectuality (Pinar, 2004). Pinar asserted “knowledge contains the craft of its creator, bears the imprint of one’s lived experience, one’s reading, thinking, writing (p. xi). Thus, nurse educators can be in a position to engage in a reconceptualized curriculum development that lends itself to a better understanding of holistic pedagogy that embraces gender diversity.

According to Henderson (2015), “Curriculum development is a key study topic in education since it touches on a host of essential practices” (p. xvii). The hope is that educators and pre-service educators become emboldened and empowered to ignite and “liberate human potential in education” (Henderson, 2015, p. xvii), that results in teaching and holistic understanding within our present educational system. This includes being aware of existing stereotypes and barriers that persist for men in nursing. Thus,
nurse educators need to embrace the uniqueness of males entering nursing and capitalize on their potential contributions to the field.

Kesson and Henderson (2010) contended that uncomplicated curriculum concerns itself with the “how” of teaching while neglecting to address the “why” of teaching. As a result, Kesson and Henderson presented a reconceptualized professional development standard that states:

Teachers who hope to facilitate “deep” subject matter understanding integrated with democratic self and social learning (“3S” learning) with their students must develop a sophisticated understanding of the nature, function, dynamics, and possibilities of deep democracy as well as its challenges . . . Educators in democratic societies will explore their most deeply held values and commitments and develop strategies for teaching in a matter that is concurrent with these. (pp. 216-217).

Dewey (1916) contended, “There is a great diversity of populations of varying languages, religions, moral codes, and traditions” (p. 75). As a result, “education is a social function securing direction and developmental education will vary with the quality of life which prevails in a group” (Dewey, 1916, p. 75). Hence, Kesson and Henderson (2010) contended that educators need to understand their learning needs in order to become more proficient at developing students’ 3S learning. Henderson (2015) stated this “way of being” is “realized through becoming processes” (p. 11), leading to a “generative journey of understanding” (p. 11).
In order to fully appreciate the context of holistic pedagogy and students’ contribution to their learning, nurse educators must engage in a caring, open, and interactive “complicated conversation” with their students (Henderson, 2015). Habermas (1971) stressed this communicative dialogue should be understandable and respectable, and result in some type of mutual agreement. In addition, he [Habermas] encouraged individuals to speak freely and non-coerced; therefore, problem-solving becomes a dialogue. Additionally, this dialogue “involves the lived experiences” (Diekelmann, 2007, p. 17) of both nurse educators and students as they share an understanding of what is being taught in the classroom and clinical setting through talking, generating questions, and interpreting situations. Thus, this dialogue can be a deepening and enriching experience for everyone involved (Diekelmann, 2007).

Noddings (1992) believed that the “main aim of education should be to produce competent, caring, loving, and lovable people” (p. 8). She contended that dialogue is an integral focus inherent in promoting a caring learning environment. Noddings (2013) believed dialogue involves an openness between speaker and listener that is intellectually stimulating and enhances our relationships with our dialogue partners. Thus, through dialogue, we can “explore ideas, argue points, raise questions, and decide to pursue further investigation” (p. 121). Further, Noddings (2005) contended that dialogue goes beyond just discussion by providing students and educators an opportunity to reflect upon, critique practices, and entertain questions. Students frequently have their own interpretations of caring, and dialogue enables them to “search for understanding, empathy, or appreciation” (p. 23). Similarly, Diekelmann (2007) noted, “dialogue is a
joint reflection” (p. 145) involving the lived experiences of everyone in order to explore shared understanding. Thus, through caring, reciprocal conversations “open themselves” to the possibility for new possibilities (Castner, 2015, p. 41).

Nurse educators need to consciously engage their students in an interactive, reflective dialogue that promotes holistic growth and understanding for both teachers and students. According to Bilek-Golias (2015), “It is imperative to create meaningful exchanges between student-to-student, student-to-teacher, teacher-to-teacher . . . with the intention of analyzing, exploring, and questioning possibilities together toward a broader cosmopolitan understanding” (p. 115). Hence, encouraging conversations between stakeholders may allow teachers to become more aware of, and embrace, the unique qualities and experiences that each student brings to the classroom. Perhaps encouraging more reflective dialogue will lead to a greater holistic 3S pedagogy and provide an impetus for reconceptualizing curriculars. However, as Dr. Henderson (personal communication, 2014) so appropriately stated, “we are not there yet.”

Social Role Theory

Social psychologist Alice Eagly (1987) proffered the concept of a social role theory to help explain the continued and persistent segregation of women and men into different jobs. Social role theory attempts to explain how societies develop gender stereotypes within the labor force and how these observed gender differences shape our perspectives of women and men’s roles and gender appropriate occupations (Cejka & Eagly, 1999; Clow & Ricciardelli, 2011). Essentially this theory suggests that a “feedback loop” exists in which certain jobs require gender stereotyped qualities that are
presumed to be characteristic of either gender group. For example, the job of a childcare worker is assumed to require a warm, nurturing orientation towards children—qualities stereotypically feminine. Therefore, since women are thought more likely to have these qualities, presumably they are better suited for this job than men. As a result, women will be more likely to apply for this job since both genders have learned and observed that societal expectations for women are deemed more appropriate for this type of work. Hence, the cycle is difficult to break and is likely to encourage the persistence of gender stereotypes associated with certain occupational roles (Lips, 2014).

It is not uncommon for men and women attempting to enter occupational fields dominated by gender to experience prejudice and discrimination (Cejka & Eagly, 1999; Eagly & Koenig, 2008; Evans & Frank, 2003). When women enter a male-dominated field or men enter a female-dominated field, the assumed masculinity or femininity of the job and the individual is often perceived to conflict. These perceptions can result in stereotypes that masculinize women or feminize men in these occupations (Clow & Ricciardelli, 2011).

Nursing remains a female-dominated profession in most nations (Brown, 2009; Clow & Ricciardelli, 2011; Meadus, 2000; O’Lynn & Tranbarger, 2007). Clow and Ricciardelli (2011) conceded that a randomly selected nurse is likely to be a woman. Consequently, men who enter nursing are often stereotyped as effeminate or homosexual (Boughn, 1994; Bush, 1976; Evans, 1997; Harding, 2007; Jinks & Bradley, 2004; Meadus, 2000). In addition,
When people assume that there is something intrinsic to being woman or a man that makes them inherently suited to perform a certain social role . . . it implies that men and women in roles that are numerically dominated by the other gender are deviant, less qualified, and lacking the ‘natural’ gift possessed by the normative gender. Thus, men are seen as inadequate in fulfilling tasks associated with the social roles traditionally fulfilled by women (e.g., men in communal professions such as nursing or day care). (Crow & Ricciardelli, 2011, p. 199)

A social role approach symbolizes how deep and pervasive societal gender stereotypes can bias evaluations of others that reinforce barriers and rules about femininity and masculinity (Lips, 2014). For example, Bartfay and Bartfay (2007) reported that 90% of their female nursing student sample concurred that nursing was a more appropriate profession for females because women tend to be more caring and compassionate by virtue of their inborn nature. This reinforces the idea that female-dominated professions are perceived as needing female personality characteristics.

Cejka and Eagly (1999) examined how the role of gender stereotypes justified the division of labor in employment. Individuals in female-dominated occupations were seen as having more feminine personality or physical attributes; whereas male dominated occupations placed more emphasis on needing masculine attributes in order to be successful. Their study supports Eagly’s (1987) social role theory that “people derive their images of women and men from observing their sex-typical work” (p. 421). There is, perhaps, something about being female that makes a person a better nurse (Eagly, Wood, & Diekman, 2000).
Interestingly, Wilbourn and Kee (2010) examined children’s gender role stereotypes via information processing. They stated, “In an ideal world, children would be raised in a society free of gender stereotypes” (p. 670). Their study supports Eagly’s (1987) social role theory in that children were more likely to correctly remember an occupation if it was paired with a male name. The children in this study found it more difficult to create sentences using the phrase “Henry the nurse” as a prompt; hence revealing children’s gender role stereotypes were more restrictive for males than for females.

Social role stereotyping arising from this division of labor may be influencing the relatively low number of males entering the nursing profession. Social role stereotypes of women as nurses may be contributing to the use of sexist language in the nursing profession. For example, Muldoon and Reilly (2003) noted that although the gender of a female nurse is unremarkable, a man who is a nurse is frequently described not just as a “nurse,” but as a “male nurse.” In addition, some men entering nursing school feel nursing education is tailored toward women. Wolfenden (2011) concluded that language used in nursing is a subtle form of discrimination. Often the use of the feminine pronoun to describe the nurse lends itself to the belief that nurses must be female. Many nursing textbooks have not moved to more gender neutral language. This coupled with a lack of male representation in nursing texts exacerbates male alienation in the nursing profession (Bell-Scriber, 2008; Villeneuve, 1994; Wolfenden, 2011). Hence, although social role stereotypes alone may not deter men from entering the nursing profession, these
stereotypes may impact, reinforce, further embitter other barriers that may be contributing to the relatively stagnant percentage of men in nursing.

According to Clow and Ricciardelli (2011), the unequal distribution of men and women in distinct occupations leads to the development of stereotypes that assume to make them successful in particular professions. Not only do these stereotypes create barriers for men and women in nontraditional roles, they continue to justify the forces that create disharmony and conflict within gender roles. These processes of stereotyping that maintain the association of certain occupational roles with men and women continue to produce the persistent cycle inherent in social role theory.

Definitions of Terms

The following are definitions of key concepts or terms used in this paper that contribute to a better understanding of the interactive nature between gender and the technical intricacies involved in the learning environment of the male nursing student.

3S Understanding: “Denotes curriculum decision making that is focused on the cultivation of enduring values that stand the test of time” (Henderson & Gornik, 2007). This concept involves facilitating and emphasizing subject, self, and social learning to promote teaching for democratic living (Henderson, 2001). The concept of 3S understanding allows for collaborative learning to take place between student and educator. The concept refers specifically to teaching for subject understandings that are deepened by democratic self and social understandings. Hence, 3S pedagogy directly addresses all “undemocratic” habits, customs, and perceptions that can be key conscious, hidden, or null curriculum features in specific instructional contexts (Henderson, 2015).
Clinical setting: A hospital, agency, or other institution that involves allowing students to engage in observation and/or direct care of a patient population.

Gender stereotypes: The concept of a stereotype introduced in 1922 suggests a way of understanding and classifying individuals into a group category. Thus, a gender stereotype may be defined as a “standardized and often pejorative idea or image held about an individual on the basis of their gender” (Pilcher & Whelehan, 2010, p. 167).

Holistic pedagogy: Acknowledging the development of the whole student while incorporating their spiritual, cognitive, social, and moral dimensions into the educational experience (Tirri, 2011). Teaching for 3S understanding is a particular application of holistic pedagogy (Henderson, 2015).

Non-traditional occupations: According to Williams (1991), there is a general social trend of sexual segregation of work in American society. Thus, the majority of jobs are labeled as either “men’s work” or “women’s work” (p. 2). Thus, most societal feminized jobs are dominated by women, while “masculine” work continues to be pursued by males (Simpson, 2009). As a result, “few individuals of the ‘wrong’ sex cross over into highly sex-segregated occupations” for fear of being labeled a “masculine woman” or a “feminine man” (Williams, 1991, p. 2).

Nurse educator: The role of the nurse educator involves the process of education, which includes the acts of teaching and instruction. Teaching and instruction involve planning, implementing, and presenting instructional experiences to meet intended learning outcomes. Currently, preparation for teaching as a nurse educator requires participation in classroom and clinical experiences in order to become competent about
nursing knowledge, skills, and values. A particular college, university, or school of
nursing determines the expectation(s) of the nurse educator (Billings & Halstead, 2012).

*Perceptions:* Understanding or interpreting something; a mental impression
(FreeDictionary.com). A more comprehensive definition was presented earlier in this
paper.

*Reconceptualizing:* Rethinking the current, dominant curriculum order to
“support and nurture progressive, emancipatory inspirations and informed judgments”
(Henderson, 2015, p. 19).

*Social justice:* Determining what someone or some group is owed, deserves, or is
otherwise entitled to (Kirkham & Browne, 2006). Without equitable distribution,
inclusivity, and humanistic recognition, there is no social justice (Henderson, 2015).
CHAPTER II
REVIEW OF LITERATURE

The purpose of this literature review is to examine the numerous perceptions of male nurses and how these perceptions may be contributing to the relatively insignificant percentage of males entering into nursing. This review begins with a brief introduction into males entering into non-traditional occupations, followed by a brief history of the contributions of men to the nursing profession. I then focus primarily on societal and educational perceptions of males in nursing. This review also includes male nurses’ perceived bias and gender barriers within the nursing profession.

An extensive literature search was conducted using nursing (CINAHL, MEDLINE, PubMed), educational (Educational Full text, ERIC), and sociological (socINDEX) databases. Key words and phrases include: barriers, clinical, faculty, gender, gender bias, gender differences, gender in education, history of men in nursing, males, male nurses, men, men/males in nursing, nursing education, perceptions, social role theory, and stereotypes.

Men in Non-Traditional Occupations

The U.S. Department of Labor (2012) defined non-traditional occupations as those where one gender comprises less than 25% of persons employed in any particular occupation. As a result, men and women often have preconceived notions of what constitutes male and female employment; perhaps impeding some individuals’ career choices including males in nursing, social work, and kindergarten teaching.
According to Simpson (2009), there continues to exist a strong impetus of the “sex-typing” of jobs within many societies. As a result, occupations continue to be labeled as feminine or masculine and the skills required for these particular jobs remain gender linked. Despite this trend, while the number of women moving into “male” jobs has increased, the number of males entering the genre of “women’s work” has been relatively stagnant (Simpson, 2009). In addition, whereas there is considerable literature on women moving into traditionally “male” jobs, there is minimal research on males who perform “women’s work” (Cross & Bagilhole, 2002; Kanter, 1977; Lupton, 2006). Simpson (2009) noted the reason for the imbalance in literature may be due to the recent tendency to highlight and focus more on women’s gender and work.

Acker (1990) argued that organizational structures are not gender neutral; rather, gender segregation is repeatedly reproduced and perpetuated, further marginalizing males and females within the workforce. Thus, Acker viewed gender segregation as a persistent and responsible embedded pattern stating, “Capitalist societies, at least partly, are built upon a deeply embedded substructure of gender difference” (p. 139).

Bradley (1993) categorized three characteristic patterns relevant to males entering female-dominated occupations: takeover, invasion, and infiltration. Although rare, takeover refers to a typically female job, taken over by a male. Invasion results when men enter into an occupation in large numbers, but women remain the majority. Thus, the intent of the men is rapid promotion. Infiltration is a slower process whereby men move slowly and in small numbers into occupations such as childcare and nursing.
Snyder (n.d.) examined why men enter female-dominated occupations using nursing as her case study. She conducted interviews with 35 RNs in the state of New Jersey; 16 of those interviewed were men. Snyder concluded that many of her male participants had previous experience in healthcare. This experience then helped them to recast nursing as an acceptable career choice (Perkins, Bennett, & Dorman, 1993; Snyder, n.d.).

Similarly, Isaacs and Poole (1996) chronicled three men’s stories and concluded that men were very conscious of their career choice in a non-traditional occupation, but used their masculinity as an advantage. The men believed their physical attributes were valued, thus empowering them in their minority position. In addition, the men regarded their gender as advantageous and more respectful among doctors and other colleagues.

Simpson (2009) interviewed 74 men working in four female-dominated professions: nursing, primary school teaching, librarian, and flight attendants. Her research was conducted in the UK over a 4-year period. Interviews with 15 nurses concluded that for males in nursing, “meanings around masculinity and femininity depend partly on the social definitions of the body” (p. 93). Thus, the men’s physical attributes were at times advantageous particularly when physically demanding nursing work was commonplace such as in psychiatric and mental health wards (Evans, 2004; Rajacich, Kane, Williston, & Cameron, 2013; Simpson, 2009).

According to Simpson (2009), “while men may be valued for their bodies, assigned for work that demands physical strength, they are also marked as different from the ‘norm’” (p. 105). First, the female “softer” side of women was more congruent with
the perceived aspects of nursing as a caring, nurturing profession. Thus, at times, the men were perceived as “out of place.” Secondly, the “presence of men in a non-masculine role calls into question and challenges the heterosexual norm in the workplace” (Simpson, 2009, p. 107). Finally, the sexualization of a male nurse’s touch often created patient discomfort and suspicion while caregiving tasks were implemented. Evans (2002) noted that contrary to a woman’s touch that is often perceived as harmless and nonthreatening, a male’s touch can often create suspicion or discomfort, leading male nurses to be labeled as “cautious” or “vulnerable” caregivers.

**History of Men in Nursing**

It is well documented that men have been part of the nursing profession from its inception (Anthony, 2004, 2006). Historically, during biblical times, caregiving was often associated with religious orders. The sick and dying were cared for by priests and their assistants who were typically male. These “caregivers” often provided care to their predominantly male patients through administration of herbal remedies, incantations, and offerings of comfort (Anthony, 2004; Evans, 2004; O’Lynn, 2007).

During the Middle Ages, the Christian belief in charity and the work of St. Ephram and St. Basil spurred a flourishing of institutions that opened to care for the sick and infirmed during the Byzantine period. However, the role of caregiver was open to both male and female. Although the majority of nurses working in these “hospitals” were male, women continued to staff the wards of the Byzantine hospitals in accordance with the established sex segregation (Anthony, 2004; Bullough & Bullough, 1993; O’Lynn, 2007).
Military nursing orders developed as Knights and Christians initiated pilgrimages to the Holy Land to pray. These pilgrimages were arduous, exhausting, and dangerous. As a result, this led to the development of three major military orders: The Knights Hospitallers, Teutonic Knights, and the Knights of St. Lazarus. These religious groups were composed of men who cared for the sick and injured. Thus, the predominance of nursing care was relegated to males (Anthony, 2004; Mellish, 1984; O’Lynn & Tranbarger, 2007).

Florence Nightingale had a significant impact on the status of men in nursing. Nightingale’s accomplishments during the Crimean War and her social and political prominence, integrated with the changing perceptions of gender, became the foundation of the belief that nursing was “natural” for women and “unnatural” for men. She believed that nursing was an extension of women’s domestic roles and their natural characteristics of caring and nurturing (Anthony, 2006; Evans, 2004; Mackintosh, 1997; O’Lynn, 2004). Nightingale “noticed that the physicians and hospital administrators who had allowed the poor conditions to develop in English hospitals were almost exclusively men” (O’Lynn, 2013, p. 25). In addition, she stated these men had “horney hands” that were detrimental to caring. Hence, Nightingale championed for the removal of men in hospitals and advocated for women to replace their positions, essentially initiating the demise of men in nursing (Meadus, 2000). According to Dossey (1996), Nightingale stated in a letter dated 1867:

The whole reform in nursing, both at home and abroad, has consisted in this; to take all power over the nursing out of the hands of the men, and put it into the
hands of one female trained head and make her responsible for everything (regarding internal management and discipline) being carried out. (p. 291)

Nightingale also advocated for improved educational training programs to improve the status of nurses. However, not surprisingly, her schools of nursing did not mix males and females, and many barred men entirely (Anthony, 2004, 2006; Donohue, 1996; Kalisch & Kalisch, 2004; O’Lynn, 2004, 2007).

In the late 19th century nurse training programs were formed specifically for men to help meet the needs of gender segregated facilities. However, males often experienced a curriculum that limited them to areas where male intervention was valued such as managing male urology and psychiatric patients. In addition, men who were eager to expand their learning opportunities were perceived as deviant and faced possible expulsion (Anthony, 2004; Painton, 1994; Villeneuve, 1994).

In 1940, male nursing opportunities and education remained limited. According to Judd, Sitzman, and Davis (2010), “Of the 28,000 nurses who graduated in 1940, only 212 men graduated from the four male nursing schools” (p. 139). Craig (1940) noted that despite some acceptance of males into nursing institutions, discrimination against males persisted. Craig (1940) stated,

The young man who is well liked and respected by his fellow and by older men is the most likely to succeed . . . however, opportunities awaiting men of such caliber are private duty nursing, institutional nursing, and industrial nursing. (pp. 666-667)
World War II introduced the Army and Navy Nurse Corp. However, since 1901, the act of Congress that created the Corp automatically barred men from enlisting and serving as nurses. The Corp believed that “men would make better soldiers than nurses” (O’Lynn, 2013, p. 29). In 1951, then President Dwight Eisenhower signed a bill allowing men to join the Army and Navy Nurse Corp (Craig, 1956). Unfortunately, the military’s refusal to commission male nurses and the inaccessibility of nursing for most males had decreased the percentage of male nurses in the U.S. to a mere one percent (Christman, 1988; O’Lynn, 2004).

Between 1960 and 1980, many male nurses participated in military nursing that provided males the chance to care for patients as part of their service to the country. Some years later, men were able to work in civilian hospitals and nursing units (Kalisch & Kalisch, 1986).

Currently, although the nursing profession remains overwhelmingly female, the increasing demand for registered nurses is helping to expand the number of males entering the profession. According to the U.S. Census Bureau (2013), the percentage of nurses who are male has increased from 3.9% in 1970 to 8.1% in 2011. Unfortunately, males continue to struggle with gender issues associated with being a male in a female-dominated profession.

**Perceptions of Men in Nursing**

According to Sullivan (2007), “at a time when all of the world’s talent must be tapped to provide the top-notch quality of healthcare that we need and deserve, no profession can afford to ignore any of its brightest and best” (p. xxii). This certainly
implies that males entering the female dominated profession of nursing must be given a fair and nonbiased opportunity to enter into a health system that delivers compassionate, caring, and holistic care to a diverse and expanding population.

Numerous perceptions of males in nursing are documented in the literature. Many of these perceptions, including societal, media, patients, and non-nursing students, have continued to perpetuate the lingering negative stereotypes of males in nursing. Perhaps we, as nurse educators, can address and change these lingering perceptions in order to create a less gendered-focused work and educational environment.

**Societal Perceptions of Male Nurses**

Holtzclaw (as cited in Villeneuve, 1994) stated, “The men in nursing have been faced with elements of myth, conjecture, and stigma for much of this country’s history” (p. 16). Genua (2005) found that often male nurses were mistaken for doctors. Hence, according to Meadus (2000), nursing’s image seems to perpetuate societal attitudes about what are appropriate male and female occupations. Overall, males encounter more negative criticism from society on entering nursing. As a result, nursing continues to be viewed as women’s work (Evans, 2004; Meadus & Twomey, 2007; Okrainec, 1994; Porter-O’Grady, 2001; Roth & Coleman, 2008). In addition, the traditional image of the nurse-angel, sex symbol, handmaiden, and woman continues to perpetuate in nursing and is reinforced in the mass media (Jinks & Bradley, 2004; Meadus & Twomey, 2007). Takase, Kershaw, and Burt (2002) found that the public’s perception of femininity and powerlessness in nursing was pervasive suggesting these findings are also applicable to
males, compelling men to conform to societal and traditional masculine roles (Roth & Coleman, 2008).

**Media Perceptions**

Media stereotyping of the nursing profession permeates and the representation of males in nursing with media is relatively unattractive (Cabaniss, 2011). Cabaniss asserted that television, perhaps more than any other medium, portrays nursing as not intellectually demanding or challenging (Cabaniss, 2011; Kelly, Shoemaker, & Steele, 1996). In addition, media perceptions reinforce inaccurate and unprofessional depictions of male nurses, further influencing and perpetuating negative stereotypes (Burton & Misener, 2007).

According to Burton and Misener (2007), male nurse stereotypes are often categorized into four themes. The first theme focuses on the male nurse as a “failed medical school applicant” (p. 257). This stereotype perpetuates historical illustrations of nursing as passive and unintelligent work. Hence, males choosing nursing are depicted as unintelligent and non-masculine.

One health drama, *Private Practice*, released in 2007 portrayed one male nurse as a “cute, surfing receptionist” (p. 116) after just receiving his nursing degree and was studying to become a midwife. The male character, “Dell,” was portrayed as lacking knowledge and was jokingly mocked for his pursuit to become a midwife. Interestingly, this prime time television show only lasted 2 seasons.

A second theme portrays males as being gay or effeminate. In the movie *Meet the Parents*, Ben Stiller faces continual criticism from his father in law (Robert DeNiro),
implying that nursing is a feminine career. Thus, men who enter into this female dominated profession are stereotyped as either gay or effeminate for choosing to enter a female dominated profession (Burton & Misener, 2007; Cabaniss, 2011).

The third category implies that male nurses are “misfits” (Burton & Misener, 2007, p. 257) and choose nursing as an alternative to a typically masculine job because “they are odd and do not fit into mainstream male occupations” (p. 258).

Stanley (2012) explored the images of male nurses in films. He examined 13 feature films and concluded that few male nurses were shown to be compassionate or caring. In addition, often the male nurses in feature films remain the object of jokes, depicted as undervalued professionals, or simply portrayed as incompetent.

Bartfay et al. (2010) also suggest that mass media portrays male nurses negatively. Their study concluded that male nurses were commonly stereotyped as oddities, psychotic killers, gay, or highly effeminate. In Bartfay and Bartfay’s (2007) qualitative study of men in nursing, one participant stated, “males are never portrayed as heroes . . . if you see a male nurse in the movies or TV, he’s crazy, psychotic, or a serial killer” (p. 211).

The fourth category portrays male nurses as ‘womanizers’ (Burton & Misener, 2007, p. 258). This theme presumes that heterosexual men enter into nursing for sexual reasons and/or as a means to advance professionally via a female colleague (Berry, 2004; Burton & Misener, 2007).
Patient Perceptions

There is a paucity of research that examines patients’ preferences for male or female nurses. Previous research has found that females prefer a female nurse in “intimate” situations including reproductive, sexual health issues, and in instances where females are required to undress (Ackermann-Ross & Sochat, 1980).

Chur-Hansen (2000) investigated the preference of both male and female patients for a male or female nurse. Her quantitative study concluded that the degree of intimacy in a clinical situation was found to be predictive of same-gender preferences. Hence, in intimate situations, both male and females preferred a nurse of their own gender. Chur-Henson noted that perhaps an in-depth qualitative study would best address patient preferences and attitudes about gender care.

Similarly, Ahmad and Alasad (2007) examined patients’ preferences for nurses in Jordan. Although males account for 65% of nursing students, they found that both male and female patients considered nursing “not a desirable professional practice for a male nurse” (p. 241). In addition, Ahmad and Alasad noted that gender preferences are stronger among female patients as evidenced by two-thirds of female patients preferring a female nurse, whereas only 3.4% preferred a male nurse.

McRae (2003) explored the issue of male gender discrimination in obstetrical nursing. Sixty-seven percent of pregnant women had positive perceptions of male nurses; however, McRae contended her study is limited in that it is based solely on a questionnaire. Conversely, Poliafico (1998) noted some male nurses have been denied
employment in specialty areas such as obstetrics/gynecology due to the intimate nature inherent in these areas.

**Educational Perceptions**

According to Davis (1998), “a female is known as a nurse but a man who is a nurse is referred to as a male nurse.” Thus, the concept of gender continues into the educational realm. McMillian, Morgan, and Ament (2006) researched the acceptance of male registered nurses by female registered nurses and concluded that the acceptance of male nurses overall was neither overwhelmingly high nor low. They found the most influential factor was the length of time employees had worked with a male nurse. Their study also concluded that rural nurses were less likely to accept male nurses into the profession and more likely to be resentful of males pursuing nursing as a career choice. Hart (2005) reported that female colleagues often perceived their male peers as helpful to have around with heavy, difficult, or violent patients.

**Nursing and Non-Nursing Students**

A number of studies have been conducted, focusing on the career choice of nursing as a profession (Cohen, Palumbo, Rambur, & Mongeon, 2004; Hemsley-Brown & Foskett, 1999; Jinks & Bradley, 2004; Lo & Brown, 1999; Muldoon & Reilly, 2003; O’Brien, Mooney, & Glacken, 2008).

Hemsley-Brown and Foskett (1999) questioned both male and female school age and high school students about their perceptions of nursing as a career choice. They concluded that although the students expressed an admiration for nurses, they had no desire to become a nurse. In addition, the authors noted the older children (15-17 years
old) perceived nursing to be “female work” (p. 1345). Middle school boys perceived male nurses as gay or being feminine. Similarly, Cohen et al. (2004) surveyed 301 middle school students about their perceptions of nursing. Their replication of a 1991 research study found that students rated nursing low on decision-making, power, leadership, and financial viability. Interestingly, when they compared boys with girls, there was more congruency between boys’ perception of nursing and the choice of nursing as an ideal career.

Muldoon and Reilly (2003) explored 385 nursing students’ perceptions about the appropriateness of nursing specialties to gender. Interestingly, gender did emerge as the single most important factor in determining nurses’ career choices. However, they concluded that females were primarily interested in highly female specialties such as midwifery, pediatrics, and school nursing. Conversely, “psychologically masculine students” (p. 98) were most interested in gender-neutral specialties that include mental health and emergency-care, areas that traditionally attract more males. Similarly, Gorman (2003) concluded in his study of 100 male high school students, that only six students indicated an interest in nursing; however, when the title of “nurse” was renamed using a gender-neutral title (registered clinician), 21 students were interested.

Jinks and Bradley (2004) compared nursing gender perceptions of two groups of nursing students. The first group was recruited for a 1992 study; whereas the second group was part of a 2002 study. Male representation in both sample groups was similar. They concluded the propensity towards beliefs in gender and nursing (as feminine) stereotypes found in the 1992 study were present but not as apparent as in the 2002 study
particularly relating to male nurse stereotyping. Thus, Jinks and Bradley (2004) asserted that although this study projects reassuring signs that distorted images are less credible, gender stereotypes “seem to still have a place” (p. 126) within nursing education.

Other studies have documented that nursing students’ image of male nurses is changing; although the perception persists that men in nursing are viewed as homosexual and/or feminine, a view that continues to permeate within the media and society (Bartfay et al., 2010; Lo & Brown, 1999; O’Brien et al., 2008).

**Male Nursing Students’ Perception of Gender Bias and Barriers**

Males in nursing education continue to face bias from society and nursing education appears to be perpetuating and contributing to this cycle of gender bias that may be impeding their academic success. Thus, male nursing students present with their own perceptions of bias and barriers that need to be addressed (Billings & Halstead, 2012). Various studies in nursing education have reported gender bias and discrimination particularly towards male students (Ellis, Meeker, & Hyde, 2006; Kelly et al., 1996; Keogh & O’Lynn, 2007; MacWilliams, Schmidt, & Bleich, 2013; Meadus, 2000; Meadus & Twomey, 2011; Okrainec, 1994; O’Lynn, 2004; Stoltenberg, Behan, & Frame, 2008; Streubert, 1994; Villeneuve, 1994; Wolfenden, 2011). Byrne (2002) asserted that nurse educators need to examine prejudice and bias as part of an ongoing process of becoming culturally competent. Thus, she has identified six specific types of bias often inherent within nursing education. They include: invisibility or omission, stereotyping, imbalance and selectivity, unreality, fragmentation and isolation, and linguistic bias.
Invisibility “occurs when particular groups are not represented in textual content, illustrations, and reference materials” (Byrne, 2002, p. 810). Bell-Scriber (2008) noted that often nursing textbooks did not represent females and males equally. For example, many of the pictures and stories within the texts pertained to females. In addition, Bell-Scriber noted that many of the male students verbalized that examples of therapeutic dialogue and caring behavior almost always were between a female nurse and a patient, further enforcing that males are underrepresented in nursing textbooks.

According to Byrne (2002), stereotyping results from “untruth or oversimplification” (p. 810) about particular behaviors. A common stereotype concerning men in nursing is that they are effeminate or gay (Boughn, 1994; Harding, 2007; Meadus, 2000; Williams, 2005). Harding (2007) explored the construction of the stereotype of male nurses as gays and concluded that although many of the participants believed the majority of male nurses are heterosexual, the gay stereotype persists. Thus, some heterosexual nurses actively utilize strategies to emphasize their heterosexuality including showing off wedding rings and family pictures (Meadus, 2000).

Imbalance and selectivity “comes from examining whose ‘truth’ is being reported” (Byrne, 2002, p. 813). As a result, an imbalanced or selective view of individuals or groups may lead to generalization(s) regarding race, class, or gender.

Unreality is a form of instructional bias evident when controversial topics are unfairly presented. As a result, students may lack credible or truthful information to understand or change circumstances. Moore (1998) noted a common example of
unreality is “racism in language . . . while we may not be able to change the language . . . we can avoid using words that degrade people” (as cited in Byrne, 2002, p. 813).

Byrne (2002) described *fragmentation and isolation* as physically or visually separating information about a non-dominant group, implying that the historical contributions of the particular group are insignificant. For example, the emergence of Florence Nightingale, and her belief that nursing was a feminine role, marked the marginalization of men in nursing. Hence, males became the “others” and information about male nurses was separated from those in the dominant group (i.e., female nurses; Byrne, 2002; MacWilliams et al., 2013).

According to Villeneuve (1994), “language is a powerful instrument that may have the effect of marginalizing any group” (p. 222) resulting in *linguistic bias*. Health and nursing texts often contain sexist and gender-laden terms that further emphasize linguistic bias and perpetuate alienation (Anthony, 2004; Bell-Scriber, 2008; Billings & Halstead, 2012; MacWilliams et al., 2013; O’Lynn, 2004; Smith, 2006; Wolfenden, 2011). In addition, Ellis et al. (2006) noted that male students “felt frustrated by what they perceived as test questions, classroom discussions, and whole courses set up by women for women” (p. 525).

O’Lynn (2004) examined the prevalence and perceived importance of gender-based barriers for male nursing students. His quantitative study revealed a list of barriers that created an “unfriendly” academic environment to males. These barriers include: a lack of male faculty and mentoring, anti-male and “female” language among faculty, different requirements for males in obstetrical clinical rotations, the concept of
caring emphasized from a feminine style, and the lack of presentation of the history of men in nursing. Additional barriers presented in the literature include social isolation, caring, role strain, and communication challenges.

**Social Isolation**

Social isolation was also a central theme inherent in the literature. Kelly et al. (1996) noted that males indicated they often “felt isolated and lonely at times and attributed this to being male” (p. 173). Additionally, male students often felt singled-out or invisible (Anthony, 2004; Kelly et al., 1996; MacWilliams et al., 2013; Stott, 2007; Wilson, 2005).

O’Lynn and Tranbarger (2007) noted the underrepresentation of male faculty contributing to social isolation. They conceded the lack of male role models in nursing education often led some students feeling isolated and alone as they struggled for support from a male perspective. In addition, they remarked that due to the lack of male nursing educators, male nursing students often relied more on the male nurses working on the clinical unit about ways to deal with gender issues, communication patterns, and the concept of touch.

**Caring**

Although caring is an integral concept within the nursing profession, males enter nursing with gendered identities and the concept of caring has pervasively been associated with women and femininity (Scotto, 2003). This association is further strengthened in Sociology and Psychology literature. Many of the traditional definitions of caring emerged from traditional sociological theories that historically associated
females with the task of caring for the health of the family and the sick. Conversely, men historically worked outside the home for the purpose of providing for and protecting the family (O’Lynn & Tranbarger, 2007). Although “both types of work are essential to the success of the family, it is the domestic work of the woman that has been identified as caring work” (p. 127). In addition, the assumption that men lack caring qualities due to their drive for status and power was further perpetuated by Florence Nightingale, who advocated that men be removed from patient care due to their masculine hands. Later, this notion was further reinforced by feminists who tied caring to womanhood while ignoring manhood (O’Lynn & Tranbarger, 2007).

According to MacWilliams et al. (2013), many males acknowledge the decision to enter into nursing was based on the desire to care for others. However, Hart (2005) revealed that being viewed as uncaring was one of the top concerns males had in nursing school. Stott (2007) noted “male students recognize that nursing is a caring profession and the notion of caring is strongly identified with being female” (p. 329). Anthony (2004) asserted that “learning to care professionally is a core behavior in nursing that may be experienced differently by male nursing students” (p. 125). Whereas, female nurses are more likely to display caring behaviors such as touch and emotion, male students in western cultures tend to minimize their emotions and develop personal ways of expressing caring behaviors (Anthony, 2004; Paterson, Crawford, Saydak, Venkatesh, & Aronowitz, 1995). Thompson (2002) suggested that males often provide care from an emotional distance; thus, focusing on task completion, problem solving, and acquiring
resources to help recipients of care (i.e., patients). As a result, caring is “work-oriented,” which may decrease the stress related to gender care behaviors and/or expectations.

Paterson et al. (1996) interviewed 20 male nursing students to investigate the life experiences of male nursing students as they learned to care. Initially the beginning male students did not report any gender differences in caring; however, by their junior year in nursing school the male students admitted that women had an easier time showing emotion and touching whereas the males felt frustrated trying to “adopt these feminine skills” (p. 32). Once they entered into the senior level, the students developed their own ways of demonstrating caring behaviors influenced by personal experiences, the expectations of female peers, faculty and nursing staff, and their individual understanding of the ways of caring. One participant noted, “I’ve seen female nurses care, and I’ve seen male nurses care. I’ve taken a little bit of both and put them together. It’s very hard to describe. That’s the way I care” (p. 605). In addition, many of the male nursing students in this study identified masculine caring attitudes related to the development of relationships with their patients that were centered more on establishing “connections” and being less “touchy-feely” then female nurses (p. 605).

Milligan’s (2001) ontological hermeneutic study explored the concept of male nurses working in an acute care hospital. Eight male nurses reflected that the concept of care was difficult to define and explain. In addition, the study noted that male nurses were aware of societal expectations and their minority status within nursing that may limit their emotionality.
Role Strain

Simpson (2005) described role strain as the frustration that males face as their masculinity conflicts with the feminine perceptions of the nursing profession. Kelly et al. (1996), in a qualitative study of males in nursing school, noted that many of the men had given up jobs in order to return to school; thus, relinquishing the role of family “provider” coupled with the perception of being ‘unmanly’ (p. 171) created an additional barrier. Similarly, Dyck, Oliffe, Phinney, and Garrett (2009) cited role strain among male students dealing with the gendered stereotype of being labeled gay or effeminate.

Communication Challenges

According to Yoshimura and Hayden (2007), communication patterns between males and females are slightly different. Since nursing is a female dominated profession, the “norms” (p. 118) of nursing communication reflect women’s speech patterns. Although the goal of communication is to get things done and establishing connections, Yoshimura and Hayden noted that men’s speech is often task related; whereas women’s is typically praising and relationship oriented.

There are differences in nonverbal behaviors between males and females as well. “Nonverbal behaviors are commonly considered to be all the messages communicated through nonlinguistic means” (Yoshimura & Hayden, 2007, p. 112). Generally, males utilize less inflection, demonstrate limited eye contact, and maintain greater personal space. Conversely, females, congruent with the norms of femininity, display a greater ease with nonverbal, attentive behaviors (Yoshimura & Hayden, 2007).
Ellis, Meeker, and Hyde (2006) examined men’s perceptions in a baccalaureate nursing program and concluded that differences in communication patterns exist. For example, one participant stated that “men get to the point more quickly, and women take much longer when discussing a topic” (p. 524). In addition, the participants viewed women as “caring, organized, and helpful, but also moody and overly dramatic” (p. 524). Thus, the negative school experiences conveyed in this study were reflective of the communication differences between males and females (Ellis et al., 2006).

Historical review of the nursing profession reveals significant male participation in nursing care during the early and middle periods (O’Lynn, 2007). This appeared to have been closely associated with religious orders and thus had no relevance to gender awareness or bias. Indeed, even during the 19th century, males were accepted into roles of nursing care as exemplified by the Civil War conflict. Not until the 20th century does it appear that social evolution towards gender bias occurred and became a dominant concept in western culture and psyche.

Nursing faculty need to be aware of men’s contributions to the profession; hence, they need to become sensitive to the impact of gender bias in nursing education. In addition, preservice, as well as nurse educators, need to become aware of and eliminate practices that dichotomize male and female experiences and refocus on strategies that promote growth and opportunity. Perhaps Dewey (1938) had insight into this concept by contending that experience has an effect on attitude, which in turn, affects future experiences.
Teaching in education is an art. Thus, like Eisner (1983), we are conductors of an educational orchestra. Therefore, pre-service and nurse educators need to be compassionate about our role and sensitive to the perceptions of an increasingly diverse student population. Only then can the experiences of students and teachers develop into a harmonious, educational experience. Thus, my hope is that this research will lend itself to thinking about nursing in a new way in order to empower nursing education to grasp the art, enable compassion and harmonize the delivery of education to all students without bias of ethnicity, creed and gender.
CHAPTER III

METHODOLOGY

The purpose of this qualitative study is to explore nurse educators’ perceptions of male nursing students in the clinical setting. The goal is not to generate a specific theory, but rather to understand nurse educators’ perceptions in order to better recognize, and be sensitive to, various perceptions associated with male nurses in the female dominated profession of nursing. Thus, I have chosen a case study approach design and collected data utilizing the following primary sources: Qualtrics survey, interviews, observations, and weekly emails.

Case Study

Merriam (1998) stated, “A case study design is employed to gain an in-depth understanding of the situation and meaning for those involved” (p. 19). It is a useful approach to present information about areas where minimal research has been conducted. Since there is scarce, if any, research that addresses nurse educators’ perceptions of male students, this research design conforms to my research question. In addition, an important aspect of case study research is its thick descriptive quality, which helps illuminate the focus of the study so the reader can more clearly understand and envision the experience had he or she been present (Merriam, 1998; Stake, 1995). Lincoln and Guba (1985) supported this notion by noting “the aim of the case is to so orient readers that if they could be magically transported to the inquiry site, they would experience a feeling of déjà vu” (p. 214). Becker (1968) further asserted the “purpose of a case study is twofold: to arrive at a comprehensive general understanding of the groups under study”
and “to develop general theoretical statements about regularities in social structure and process” (p. 233). Additionally, Bromley (1986) stated, “The aim of a case study is not to find the ‘correct’ or ‘true’ interpretation of the facts, but rather to eliminate erroneous conclusions so that one is left with the best possible, the most compelling, interpretation” (p. 38). Thus, my goal is to describe nurse educators’ perceptions of male nursing students so the reader can fully understand and comprehend how or if these perceptions may or may not be influencing males’ decisions to enter into the nursing profession.

There are four inherent features that help differentiate case study research from other types of qualitative research: particularistic, descriptive, heuristic, and inductive. Although some of these characteristics may seem familiar to other methodologies, they are of particular importance in case study research (Merriam, 1988).

**Particularistic** refers to the case study focusing on a particular situation or program. This specificity on a particular experience enables the researcher to concentrate attention on the way particular groups of people handle or confront unique situations. Accordingly, this study centered on nurse educators’ perceptions of male students in the clinical setting.

**Descriptive** denotes “the end product of a case study is a rich, ‘thick’ description of the phenomenon under study” (Merriam, 1988, p. 11). As a result, case studies utilize many variables that result in the use of “prose and literary techniques to describe, elicit images, and analyze situations” (Wilson, 1979, p. 448). Olson (as cited in Merriam, 1988) noted the descriptive nature of the case study can show how the passage of time influences an issue.
Heuristic refers to the idea that case studies “illuminate” (Merriam, 1988, p. 13) the reader’s understanding. Hence, the study reveals to the reader new meanings or a confirmation about what is already known about males in the nursing profession.

Inductive means that generalizations or concepts are extrapolated from the data as the data are examined. As a result, “bits and pieces of information from interviews, observations, or documents are combined and ordered into larger theses as the researcher works from the particular to the general” (Merriam, 2009, pp. 15-16).

Rationale

The rationale for my using a case study methodology is multifactorial. First, it is ideal for revealing the participant’s point of view, particularly when I am interested in obtaining an in-depth understanding of a relatively small number of individuals (Patton, 1990). Second, case study is “anchored in real-life situations” (Merriam, 2009, p. 51) that are intended to take the reader into the world of the participants. As a result, this method can provide a much richer and more vivid picture of what is being studied (Marshall & Rossman, 1999). Third, case study is a particularly appealing form of inquiry that is consistent with the holistic design of nursing that focuses on the individual as a whole and is best understood within their social context (Gangeness & Yurkovich, 2006). Fourth, a case study design should be considered when you want to address contextual conditions because you believe they are relevant to what is being studied (Baxter & Jack, 2008). Last, case study research uses multiple forms of data collection with systematic analysis to enhance the understanding of what is being examined (Gangeness & Yurkovich, 2006). Thus, my goal is to examine and obtain a greater
understanding of how nurse educators perceive male students in the clinical setting. In 1960, the percentage of males in nursing profession was 1%. Despite the current nursing shortage, the percentage of males choosing nursing remains at a mere 9 to 10%. As a result, observing nurse educators within the clinical provides a premier opportunity to explore interactions between educator and student. That, coupled with multiple data sources, including interviews, weekly emails, and a Qualtrics survey, allows for thick, rich description, inviting the reader into the “real life world” of the clinical setting. This methodology allows for a better understanding of how educators perceive male students and how these perceptions may or may not influence how males perceive the nursing profession and their decision to consider nursing as a career.

In addition to the above rationale, case study methodology is consistent with my research inquiry that examines nurse educators’ perceptions of male nursing students in the clinical setting. Yin (2003) supported this by stating, “If research questions focus mainly on ‘what questions, this type of question is a justifiable rationale for conducting an exploratory case study” (pp. 5-6). In addition, Yin based his approach to case study design on a constructivist paradigm. This paradigm “recognizes the importance of the subjective human creation of meaning” (Crabtree & Miller, 1999, p. 10) and “truth is relative and dependent on one’s perspective” (Baxter & Jack, 2008, p. 545). Thus, one educator’s perceptions of male nurses may look quite different than another’s resulting in a multifaceted understanding of males in nursing. Therefore, exploring multiple participants’ experiences gives us a more varied, holistic, and subjective view of what are nurse educators’ perceptions.
Multicase Study

According to Stake (2006), in order to utilize multicase research, the cases need to be similar in some ways. As a result, this type of study involves collecting and analyzing data from several cases (Merriam, 2009). In addition, a multicase study enables the researcher to explore differences, as well as similarities, within and between cases with the goal of replicating findings across cases (Baxter & Jack, 2008). Thus, for this study, data collection and analysis includes perceptions of four nurse educators.

For the purpose of this study, each of the four cases is presented as an individual case study followed by a cross-case analysis. Cross case analysis is employed to better understand issues that may yield increased generalizability (Yin, 2003). Cross case analysis is elaborated further in the data analysis section.

Procedures

Consistent with case study design, my study utilized purposeful sampling techniques in order to obtain participants who would be able to provide thick, rich descriptions about their interactions with male nursing students. This section describes purposeful sampling, sample size, and site selection.

Purposeful Sampling and Participants

Patton (2002) argued, “the logic and power of purposeful sampling lies in selecting *information-rich* cases for study in depth” (p. 230). It is based on the assumption that the researcher’s aim is to discover, understand, and gain insight (Merriam, 2009); therefore, “one needs to select a sample from which one can learn the most” (Merriam, 1988, p. 48). In addition, Erlandson, Harris, Skipper, and Allen (1993)
indicated that a researcher has two decisions to make regarding purposeful sampling: who to study, and who not to study. As a result, there is not an exact sample size number, or as Erlandson et al. (1993) pointed out, “There are no rules for sample size” (p. 83). Thus, I used purposeful sampling to obtain study participants who would afford me “information-rich cases for study in depth” (Patton, 1990, p. 169) to help me.

Since I collected and analyzed data during the summer, I emailed nurse educators within the Kent State system who had at least two years of experience teaching students in the clinical setting and were prepared at the Master’s level. This is consistent with the National Council of State Boards of Nursing (NCSBN) that requires that nurse educators have graduate preparation in clinical practice as well as in teaching and learning. I found potential participants from the list of clinical courses being offered in the summer over the eight-week summer session. Initially, I emailed a study invitation (Appendix A) to 12 educators who were scheduled to teach clinical during this time asking if they had at least one male student in their clinical and thus be willing to participate in my study. All 12 educators responded; however, only 5 had a male student on their clinical roster. In addition, after discussing the focus of my study, via a phone conversation, one individual declined to participate. Thus, my participants included 4 nurse educators: 3 females and one male. All four participants opted to use pseudonyms for this study and are described in greater detail in the following chapter.

I chose the clinical setting rather than the classroom setting because the ratio of educators to students in a clinical setting is no greater than 10 to 1, based on the Ohio Board of Nursing (OBN) Standards. This ratio in the clinical setting ensures the safe
delivery of nursing care by both students and educators (OBN, Chapter 4723-5). In addition, the clinical setting tends to be somewhat subjective since evaluation and assessment are based on educator interactions and observations with students rather than objective testing. Also, educator interaction with students is an integral part of the clinical experience since clinical is an extension of the classroom learning environment. Additionally, many of the clinical experiences inherent in nursing school curriculums are 8 to 15 weeks in duration, and time spent in one clinical day can range from 6 to 12 hours. The amount of time allocated for clinical is determined by the OBN and must be adhered to. Thus, educator/student interaction is a critical component in nursing education.

**Site Selection**

Site selection is a critical decision made in case study research that ultimately affects the viability of the study. Therefore, the researcher needs to choose a site that maximizes opportunities and allows for information to occur as it normally and naturally would (Erlandson et al., 1993; Guba & Lincoln, 1982). In addition, Erlandson et al. (1993) emphasized that “attention should be given to constructing a comprehensive holistic portrayal of the social and cultural dimensions of a particular context” (p. 85). Marshall and Rossman (1999) noted:

The ideal site is where (1) entry is possible; (2) there is a high probability that a rich mix of many of the processes, people, programs, interactions, and/or structures that may be a part of the research question will be present; (3) the research can devise an appropriate role to maintain continuity for presence for as
long as necessary; and (4) data quality and credibility of the study are reasonably assured by avoiding poor sampling decisions. (p. 54)

According to Erlandson et al. (1993), considerations when choosing a site include accessibility, including geographical location, cooperation from gatekeepers, the possibility of utilizing multiple sites, and planning for the proper and necessary amount of time to spend at the site.

Faculty and students typically utilize clinical agencies including area hospitals and nursing homes for their clinical experiences. The typical clinical experience lasts from seven to 15 weeks and includes six to 10 hours of clinical per week. I spoke, in person, with the IRB representative at each of the healthcare agencies and explained my research topic to all parties involved. I was then granted approval to conduct my research observations at their institutions. This enabled me to observe student/educator interactions, take notes, and analyze data in a typical clinical setting over an 8-week period.

**Data Collection**

According to Patton (2002), qualitative data consists of “direct quotations from people about their experiences, opinions, feelings, and knowledge” (p. 4) obtained through interviews, people’s behaviors, observations, and other types of documents. Merriam (2009) stated, “Data collection is about asking, watching, and reviewing” (p. 85). Thus, data collection and data analysis occur simultaneously, resulting in frequent revisions to data collection (Lincoln & Guba, 1985). As my study evolved, data
collection procedures were revised based on the ongoing analysis. A timeline for data collection can be found in Appendix B.

Erlandson et al. (1993) recommended that the novice researcher, such as myself, consciously engages in the analytic process at the end of every interview or observation session asking questions such as:

What did I learn from this respondent that will shape my questions for the next respondent? What hypotheses have emerged that suggest additional questions, additional respondents, or a follow-up interview with this respondent? What are the major working hypotheses that are emerging from my observations? What data have I picked up that challenge these hypotheses? How can I modify my observational techniques to amplify, extend, or shift my working hypotheses? (p. 114)

According to Merriam (1998), the primary sources of data collection for case study design include interviews, observation, and other documents. As a result, the sources of data collection for my study included: A Qualtrics survey that participants were given prior to our first interview; 2 interviews, the initial interview during week 1 or 2 of the study period and the second interview during weeks 7 and 8; 3 observations visits with each participant staggered throughout the 8 weeks and weekly emails consisting of 2 questions or statements that participants were asked to comment on or reply to. My data collection occurred for 8 weeks between July 2016 and August 2016.
Qualtrics Survey

Qualtrics is a cloud-based platform widely used for academic and market research. Qualtrics creates and distributes web-based surveys that are highly customizable, and can be used on any internet-connected computer (www.kent.edu/introductiontoqualtrics).

For my study, the four participants were asked to evaluate eight statements relative to males in nursing. These statements were extrapolated from my literature review and reflected much of what permeates the literature regarding males in nursing. This particular Qualtrics survey enabled the participants to choose from one of five options, including strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree. The Qualtrics survey (Appendix F) was not anonymous since I would need to utilize those results as part of data analysis.

Interviews

According to Patton (1980), “The purpose of interviews is to find out what is in and on someone else’s mind” (p. 196). Dexter (1970) suggested that an interview is a “conversation with a purpose” (p. 136). Interviews allow the researcher and participants to reconstruct the past, focus on the present, and project the future (Lincoln & Guba, 1985). In addition, interviewing is often the major source of qualitative data in case study design (Merriam, 1998).

The most common type of interview format in case study research is the semi-structured interview that is guided by a set of basic questions and problems of interest; therefore, there is no specific order of questions or words. Rather, researcher
and respondent dialogue in a mixture of conversation and embedded questions (Erlandson et al., 1993). Consequently, “your research questions formulate what you want to understand; your interview questions are what you ask people to gain that understanding” (Maxwell, 2013, p. 101).

I interviewed each participant twice during the 8-week clinical. All interviews were held on the Kent Campus per request of the participants. Two of the participants were interviewed on two separate days in Week 1, and two participants were interviewed on separate days during Week 2. Three of the four initial interviews lasted 50 minutes; one of the interviews lasted 60 minutes. The second set of interviews took place during Week 7 and Week 8, after the observations were complete. My goal of the 2 separated interviews was to assess whether there were inconsistencies between what the participants said in the initial interview, their interactions with students throughout the observation periods, and their responses from the Qualtrics survey. All four of the interviews lasted approximately 45 minutes.

I utilized a semi-structured interview format employing Rubin and Rubin’s (2012) responsive interviewing technique. I particularly like the concept of responsive interviewing because “it emphasizes the importance of building a relationship of trust between the interviewer and interviewee that leads to more give and take in the conversation” (p. 36). Thus, although I had questions in hand (Appendix C), the questions were flexibly worded. This allowed me to respond to any emerging ideas about the question or the topic in a more relaxed interview format. As a result, the participants’ answers often prompted subsequent questions.
Each interview was audio taped with participant consent (see Appendix D), and transcribed in a timely manner. Participants were given the opportunity to review the transcription for inconsistencies; however, all declined. Throughout the interviews, I took notes describing nonverbal cues, such as facial expression and body language.

**Observation**

Informal interviews are often interwoven with observation and enable the researcher to record behavior as it is happening. In addition, observations aid in the triangulation of emerging findings (Merriam, 2009). Patton (1990) suggested “observations provide a check on what is reported in interviews” (p. 245). Thus, the combination of interviews and observations “allows for a holistic interpretation of the phenomenon being investigated” (Merriam, 2009, p. 136).

Merriam (2009) presents a “checklist” (p. 120) of elements to take into consideration when initiating the observational process: the physical setting, participants, activities and interactions, conversations, subtle factors, and the researcher’s own behavior. The **physical setting** includes noting the physical environment and resources available in the setting. The **participants** refer to describing who is involved in the study and what are their roles. **Activities and interactions** focus on the sequence of activities and the interactions that take place within the setting. The element of **conversation** examines the content of conversations in the setting. This includes observing who is speaking to whom and who is listening. **Subtle factors** include nonverbal behaviors that may include “what does not happen” (Patton, 2002, p. 295). Finally, the **researcher’s own behavior** includes my thoughts about what I am observing and taking notes that help
contribute to thick, rich, and descriptive data. Utilizing this list enabled me to be more aware of elements that I may have tended to overlook.

The process of observation typically consists of three stages: entry, data collection, and exit (Merriam, 2009). The entry stage consisted of gaining approval of the healthcare agencies I would be using for my study. I met personally with the IRB representatives at each of the settings where I reviewed the purpose of my study and the amount of time I would be spending there. During this stage I also spoke with each of my participants to find out about their routines on the clinical unit. This helped coordinate my visits and observation schedule.

As part of the data collection stage, I observed each of the four participant’s interactions with nursing students three times over the 8 weeks in the clinical setting. Two of the participants I observed during weeks 1, 3, and 5. The remaining two participants I observed during weeks 2, 4, and 6. I staggered the observation times throughout the 8-week clinical to ensure that each participant was observed in the morning as well as the afternoon. Since early mornings and late afternoons tend to be very hectic during the clinical day, I observed each participant from 9:00 AM to 12:00 PM, or 1:00 PM to 4:00 PM. The third clinical visit for each participant was an afternoon visit. I decided the afternoon visit would be the third visit after I realized that this time allowed me better observations with minimal disruption. All observations took place in healthcare settings located in northeast Ohio. Each visit lasted approximately three hours. Throughout the observational process, I utilized a “checklist” I developed based on what interactions between educator and student typically occur in a clinical setting.
The items on the checklist are inherent in clinical interactions and were based, in part, from my teaching clinical experiences. This checklist then became a source for my observation data collection (Appendix G). Figure 1 depicts the timeline for the interview and observations. In addition, I kept copious notes on nonverbal cues and my thoughts as participant observer and recorded them as they occurred in the form of “field notes.”

My participants knew the exit stage of my study since they all had the observation schedule ahead of time and knew which days and times I would be visiting. However, although I was able to obtain and capture a range of rich, descriptive information, I found ending the observation quite a challenge since I had established a working relationship with my participants and even with the students in the clinical groups.

<table>
<thead>
<tr>
<th>Name</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
<th>Week 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timmy</td>
<td>9AM - 12PM</td>
<td>Interview #1</td>
<td>1PM - 4PM</td>
<td>1PM - 4PM</td>
<td>Interview #2</td>
<td>10AM</td>
<td></td>
</tr>
<tr>
<td>Kate</td>
<td>1:30PM</td>
<td>Interview #1</td>
<td>9AM - 12PM</td>
<td>1PM - 4PM</td>
<td>1PM - 4PM</td>
<td>Interview #2</td>
<td>11AM</td>
</tr>
<tr>
<td>Mimi</td>
<td>9AM - 12PM</td>
<td>Interview #1</td>
<td>1PM - 4PM</td>
<td>1PM - 4PM</td>
<td>Interview# 2</td>
<td>10AM</td>
<td></td>
</tr>
<tr>
<td>Sally</td>
<td>3PM</td>
<td>Interview #1</td>
<td>9AM - 12PM</td>
<td>1PM - 4PM</td>
<td>1PM - 4PM</td>
<td>Interview2</td>
<td>2PM</td>
</tr>
</tbody>
</table>

*Figure 1. Interview/Observation schedule*

**Weekly Email Questions**

Online data collection was another source of data collection for this study. Each week, I emailed the participants one to two questions pertaining to their clinical
interactions with male and female students that week. I prefaced each question by stating that answers can be any length. For example, the question for the first week was, “Describe the male students’ performance this week in three words.” I asked them the same question regarding the female students. Questions varied depending on the clinical makeup of each group. For instance, Kate and Sally had more than one male in their clinical group. There were several weeks where the same questions were emailed as a means for comparison. Table 1 lists the weekly questions sent to each participant.

Table 1

*Online Weekly Email Questions*

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Describe your male nursing student(s) in clinical this week using two (2) words. Describe your female nursing student(s) in clinical this week using two (2) words.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 2</td>
<td>Keeping your male student in mind, fill in the following statement: One thing I’d like to help you with is . . . Keeping your female student in mind, fill in the following statement: One thing I’d like to help you with is . . .</td>
</tr>
<tr>
<td>Week 3</td>
<td>Describe your male nursing student(s) in clinical this week using two (2) words. Describe your female nursing student(s) in clinical this week using two (2) words.</td>
</tr>
<tr>
<td>Week 4</td>
<td>One thing that surprised me this week about my male student(s) was? One thing that surprised me this week about my female student(s) was?</td>
</tr>
<tr>
<td>Week 5</td>
<td>Describe your male nursing student(s) in clinical this week using two (2) words. Describe your female nursing student(s) in clinical this week using two (2) words.</td>
</tr>
<tr>
<td>Week 6</td>
<td>One thing I observed about my male student(s) this week was? One thing I observed about my female student(s) this week was?</td>
</tr>
<tr>
<td>Week 7</td>
<td>Now that the semester is almost over, have you noticed or observed anything in your clinical that has surprised you about your students?</td>
</tr>
</tbody>
</table>

The asynchronous idea of online data collection had the benefit of adding reflection time that may have been unavailable in a face-to-face interview or during the
observation times. Further, weekly email questions may have allowed the participants to respond in a more thoughtful way without extraneous noises and feeling “put on the spot.” For some, articulating thoughts via writing may be beneficial (Merriam, 2009).

**Data Analysis**

According to Merriam (2009), “Data analysis is the process of making sense out of data” (p. 175). It is a matter of organizing data in order for others to comprehend what has been collected in a succinct fashion. Data analysis is a complex and on-going task done concurrently while collecting data. Thus, the process of data analysis continued throughout the 8-week study interval. Once the data collection period ended, I was better able to examine the data from multiple sources in a more holistic manner.

Lincoln and Guba (1985) noted, “Data analysis involves taking constructions gathered from whole” (p. 333). In addition, Merriam (1998) asserted, “communicating understanding is the goal of data analysis” (p. 193) in case study research.

I organized my data collection by focusing on the analysis of one participant at a time. Since I am a visual learner, I decided to use colored 3x5 note cards to represent an individual’s specific codes and colored circular stickers to indicate the source of the data. For example, Timmy was assigned a blue notecard, Kate’s was pink, Mimi’s was yellow, and Sally’s card was white. I then added a round sticker to the upper left corner of each note card indicating the source of the data. For instance, orange represented data from the initial interview, green corresponded to observational data, blue indicated the second interviews, red reflected codes extrapolated from the Qualtrics survey, and purple
illustrated information gleamed from the weekly emails. Hence, a code from Timmy’s first interview would be on a blue card and have an orange sticker in the left corner.

**Data Coding**

Similar to other research methodologies, case study analysis begins with coding data. This entails carefully reading all information gathered and making notations about data that is interesting, relevant, and/or pertinent. These data are then coded into a master list of concepts that reflects recurring patterns. As a result, “coded” information evolves into categories or themes (Merriam, 2009). According to Merriam, this is the way the researcher begins to construct categories.

Following the initial interview, I read through the hard copy of the interview transcripts line by line, underlining key concepts and ideas, then jotting down words, phrases, or comments in the margin. Examples of these codes included *stereotypes* and *gender differences*. I repeated this process for the same participant’s second interview, Qualtrics survey, observation notes, and weekly emails. I then reread each interview transcript, my observation notes, and weekly emails looking for recurring regularities. This same process was used for each of the remaining participants until no new codes were identified.

Once I had coded my units of data for each participant, I then transferred the coded data onto the colored note cards, by hand, as described above. As a result, at the conclusion of my coding, each participant had 5 stacks of colored note cards that corresponded to their codes with round stickers on each card indicating the source of the data. Table 2 lists the codes deduced from the data collection process.
Table 2

Data Collection Codes

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Interview</td>
<td>different, lazy, lack of confidence,</td>
</tr>
<tr>
<td></td>
<td>mechanical, hesitant, not serious,</td>
</tr>
<tr>
<td></td>
<td>task or tempted, less gossipy,</td>
</tr>
<tr>
<td></td>
<td>why nursing?, feminine, skeptical,</td>
</tr>
<tr>
<td></td>
<td>“good money”</td>
</tr>
<tr>
<td>Observations</td>
<td>faculty focused, task driven, probing,</td>
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<td>more direct communication, critical,</td>
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<td>relaxed, negative nonverbals, many</td>
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<td>questions</td>
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<td>Second Interview</td>
<td>task oriented, disappointed, differences</td>
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<td></td>
<td>exist between genders, need direction,</td>
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<td></td>
<td>uncertain, different, less gossipy,</td>
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<td>sidetracked, needy, outcome oriented,</td>
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<td>need direction, less talking</td>
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<td>Qualtrics Survey</td>
<td>gender stereotypes persist,</td>
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<td>difference in concept of caring,</td>
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<td></td>
<td>gender difference in communication styles,</td>
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<td></td>
<td>viewed as feminine or gay,</td>
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<td>negatively stereotyped</td>
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Sorting and Naming Categories

According to Merriam (2009), as a researcher progresses in the analysis process, “there is a subtle shift to a slightly deductive mode of thought—you have a category and you want to see whether it exists in subsequent data” (p.185). Hence, once the coding process was complete, I began to sort the codes into recurring themes or categories. The first card from my interview pile became the initial category. I then sorted through the remaining data source cards as a means to examine if the contents fit into the first category. If this data “fit,” it remained there; if it did not fit, that card became the first code in the second category. For example, the words feminine and different emerged as stereotypical themes (category); whereas task driven resulted in the emergence of a new category. I continued this process until all units of data were sorted and assigned a category. Additionally, as I progressed through this process, I often reduced, combined, or added new categories to reflect what my participants were “telling” me. As a result of this deductive approach, my “stack” of note cards was reduced based on the overarching themes that emerged.

Cross Case Analysis

I analyzed each participant as an individual case and then began a cross-case analysis. According to Yin (1994), the researcher attempts “to build a general explanation that fits each of the individual cases, even though the cases will vary in their details” (p. 112). Stake (2006) emphasized “the multicase study is not a design for comparing cases” (p. 83); but, rather a way to better understand the “quintain” (p. 4) or condition, object, or the area being studied. Thus, Stake (2006) asserted a multicase
study is not about each individual case, but rather, what each individual case tells us about the quintain being studied. Thus, I did not compare cases; but rather, looked at and analyzed what each case is “telling,” while I searched for similarities and differences.

Once I had my data sorted and categories named for each participant, I began to combine the similar codes from all the participants. It resembled a card game where I began with a common theme from one participant and reviewed my data cards to see whether there was any other participant data that were related and could be combined. This process continued until the categories were exhaustive, meaning all the data I deemed important to my study were in a category or subcategory. Consequently, I had a mixture of color-coded note cards that represented similarities in categories and themes inclusive of all participants.

**Quality Criteria**

The intent of trustworthiness is to support the argument that the “findings of an inquiry are worth paying attention to, worth taking account of” (Guba & Lincoln, 1982, p. 290). Although Merriam (2009) referred to trustworthiness with the traditional terminology of validity and reliability, I utilized Lincoln and Guba’s (1985) strategies for ensuring trustworthiness that creates standards by which responsiveness to multiple realities can be assessed. They asserted trustworthiness involves establishing credibility, transferability, dependability, and confirmability.

**Credibility**

The major concern in establishing credibility involves having confidence in the ‘truth’ of the findings. Are the interpretations of the researcher believable (Guba &
Lincoln, 1982)? According to Lincoln and Guba (1985), there are a number of strategies to ensure credibility: (a) prolonged engagement, (b) persistent observation, (c) triangulation, and (d) peer debriefing.

**Prolonged engagement and persistent observation.** Prolonged engagement and persistent observation can be attained by spending adequate time with the study participants in order to get a complete understanding of what is being reported and observed. In addition, spending adequate time in data collection is necessary in order to build trust and a rapport with my participants. For this study, I interviewed each participant for a minimum of 50 minutes and spent at least three hours on three different occasions observing the interactions between educator and male student in the clinical setting.

**Triangulation.** According to Stake (2006), triangulation occurs throughout the collection and analysis process to assure data are meaningful, free of our biases, and will not mislead the reader. Triangulation means “being redundant and skeptical in seeing, hearing, coding, analyzing, and writing” (Stake, 2006, p. 77). It also involves utilizing a variety of data sources and methods to confirm emerging findings (Guba & Lincoln, 1982). Thus, for this study, I have obtained data from various sources, including a Qualtrics survey, interviews, observations, and weekly emails.

**Peer debriefing.** Peer debriefing allows a peer, outside the study context, to analyze data and provide insight and feedback to the researcher. Lincoln and Guba (1982) described peer debriefing as keeping the researcher “honest” (p. 247). Peer debriefing commenced as my data analysis progressed. One professional colleague had
experience in coding, and I conferred with her regarding my data. We met twice to review and compare what I extrapolated from my data and she confirmed my conclusions.

**Transferability**

Although qualitative research, unlike quantitative, does not seek generalization, Guba and Lincoln (1982) asserted that “some degree of transferability is possible under certain circumstances” (p. 247). However, “the person who reads the study decides whether the findings can apply to his or her particular situation” (Merriam, 2009, p. 226). Purposeful sampling and thick descriptions are two strategies to enhance the possibility of the results of a qualitative study ‘transferring’ to another setting (p. 227).

**Thick description.** The “thick description” generated in a study brings the reader vicariously into the experience being described (Lincoln & Guba, 1985). According to Lincoln and Guba, the best way to ensure transferability is to create a “thick description of the sending context so that someone in a potential receiving context may assess the similarity between them and the study” (p. 125). Creswell (2009) added that entries using thick description “give the discussion an element of shared experiences” (p. 192). This study utilized open-ended interview questions and probes to elicit thick, rich descriptions from the participants. In the following chapter I describe in greater detail the participants and the clinical settings with the intent of inviting the reader to experience what I saw and heard as if they were present.

**Purposeful sampling.** The use of purposeful sampling may “allow for the possibility of a greater range of application by readers or consumers of the research”
(Merriam, 2009, p. 227). This study used purposeful sampling, as described earlier in the *Purposeful Sampling and Participants*’ section of this paper.

**Dependability**

Dependability in qualitative research is often referred to as reliability in quantitative design, although it is important for the researcher to acknowledge how the study was conducted so other researchers can replicate the study. As a result, dependability requires that “the inquiry meet the criterion of consistency” (Erlandson et al., 1993, p. 33). I achieved dependability in this study through the use of predetermined interview questions. Although my interviews were semi-structured, the initial questions remained constant. Dependability can be enhanced through the use of an *audit trail*.

An audit trail consists of documenting and keeping a detailed account of the methods and procedures used to carry out a study. Lincoln and Guba (1985) advocated the use of an *audit trail* where the researcher details his or her “journey” so others can follow the trail. Dey (1993) noted, while “we cannot expect others to replicate our account, the best we can do is explain how we arrived at our results” (p. 251). Thus, I kept a relatively detailed account of how I conducted my study, how data were analyzed, and any thoughts, comments, or concerns I encountered in a separate spiral bound notebook.

**Confirmability**

Lincoln and Guba (1985) suggested confirmability can be compared to objectivity. However, the qualitative researcher acknowledges that complete objectivity cannot be guaranteed and refrains from ensuring that observations are free from
contamination (Erlandson et al., 1993). Thus, confirmability is desired so that findings extrapolated from a study are not based on the biases of the researcher. The goal is that the interpretations that the research makes can be corroborated with the data and sources. Confirmability can be aided by the use of a confirmability audit and reflexive journal that was established to ensure dependability.

**Confirmability audit.** The confirmability audit is similar to the dependability audit that allows for interpretations and findings to be traced back to the original sources (Erlandson et al., 1993). For this study, I kept the procedural aspects of my study including interview questions, survey results, observation notes, and weekly email interactions. In addition, all aspects of the data analysis process were maintained. This enables others to follow my line of inquiry and interpretations.

**Reflexive journal.** Utilizing a reflexive journal enables the researcher to critically self-reflect and address any biases, assumptions, and/or worldviews that may affect the findings (Merriam, 2009). For myself, this was particularly helpful as I struggled to keep my biases and thoughts from interfering with the data collection process. As I conducted the interviews and observations, I immediately recorded my thoughts, ideas, and questions that would help me prepare for subsequent data gathering. The motivation and inquiry into this study stemmed from my 20 plus years of teaching nursing and continually examining why the number of males in nursing school continues to be relatively low. Thus, my teaching background initiated the thought process while my reflective journal allowed me to critically examine my ongoing perspectives.
Ethics

Prior to initiating my study, I confirmed my CITI certificate is current, then completed the application for IRB approval in accordance with Kent State’s policy. Upon receiving approval for my research, all participants were given an “informed consent” document (Appendix E) that included the purpose of the study, procedures, any use of photography or audio taping, benefits, risks/discomforts, privacy/confidentiality, compensation, voluntary participation, and contact information. I also provided each participant with a consent form to audiotape the interviews (Appendix D). It is imperative that participants are provided an explanation of the research and understand and have knowledge of all relevant aspects of the study. The participants read through the consent, had the opportunity to ask questions, and were given a copy of the form. In addition, I emphasized to participants and encouraged them to provide input during data analysis and interpretation. I reiterated that privacy and confidentiality will be maintained and participants always have the option of discontinuing their involvement in the study.
CHAPTER IV

THE CASES

In this multicase study design, I examined nurse educators’ perceptions of male nursing students in the clinical setting. A cross case analysis is presented following the cases. I collected data for this study through two interviews, three observation periods, weekly emails, and a Qualtrics survey.

Timmy and the Mechanics

Timmy was a first-generation college student working full time when he “stumbled” upon nursing as a career choice. He had changed his major seven times his freshman year of college then finally chose nursing “because it was the path of least resistance” and he wanted to marry his high school sweetheart (they eventually broke up!). Timmy said mentally he did not take nursing school very seriously. Rather, there were

Multiple times in my nursing program where I literally would walk in, put my name on the final, answer the questions I knew I had to answer to get a B, go home, be happy, and spend my day doing something more enjoyable.

Timmy graduated from nursing school in 2002 where only 2 students out of 30 were male. He stated that when he enrolled in a nursing program in 1998, his family was “neutral” about his decision, but his friends “would josh me a lot.” He added, his friends often joked, “You’re gay,” although he added, “My friends made fun of everybody, that’s just how they were.”
Currently, Timmy has been a clinical nurse educator for 10 years as well as working as a staff nurse part time. He stated, “I enjoy working with male nurses, being able to talk guy stuff.” He said for over three years he was the only male on his floor where “there were a lot of bridal showers and baby showers!” He enjoys working with his male colleague because “we can talk about sports, hunting, fishing . . . women are not generally interested in that.”

**Clinical Setting**

Timmy’s clinical took place on a 32-bed acute medical surgical unit in a healthcare facility in Northeast Ohio. It was a very busy unit with a typical patient stay of 3 to 4 days. The unit was clean, well lit, spacious, and provided the students a plethora of patients to care for.

Timmy had one male and nine females in this clinical rotation that commenced over an 8-week period, beginning in mid-July. His clinical took place on Wednesdays from 7:00 a.m. until 5:30 p.m. All of the students in this particular group were at the sophomore level in their nursing program.

I asked Timmy how he proceeds each week to select his students’ clinical assignments. He stated,

When I do my clinical assignments, I arrive to the floor about forty-five minutes to an hour early. I go around to all the night shift nurses, saying, “Hey, who did you have—who would be good for your patients?” Then I just get a list of, you know, maybe total patients and I just randomly assign them.
He stated that he does not take the student’s gender, nor the patient’s gender into consideration when assigning patient care. He stated he has never had a patient refuse a male nurse.

My Interactions With Timmy

I first interviewed Timmy the week prior to my initial observation of him. He seemed excited, yet slightly nervous about what I may be asking him about male nursing students. However, he appeared to be an eager and willing participant. When I asked Timmy, “What comes to mind when you think of males in the nursing profession?” he hesitated, then he compared “males to mechanics; more direct, more linear, like that stuff has to get done before that stuff, and so-forth.” He continued, “So, when I think of males in nursing, my direction seems to be medical/surgical, ICU (Intensive Care Unit), ER (Emergency Room) nurse, very much task nursing. Males are much more ‘ba-da-bing, ba-da-boom.’” He also commented that he felt his male nursing students were more “side tracked. They know they’re not allowed to have their phones outside the break room—they’re just not. I would walk by and see their phones out.” Timmy learned that males were on social media sites more than females throughout the day, so he reinforced that phones were not to be used. Consequently, he told them to put the phones away.

We discussed the concept of caring in relation to gender differences and Timmy felt there was a distinct difference in the way males and females describe their concept of gender.

Males are more outcome oriented as far as, like, physical health. I think females are better at the social psychological, and spiritual domains, whereas male nurses
tend to fall into more of the medical “let’s fix the disease and worry about those other things after.” Females tend to be more able to manage the other domains of nursing.

He continued, “Males miss out on the heart of nursing, they sometimes don’t get what nursing is and they often have difficulty expressing themselves.” He explained this focus on physical well-being may have something to do with the nursing student’s age. For example, Timmy stated that young students, particularly those in their early 20s, tend to be “very timid with patient interactions. This is particularly true for males who tend to be more uncomfortable with touch. Thus, it takes more time for them (males) to feel comfortable. As a result, they’re a little more hesitant.” However, he strongly disagreed with the idea that males are less nurturing than females. “This,” he says, “is part of the stereotypical thinking that males can’t care or nurture that well.” He said he is “very cognizant of this societal view and works hard nurturing to his patients so that his students all view him as a good role model.”

When I first arrived on Timmy’s unit at 9:00 a.m. to observe his interactions with male nursing students, I was struck by the spaciousness and cleanliness of the clinical floor. There were no linen carts in the hallway, no medical equipment loitering around, and the halls were wide with rooms spaced generously apart. Timmy was very busy with his male nursing student in a patient’s room as they were attempting to transfer an elderly gentleman from the bed to a chair. Timmy was very relaxed and patient with the student as he “instructed” him on the best and most-safe way to transfer. In addition, he relayed this information to the student in a friendly and non-threatening tone. Thus, his
“instructions” were conveyed more as “suggesti on s.” For example, rather than telling the student how to transfer his patient, he offered ideas that may be helpful. Since this patient had multiple problems and was not able to ambulate, Timmy spent 20 more minutes in this particular room with the student before he noticed I was “observing.” When he and the student exited the room he put his arm on the male student’s shoulder and stated, “I pick on Sam every week.” When I asked him what he meant, he said, “We guys have to stick together.” The student blushed, Timmy laughed, and then proceeded to explain to me how he assigns patient care to students and how he plans out his day.

During my nine hours observing Timmy interacting with his students, I noticed him consciously making an effort to spend equal time with each student. On average, he spent five to seven minutes per hour with each student regardless of gender. When a student needed his assistance, he was readily available and willing to help. The times when Timmy spent additional time with any student was related to the activity of the patient or if a particular student was assigned to administer medications that week. Those situations required much more instructor intervention and assistance. I did, however, notice Timmy would occasionally spend additional time with his male student just “chatting” with the student and a patient, particularly if the patient was a male and sports was the topic.

The students often would meet to break in a floor-to-ceiling glass alcove that was usually a patient relaxation room. This room overlooked the healthcare campus and was quite soothing and quiet. Throughout my visits, the students and Timmy would meet to discuss patient care in this room. The interactions were light, relaxed, and respectful.
Interestingly, I very rarely saw the male student in this room with the female students. I brought this up to Timmy, and he stated, “Sam keeps himself busy. Anyways,” he said, “males tend to be less gossipy,” perhaps indicating that these breaks would be more directed towards gossip than work. This was reinforced when later that week Timmy described in an email that his male student was “relaxed and inquiring.” He described his female students as “calm yet energetic.” Subsequent emails described his male student as “empathetic, sensitive, eager to help, and task oriented,” whereas the females he characterized as “compassionate and engaged.”

Timmy’s interactions with both genders were relatively consistent throughout the semester. I observed he frequently used humor with all his students to help decrease some of their anxieties and fears regarding patient care. In addition, he would approach a student who was charting and ask them questions about their patient’s condition. Consequently, all the students verbalized Timmy was approachable and engaging.

As the semester progressed, the discussions during clinical were veered towards Timmy’s interactions with clinical educators, both currently and in the past. He felt that female educators “tend to be very flirtatious with the male students.” Timmy recollected when he was in nursing school he felt that educators were flirtatious as well as biased against him. He described one incident while he was in nursing school when the clinical educator embarrassed him about his having never given an intramuscular injection. It was a female patient and the instructor stated, “You’re embarrassed to be around a woman who just gave birth.” Timmy said he was outraged at her insinuation that his hesitation was a gender issue. Currently, he believes that some nurse educators continue
to be gender biased against males. He stated, “I’ve had males come talk to me about
that,” he continued, “and I’ve never had a female approach me about this situation.” As a
result, when he speaks with male students that believe they are facing gender bias, he
tells them, “You’re going to have to overachieve” (in order to prove them wrong).

Timmy also contends that often male students are “used” for their physical
strength. For example, he notices female nurses will often call on males, including
students, “to move, for transfers, a lot of physical activities.” Thus, he typically complies
with these requests because his grandmother’s statement, “Chivalry will not die with a
man,” echoes in his mind. I noted the demeanor and nonverbal behavior as he said this.
He tensed up some and became very serious. He realizes he can say no, and often wants
to, citing the “literature that looks at the incidence of back injuries from male nurses
doing added physical work.” However, despite his reluctance, he states, “I don’t want to
say a lot.”

Timmy is “passionate” about being a nurse and has committed himself to helping
other educators recognize the different perspectives that male nursing students can
contribute. He contends that nurse educators are biased against both genders, particularly
males; however, he focuses on trying not to be biased, keeping an open mind and helping
male nursing students nurture their passion for the profession.

**Mimi and the Oceanographers**

Growing up in the late 1960s, Mimi often dreamt of, and at times, obsessed about
becoming an oceanographer. She said she really did not know much about this career but
thought it was something “different and interesting.” However, while a sophomore in
high school, her father, rather bluntly, told her she should not become an oceanographer since “you’ll never make a living, you probably won’t find a job, the oceans are too far from home, and besides, you’re not that great of a swimmer!” Hence, Mimi made the decision to focus on taking care of people rather than taking care of fish.

Mimi graduated with an Associate degree in Nursing (ADN) in 1986 and several years later obtained her Bachelor of Science degree in Nursing (BSN). She stated in both her ADN and BSN class there was only one male student out of approximately 40 students. Initially, she said the class “was curious about why a guy was going into nursing,” but after several weeks, “no one really paid attention.” She admitted initially many of her female classmates thought the male student “must be gay.” She continued,

In both degree classes, the guys were older than most of the females, married, and had aspirations to move onto bigger and better things after graduation. As the semester weeks progressed no one really paid attention because the male student pretty much kept to himself and didn’t really hang around after class.

Much of Mimi’s nursing career was spent taking care of the smallest babies in the Neonatal Intensive Care Unit (NICU). She said that in her 25-plus years in the NICU, no males ever applied. As she said this, she stated, “I never really thought about that.” Currently, Mimi works per diem (as needed) in the Mother-Baby unit in an area hospital. When I asked whether any males work there, she chuckled and stated, “Never.” She continued, “I think a male nurse working in a Mother/Baby unit or in Labor and Delivery would be too uncomfortable for both the nurse and the patient.” Although she admitted,
“Many obstetricians are male, and that doesn’t seem to be an issue.” In addition to her per diem work, Mimi has been a full-time nurse educator for the past eight years.

**Clinical Setting**

Mimi’s clinical took place on a 20-bed, medical-surgical floor that cared primarily for patients with cardiac (heart) problems. As a result, the majority of the patients were hospitalized for a minimum of three days and were connected to monitors that continually monitored their heart and respiratory rates simultaneously. The unit is small and cluttered but brightly lit which added to a sense of chaos.

Mimi had one male and seven females in this clinical rotation that commenced over an 8-week period beginning in mid-July. Her clinical took place on Thursdays from 7:00 a.m. until 5:30 p.m. All the students in this particular group were at the sophomore level in their nursing program.

I asked Mimi how she determines the weekly clinical assignments for her students. She stated, “Initially I give a male student a male patient.” She continued, I think because I feel males are more hesitant, they feel more comfortable at the beginning of the semester taking care of someone of the same gender. I pretty much do the same for the females. After that, there’s no consideration regarding student or patient gender.

**My Interactions With Mimi**

I first interviewed Mimi the week prior to my initial observation. We met in her campus office, which was cluttered with stacks of paper. Her walls were adorned with what she called “goodies” her students had given her including tapestries and framed
photos. She was excited, very animated, and eager to help. However, it was her nonverbal behaviors during the interview that were noteworthy and telling.

When I asked Mimi, “What comes to mind when you think of males in the nursing profession?” she hesitated, looked up at me with her bifocals perched low on her nose, waved her arms up, and stated, “They’re a little out of place.” She continued, “For some reason, they seem to struggle and I usually end up asking them are they aware of what a nurse does? For some, I am tempted to offer oceanography as an alternative career choice!” She paused then continued,

I see male students as more hesitant, more focused on tasks rather than worrying about the whole patient. I don’t think they see the patient as a person; rather, they see the patient as a person in a bed that needs specific treatments of assistance.

As a result, I find myself constantly redirecting them and to some extent codding them. It can be quite challenging (shaking her head).

This led into a discussion focused on the concept of caring in relation to gender differences. Mimi verbalized she felt “females convey more nurturing activities compared to males.” For example, she said that when she typically asks her students, “How did you care for your patient today?” females often respond with statements such as, “I rubbed my patient’s back,” or “I sat and talked with my patient today.”

Conversely, male students often reply with, “I gave my patient a bath, then I made their bed.” Thus, she added, “Males tend to focus on the tasks, and physical care, while often overlooking psychological aspects of their patient’s care.” In addition, she added, “While providing physical care, their (male) conversations with the patient tend to be
male-oriented topics or task focused and often staccato in nature. Not to say they’re not as nurturing but they’re not.”

When I first arrived on Mimi’s clinical unit at 9:00 a.m. for my first observational visit, my senses were bombarded with various stimuli. Since the unit is relatively small, conversations between medical staff and patients are pronounced and seem to “bounce off the walls.” Add to that the constant beeping of patient monitors and IV (Intravenous) alarms leaves you feeling in a state of auditory overload. In addition, the unit is brightly lit and the floor is wooden with a dizzying pattern that resembles a game board. I noticed numerous linen carts, medication carts, cleaning carts, and other portable equipment that seemingly lined both sides of the hallway giving visitors the sense they were walking into a noisy maze!

About midway down the hallway I noticed Mimi talking to two female students who seemed perplexed. As I approached and greeted them, I noticed once again, Mimi’s glasses perched low on her nose, while she rolled her eyes. She directed the two students to what they should focus on and then redirected her attention to me. She noted, “Sophomores are tough. I’m generally quite patient but at times I wonder if they got shorted on the common sense gene.” As we continued to converse about pleasantries, her male student approached and she initially ignored him as he stood next to her and said nothing. She then paused, turned toward him, and asked him what he needed. He asked, “Do you think I should give my patient a bath now or after he takes a nap?” Mimi replied, “What does the patient prefer?” The student replied, “I don’t know.” Mimi then abruptly told him, “Perhaps you should ask him.” When the student turned to follow
through on this suggestion, Mimi turned to me and said, “He is repeating this nursing course and he just doesn’t get it. Perhaps he is someone who might want to consider oceanography!”

Throughout my hours of observing Mimi interacting with her students, I noticed her spending equal time with each of her female students but significantly more time with her male student. On average, she spent approximately five minutes per hour with her female students and the remainder of the hour with her male student who continually sought her out for guidance and direction. Even when passing medications with her male student, time was significantly greater. At times, she would see him coming, shake her head, roll her eyes, and comment to herself, “Now what?” However, despite her nonverbal behavior, she was very patient and tolerant of the male student’s requests. These observations and comments were supported by Mimi’s weekly emails that often described her male student as “disorganized, apprehensive, overconfident, looking for a career choice, and needy.” Conversely, she commented about her female students using words such as “eager, compassionate, and confident.”

The students would often meet for an occasional break in the unit’s locker room that resembled a large size closet. It was not conducive for meeting or gathering, and inevitably the students said they felt claustrophobic meeting there. Thus, most of the verbal interactions that transpired between Mimi and the entire group took place at the end of the shift in a remote part of the facility’s cafeteria. During my second visit, I joined them for their group discussion. Mimi asked each student individually to tell the group about their clinical experience for that particular day. All of the students
contributed input equally by stating how they cared for their patient. Interestingly, Mimi started the group conversation by directing her male student to share his experiences first. He responded, “My patient didn’t want a bath so I just changed his sheets.” When Mimi prompted him to include more details, he was stumped, but stated, “I did pretty good today!” Later, Mimi added that she typically finds “male students always say they are ‘caught up’ with all their work and often their opinion of their care is overinflated.” This comment was supported the following week when this same male student approached both of us mid-morning and stated, “I’m doing really good today. I feel proud of myself.” Mimi then asked him, “Have you charted your physical assessment and recorded your patient’s intake and output?” The student replied, “I was just getting to that.” Mimi then replied, “I suggest you do that now.” The student then left to follow through on these instructions. At that time, Mimi turned to me, rolled her eyes, shook her head, and stated, “Every week he says he’s just getting to that. You would think after five weeks he would get the work done and then tell me!”

As the semester progressed, the discussions during the interviews and observational periods diverged towards Mimi’s interactions and discussions with other educators both past and current. Mimi admitted that she has spoken to other educators and they “seem to have similar thoughts about men in nursing.” She added, “I believe gender stereotypes do persist and I try really hard not to be biased.” She continued, “I have had staff during clinical tell me they sometimes wonder why a guy might go into nursing.” However, they like having male students around because “they’re great for helping to lift and transfer patients.” She then hesitated and stated, “I guess I’m guilty of
that too since I just suggested my male student help another student transfer the patient to a chair.” Mimi continued, “I think we ask them (males) to help with physical care without giving that any thought.”

Mimi says she “loves nursing and loves being a nurse educator.” She smiled when she spoke about the satisfaction she gets when a student says, “I get it.” Mimi continued, “I’m passionate about educating the next generation of nurses who will most likely take care of me. Male or female, I want to be the best educator so my students will ultimately become the best nurses.” She concluded, “I never reconsidered oceanography; rather I bought a fish tank and that made my dad proud.”

**Kate the Mother**

Kate grew up in a large family of mathematicians and joked, “I can barely add double digits!” Thus, she knew at a very young age that she was not going to pursue a career where numbers and mathematical skills were a necessity. She said she had always had an interest in the health fields but did not really know much about nursing. However, she had four young siblings she took care of while growing up and has always loved kids so she said, “Pediatric nursing sounded like a valid and reasonable career choice.” She chuckled, “You would think that raising your siblings would deter you from taking care of other people’s kids!”

When she started nursing school in the early 1980s, there was one male in her class of 45 students. She recalls the male student as being “somewhat feminine.” However, she noted, “We were all young, single, and no one paid much attention to what
went on outside of school.” She does remember initially thinking to herself (about the male student), “Why nursing, why not math?”

Kate graduated with her Bachelor of Science degree in Nursing (BNS) in 1984, and subsequently worked for 18 years as a pediatric nurse. Recalling her undergraduate schooling, Kate stated,

There were two other male nurses that worked on her floor who were wonderful nurses. I remember the little kids loved the guys; especially the boys. I remember these two male nurses making footballs out of latex gloves and tossing them to the kids as if they were out on a ball field. Everyone thought they (male nurses) were great.

Currently, Kate is a full-time clinical nurse educator and no longer works as an RN in a healthcare setting. She said, “Raising a family and working full time is enough stress without adding hospital nursing to the mix.”

Clinical Setting

Kate’s clinical took place on an extremely hectic 42 bed medical unit in a healthcare facility in Northeast Ohio. According to one staff member who worked on this floor, the majority of the inpatients were elderly, often from the nursing home who suffered from multiple chronic ailments. As a result, the length of stay for patients averaged five to seven days. The nursing unit was rectangular in shape with a central nurses’ station in the middle. The patient rooms were located on the periphery of the floor and supplies rooms, a kitchen, and a linen room were located within the nucleus of
floor behind the nurses’ station. The unit was well lit and the halls were being carpeted yet the noise level was relatively high.

Kate had three male students and five female students in her clinical rotation that commenced over an 8-week period beginning in mid-July. Her clinical took place on Tuesdays from 7:00 a.m. until 5:30 p.m. All the students in this particular group were at the sophomore level in their nursing program.

I asked Kate how she determines her weekly clinical assignments for her students. She stated, “I generally get here about 30 to 40 minutes before the students then ask the RNs for patients that would provide a good learning opportunity for my students.” She admitted,

I do take gender into consideration when making out my assignments; particularly if my patient happens to be a young female, then I typically avoid assigning a male student to that patient. Also I feel male students need to be guided, so I initially give them patients that are not as difficult. Maybe that is being biased, but they (males) seem to struggle more.

Kate did encounter an elderly female patient not long ago that thought the male student was a doctor. When the patient was told the student was a nurse, the patient responded, “Oh well then, I’ll take the girl nurse.” Kate said she thought the patient was joking but soon realized she was not.

**My Interactions With Kate**

My initial interactions with Kate occurred during my first observation period. I arrived on the nursing unit at 8:55 a.m. and was bombarded by sensory overload. The
unit was very brightly lit and the hallway was wide. However, there was a multitude of equipment nestled on both sides of the hall including linen carts, portable computers, patient isolation carts, medication carts, and sporadic housekeeping carts. In addition, my ears were deluged with the plethora of noises comprised of patient monitors, medical staff communications, patient’s moaning and hollering all coupled with the constant barrage of patient call lights blinking and beeping. It made me want to stop and take a deep breath before proceeding.

I located Kate outside a patient’s room talking with three female students. As I approached, the students dispersed. As Kate and I dispensed pleasantries, we noticed one male student looking in our direction. We both walked in the direction of the male student who was charting on his patient. Kate asked him, “Do you need any help with anything, or do you have any questions?” The student looked at both of us, rather sheepishly, and stated, “My patient is sleeping. Should I wake him up to take his vital signs?” Kate replied, “Is it possible to take vital signs without waking him (the patient) up?” The student responded, “I’m not sure.” Kate, trying to maintain composure, said, “Why don’t you tap him lightly and let him know that you need to check his blood pressure, pulse, and temperature; that should be fine.” The student then left to implement this suggestion while Kate stated, “The guys seem to hesitate with initiating activities. I sense they are timid, but once you direct them to do a task, they are eager to complete it.” We then proceeded to walk the halls and see if other students needed any assistance. I did notice the males tended to work together and the females tended to work together.
This pattern of redirecting the males and offering assistance to all students continued for the remainder of the three-hour observation period.

When I interviewed Kate the following week, I asked her, “What comes to mind when you think of males in the nursing profession?” She quickly responded, They are hesitant, timid, and seem to need more guidance and direction. Also, they (males) seem to be more task-oriented as opposed to focusing on the psychological aspects of patient care. Additionally, my male students ask fewer questions but ultimately need more help and direction which I find interesting.

This discussion began to focus on the concept of caring in relation to gender differences. Kate commented, I definitely think males and females have a different definition of caring when it comes to patient care. I tend to think my male students focus more on physical care and often overlook talking or touching as part of caring. I see this even in their (males) paperwork where the psychological aspects of patient care are often missing and/or minimized. When I bring this up, the males don’t seem surprised; rather, they seem like it wasn’t something they even thought of.

Throughout my nine hours observing Kate interacting with her students, I noted her conscious effort to spend equal time with each student. However, I did note that she usually spent two extra minutes each hour with the male students. Typically, they approached her for guidance and direction. I commented to her that she often seems like a mother to them. She replied, “I feel like that sometimes too. I suppose I sense they struggle so I try and take them under my wing. Sometimes I want to ask them, ‘Why are
you here?’” For example, during my first visit with Kate, one of the male students approached her very hesitatingly. Kate asked him, “Is everything going ok?” The student replied, “I don’t think my patient likes me that much.” Kate, very patiently, took the student aside and imitated a very calming and soothing conversation with the student. Afterwards she said to me, “They’re students, but they’re just kids.”

During my second observation period, Kate and I were sitting at the nurses’ station co-signing the students’ charting. One male student approached and stated, “You know Ms. ______, I think I’m doing really good; I feel like a nurse.” Kate replied, “Good for you. Tell me, did you give your patient a bath?” The student replied, “He didn’t want one.” Kate then asked, “Did you listen to your patient’s breath sounds and abdominal sounds?” The student replied, “Not yet, he’s sleeping.” Kate asked a third question (patiently), “Did you chart your vital signs?” The student, still confident and smiling, stated, “I was just going to do that,” then subsequently left to complete what Kate thought were tasks that should have been completed. After the student left, Kate looked at me, rolled her eyes, and stated, “I wonder what he’s been doing. Apparently whatever he’s been doing, he thinks he’s good at it!” Later that afternoon one of the female students asked Kate if she (the student) should get help to transfer her overweight patient from the chair back to bed. Kate replied, “Since you really don’t know if the patient is able to bear weight, it is probably a good idea to ask someone to assist you. Why don’t you ask ‘Sam’ (male student) to help you?” I asked Kate why she chose “Sam” to be the assistant. She replied,
I’m pretty bad at that. I tend to ask my male students to help with the more physical aspects of care like moving and transferring patients. I notice the staff does that as well. They often ask me if my male student can assist them with their patients.

Right after this conversation Kate asked one of her male students if they would assist the staff nurse.

As the semester progressed, Kate’s interactions were relatively consistent. She typically spent more time with her male students and they generally would seek her out for guidance. During break periods, the students often congregated in the employee lounge. Although it was small, it had 10 chairs in the room that students often utilized if no staff was present. In addition, one wall was a large window that overlooked a green space giving the illusion of being part of a park setting. It was during one of these gatherings that the students extemporaneously spoke of Kate. They stated, “She is like a mom to us; nice but we know when she means business.” One male student added, “Yeah, she really helps us.” When the students were gone, I relayed these comments to her and she stated, “They’re like my kids, I guess, especially the males. Sometimes I think they struggle more.” Kate’s comments were reinforced by her weekly emails that often described her male students as “timid, yet confident, hesitant, and task oriented,” whereas she described her female students as “independent, comfortable, and nurturing.”

The discussion during this 8-week clinical then diverged towards Kate’s interactions with other clinical educators and their perceptions of gender within the nursing profession. Kate acknowledged that,
Oftentimes I hear other educators make the same comments about the male students in their clinical as well. It’s not that the comments are negative, rather they (other educators) make statements that tend to support that gender differences do exist in nursing.

But, she added, “we should use this to have more patience for males who may be struggling in this profession.”

Kate loves nursing and enjoys being a clinical nurse educator. She stated, “If I had to do it all over again I would choose nursing and teaching again.” She continued, It’s so rewarding to see how the students grow in the program. They start out eager, nervous, hesitant, and sometimes fearful, but usually by the time they graduate they feel more confident and empowered. It is then that my mothering ends and they move on to the real world.

**Sally the Big Sister**

Sally grew up in a family with one older brother and two younger brothers. As a result, she stated, “I can relate very well with males and I feel very comfortable around them.” She continued,

They were very protective of me and I looked to them for guidance and reassurance. My older brother was like my dad, and my younger brothers were like my kids. So I guess I was the older sister and the younger sister.

Sally graduated in the mid-1980s after obtaining a Bachelor of Science Degree in Nursing (BSN). She attended a very small liberal arts college outside the state of Ohio. She said despite the small college, she had 40 students in her nursing class and two of
those students were male. She remembers the males as “both really good students.”

Sally continued,

I liked having the male students in my class because it made me feel like I was around my brothers. We got along very well and hung out to study together too. I guess even at school I was one of the guys!

After graduating nursing school in the late 1980s, Sally began working on a medical surgical unit near her home. At that time, she worked with one male nurse and said, “I really enjoyed it. We got along well and worked well together. Having brothers really made it easier to work with men. I was never intimidated and I could easily joke with the males.”

Currently, Sally is a full-time nurse educator and no longer works as an RN in any healthcare facility. She said, “Nursing education keeps me plenty busy.”

Clinical Setting

Sally’s clinical took place on a 34-bed long-term care facility in Northeast Ohio. She stated many of the patients admitted to the facility were admitted for rehabilitation services. As a result, the length of stay for the majority of patients was greater than 14 days.

Sally had three males and seven females in this clinical period beginning in mid-July. Her clinical took place on Tuesdays from 7:00 a.m. until 5:30 p.m. Two of the students, one male and one female, from this particular group were part of the accelerated nursing program. The accelerated nursing program is a program that allows a student who already holds a Bachelor’s degree in any field to complete a Bachelor of Science
degree in Nursing (BSN) within 15 months. Thus, these two students were at the
beginning of their senior year while the remaining eight students were at the junior level
in their nursing program.

I questioned Sally how she proceeds each week to determine her students’ clinical
assignments. She stated she gets to her clinical site approximately one hour prior to the
students’ arrival and assigns students to patients based on what the class didactics is
focused on for that particular week. For example, Sally stated, “If we are talking about
the urinary system this week, I try and assign patients that have urinary problems.” Sally
admitted that she has a tendency to assign her male students to male patients. She also
“tends to focus on the males” and their assignments more than giving thought to the
female students’ assignments. “In addition,” she added, “sometimes I intentionally give
males more complex patients because I think they want to do tasks.” “Often,” she said,
“I’ll ask the staff nurses if it is okay to assign this patient to a male nurse and they’ll tell
me yes or no.” She admitted, “Sometimes on purpose I assign my male students to male
patients” to avoid any potential discomfort. Occasionally, she will notice a sign on a
patient’s door that says, “Male nurses not to bath.” She added, “It’s not very often
though and it’s usually an older female person who has more discomfort with the male
student.” Conversely, she admitted that on one instance,

We did have a male that did not want the male student to catheterize him. So, it
was sorta . . . I called it homophobia. As a result, sometimes it’s easier to assign
male patients to male students and females to female patients.
My Interactions With Sally

My initial interactions with Sally occurred during my first observation period. I arrived on the nursing unit at 9:00 a.m. and felt like I was trapped in a time warp. The hall was very narrow, the ceiling was low, the walls were painted a pale salmon color, and the lighting was dim. The flooring resembled flooring from the early 1970s and the wood trim on the patient doors resembled basement paneling. Both sides of the hall were cluttered with various types of equipment including linen carts, portable computers, and numerous patient isolation carts. I noticed even an empty patient bed near the end of the hall, apparently waiting for repair since it had a large “To be repaired” sign taped to one of the side rails. However, despite the visual barrage, the noise level was somewhat subdued.

Sally was busy talking about medications with one of her female students when I approached them. She seemed relaxed, talkative, and stated, “So far we’re having a good morning.” She then proceeded to “make rounds” on her students by checking on each of them individually to assess whether they needed assistance or had any questions. When she approached ‘Sam,’ she asked, “Are you all caught up with your patient care?” Sam replied, “Yes. I’m done with everything.” Sally, seemingly skeptical, then asked, “Has your patient had a bath?” Sam replied, “No. He’s resting and wants to take one later.” Sam then wandered off and Sally turned to me and stated, “I don’t think he’s given a bath yet. Every time I ask him he tells me the same thing. I think it’s time he and I had a talk.”
As we continued our walk down the hall to check on the other students, Sally appeared frustrated and a bit irritated. I brought this up to her and she confessed,

My clinical rotation is not high on a lot of tasks. It’s more of interpersonal because of the setting. And, so, sometimes they’re (males) not as content with it. And, they (males) sometimes even voice their discontentment. I think the males are a little more bored. I had one male student even tell me, “This is dumb, I don’t like this and I shouldn’t have to be here.” Male students particularly like the action of the ER (Emergency Room) much better.

Sally’s remarks were further supported by her emails that week that described her male students as “casual and bored” whereas the females she described as “anxious and friendly.” She admitted many of her female students preferred “tasks and action” as well; however, Sally conceded it seemed to be much more common in males.

When I interviewed Sally the following week, I asked her, “What comes to mind when you think of males in the nursing profession?” She paused briefly, then stated,

I feel like they’re looking for a stable career with good pay or someone in their family is a nurse and that’s why they’ve chosen this profession. I think this is a great profession for males and I feel it’s becoming more acceptable, but I think barriers still exist. Clinically, I think males are less confident, timid, and ‘fly under the radar’ sometimes.

She added,

I guess I would say they are task oriented in that they want a list and want to do what’s on the list. I think if they’re (males) sitting and talking to a patient, they
don’t feel like that was as much of an intervention. So they like to do things step by step then they (males) can say “I accomplished this,” “I did this,” or “I helped with this.”

Sally and I then began to discuss the concept of caring in relation to gender differences. Sally hesitated then stated, “I think males sometimes have a little bit harder time with the psychosocial nursing diagnosis and tend to focus more on the tasks.” She added, “For women, it is a little more nurturing and for men, it’s not that they’re not caring, it is more of an advocacy, um, teaching focus for them.” Sally refers to this as “verbally nurturing” patients. She also contends that males’ concept of caring might perhaps be related to the idea that males may be more uncomfortable with touch. Sally stated, “I notice, in general, males tend not to touch as much. So is it the nurture idea or is it that they don’t or are worried that patients might be wary of touch—I’m torn.”

Throughout my nine hours observing Sally interacting with her students, I noticed her working very hard to equalize her time spent with each student. On average, she spent six minutes per hour with each student regardless of gender. Any additional time spent with any student, male or female, was related to a nursing task or activity where the instructor was needed to help the student perform a task. For example, there was one period of time where Sally spent 20 minutes with her female student because the student’s assigned patient had a wound dressing that needed cleaned and changed. Thus, Sally’s time was proportioned based on student and patient needs.

Throughout the 8-week clinical period, the students and Sally met for an hour to discuss what was occurring in the clinical unit that day. They met in a part of the facility
away from the patient care area. Usually it was a conference room that resembled a typical boardroom. I was excited to be part of this discussion since it gave me a “bird’s-eye view” of interactions. During these weekly one-hour sessions, I noted Sally had equal eye contact with all students; however, when she asked the group a question and no one wanted to answer, she routinely called on the male students first. At one point, she called on ‘Joe’ several times and continued to question him about his patient. Her tone was friendly and casual but I sensed her frustration and she later recounted, “Did you see the guys all yawning?” Thus, during these discussion hours, much of Sally’s focus was directed to the males. At the same time, a female student had her laptop open and seemed not the least interested in the discussion. After the last discussion hour I attended near the end of the 8 weeks, Sally was visibly frustrated and stated, “This group underwhelmed me. I was disappointed in the group especially the males as I was hoping they would be more dynamic; rather, they were not eager to please.” She added, “They just seemed uninterested.” It appeared Sally the Big Sister was disappointed with her young male students. She said initially she was thrilled to see three males on her clinical roster but ultimately she stated,

In the past, males have appeared somewhat bored but also proactive in seeking out extra learning opportunities or even seeking out something to make it more interesting. This group, the males did not seem to make an extra effort yet when quizzed about information, were found to be a bit lacking. So I describe them as overconfident because they acted as if they knew more than they really did.
As the semester progressed, the discussions during the interviews and observations veered towards Sally’s interactions with other clinical educators and male nursing students. Sally stated, “I think male nursing students seem to get away with more and I see nurses on the units chumming up to the males.” She added, “I sometimes hear my peers say ‘He’s my bud’ (referring to a male student).” “Conversely,” she said, “I’ve also heard peers say ‘arrogance’ when talking about male students.” In addition, Sally says she often sees staff “use” male students to do a lot of lifting (laughing). I bet we’re all guilty of that.” Thus, she does feel gender bias exists and said, “I think they (males) need support for their unique issue of being in a female-dominated profession.”

Sally stated, “I’m very happy we’re getting more and more males in the profession.” “However,” she added, “I would tell future males to be prepared for the stereotypes by society of being feminine or gay and being confused by patients who think they (males) are doctors.” In addition, she wants to give them as much help and support as she can. She noted,

One thing I want to do for the male student is to let them know where they may get support to understand how nursing is different for them because they are a male. I think they need a different kind of support, just for their unique issue of being in a female-dominated profession.

All of this spoken like a big sister!

Cross Case Analysis

According to Stake (2006), the purpose of the cross case analysis is to provide the reader an opportunity to better understand the research questions within a study. In addition,
the cross case analysis relies on thick, rich descriptions, and involves extrapolating themes as well as exploring similarities and differences within a multicase study. As part of this multicase study, a cross case analysis approach was utilized.

This cross case analysis resulted in four themes that emerged from the date collection methods utilized including a Qualtrics Survey, two interviews, three observation periods, and weekly emails. These weekly emails consisted of one to two words or short phrases that described the educators’ thoughts about male students on a weekly basis. The themes extrapolated included: preconceived assumptions about male nursing students are evident; the concept of caring differs between males and females; gender stereotypes persist; and, physical strength is exploited. Table 3 depicts the results of the Qualtrics Survey done prior to the other forms of data collection. The Qualtrics Survey was the initial method of data collection that was done prior to the other methods of data gathering. As a result, it is presented here and was then compared with the results of the remaining collection methods.

**Preconceived Assumptions About Male Nursing Students**

The four participants in this study have been nurse educators for a combined average of 10 years. As a result, each has admitted to having preconceived assumptions about male nursing students. For example, when I asked each of them what comes to mind when you think of male students in the nursing profession, all four participants had numerous, similar comments. Timmy compared male students to mechanics; wherein, males are “more task oriented, more direct, more linear.” Mimi, Kate, and Sally also described their male nursing students as “task oriented” in both of the interviews and weekly email descriptions. Additionally, all participants described their male nursing students as either “hesitant,” “timid,” or both, although Timmy also described his male
Table 3

*Qualtrics Survey Results*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Timmy</th>
<th>Sally</th>
<th>Mimi</th>
<th>Kate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Male nurses are often mistaken for doctors</td>
<td>A</td>
<td>A</td>
<td>SA</td>
<td>A</td>
</tr>
<tr>
<td>2. Media portrayal of male nurses is relatively unattractive</td>
<td>D</td>
<td>A</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>3. Males in nursing tend to be viewed as feminine or gay</td>
<td>SA</td>
<td>A</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>4. Male nurses are not overly nurturing</td>
<td>SD</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>5. Male nurses communicate differently than female nurses</td>
<td>SA</td>
<td>A</td>
<td>SA</td>
<td>A</td>
</tr>
<tr>
<td>6. Gender bias exists in nursing</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>7. Patients prefer female nurses</td>
<td>N</td>
<td>A</td>
<td>D</td>
<td>N</td>
</tr>
<tr>
<td>8. Males in nursing are negatively stereotyped</td>
<td>N</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
</tbody>
</table>

SA = strongly agree; A = agree; N = neither disagree nor agree; D = disagree; SD = strongly disagree

nursing student as empathetic, relaxed, and inquiring. Throughout the observation periods, Timmy’s interactions with his male student were more casual and relaxed; whereas, Mimi, Kate, and Sally displayed obvious nonverbal frustration such as eye rolling and head shaking. In addition, Timmy was the only participant who did not consider the patient or student’s gender when considering the student’s assignment for the clinical day. Table 4 presents a summary of the data that supports this theme.
### Table 4

**Preconceived Assumptions About Male Nursing Student**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
</table>
| Timmy       | Agrees gender bias exists | • Compares males to mechanics  
• “Very much task nursing”  
• Males are more “side tracked”  
• “Enjoys working with males”  
• “Timid with patient interactions”  
• “Males are more outcome oriented” | • Timmy spent additional time “chatting” with the male student.  
• Timmy placed his arm on male student’s shoulder. | Task oriented  
• Timid  
• Relaxed  
• Inquiring |
| Mimi        | Agrees gender bias exists | • Males are “a little out of place”  
• “Seem to struggle”  
• “See patient as a person in a bed that needs specific treatments”  
• “Hesitant”  
• “Constantly need redirecting”  
• “Focused on tasks” | • She spent approximately two minutes more per hour time with the male student.  
• Mimi was observed rolling her eyes when the male student approached.  
• Mimi would shake her head when male student would leave her presence.  
• She was patient and firm but visibly frustrated at times.  
• She appeared trying to be tolerant. | Disorganized  
• Apprehensive  
• Needy  
• Timid  
• Overconfident |

*(table continues)*
Table 4 (continued)

*Preconceived Assumptions About Male Nursing Student*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate</td>
<td>Agrees gender bias exists</td>
<td>“Males are hesitant”</td>
<td>She spent two extra minutes hourly with males</td>
<td>Timid</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Timid”</td>
<td>Kate was very patient; “motherly,” and soothing</td>
<td>Over confident</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Need more guidance and direction”</td>
<td>She was frequently approached by the male students</td>
<td>Resilient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Task oriented”</td>
<td></td>
<td>Task oriented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Ask fewer questions than females”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sally</td>
<td>Agrees gender bias exists</td>
<td>“Task oriented”</td>
<td>Sally was frustrated with the males for their lack of interest</td>
<td>Casual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Looking for a stable career”</td>
<td>She spent equal time with all students.</td>
<td>Bored</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Timid”</td>
<td>She routinely called on male students to answer questions.</td>
<td>Overconfident</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Less confident”</td>
<td></td>
<td>Disappointing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Fly under the radar”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Not as content”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“A bit lacking”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Visibly frustrated”</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Likely to do things step-by-step”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Concept of Caring**

The definition of caring can be somewhat broad and complex. However, this cross case analysis specifically addresses nurse educators’ recognition of the differences in the concept of care based on gender. Overall, all of the educators relayed that male students tend to define caring as completing or assisting a patient with their physical care such as dressing and bathing; thus, male student’s concept of caring was described as
“task oriented” by the educators. In addition, the educators agreed that while physical care was important, the patient’s psychological care was often overlooked. For example, despite prompting from Sally, her male nursing students failed to recognize that talking to a patient can be recognized as a caring task. In addition, Timmy and Mimi noted that conversations between patients and male nursing students tend to focus on more “male-oriented” topics such as sports. Additionally, Mimi stated male students’ conversations tend to be “staccato” in nature; meaning they get to the point. Table 5 presents an overview of the data collection supporting this theme.

**Gender Stereotypes Persist**

All four participants agreed that gender stereotypes persist in the nursing profession. The results of the Qualtrics Survey indicated that all four participants either agree or strongly agree that male nurses are often mistaken for doctors. In addition, despite “using” males for their physical strength, all participants were in agreement that males in nursing tend to be viewed as feminine or gay. However, only Sally agreed that patients prefer female nurses, and Timmy had no comment on whether males in nursing are negatively stereotyped. In addition, only Timmy did not take gender into consideration when assigning patient care to male students. The summary of data supporting this theme can be found in Table 6.
Table 5

**Concept of Caring**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
</table>
| Timmy       | • Strongly disagrees males are not overly nurturing  
  • Strongly agrees male nurses communicate differently from female nurses | • “Males are more outcome oriented”  
  • Males focus on “let’s fix this”  
  • “Males miss out on the heart of nursing”  
  • “Focus on physical well-being”  
  • “Takes more time to be comfortable” | • He was very relaxed and patient with the male student.  
  • Timmy was not intimidating.  
  • He used a friendly tone of voice.  
  • He stated, “Males can talk about sports, hunting.”  
  | • Empathetic  
  • Sensitive  
  • Gentle |
| Mimi        | • Agrees male nurses are not overly nurturing  
  • Strongly agrees male nurses communicate differently | • “Females convey more nurturing activities”  
  • “Males tend to focus on tasks”  
  • “Overlook psychological aspects of care”  
  • “Conversations tend to be male-oriented topics”  
  • “Staccato conversations”  
  • “Not to say they’re not as nurturing but they’re not” | • She prompted the male student to elaborate on how he “cared” for his patient.  
  | • Needy  
  • Task oriented  
  • Overconfident  
  • “Opinion of their (male) care is overinflated” |
| Kate        | • Agrees nurses are not overly nurturing  
  • Agrees male nurses communicate differently | • “Males have a different definition of caring”  
  • “Focus more on physical care”  
  • “Psychological aspects of care are often missing and/or minimized” | • She was approached frequently by male students for guidance.  
  • Kate compared her students to “kids.”  
  • She spent about two minutes more per hour with her male students.  
  | • Task oriented |

*(table continues)*
Table 5 (continued)

*Concept of Caring*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
</table>
| Sally       | • Agrees male nurses are not overly nurturing  
• Agrees male nurses communicate differently than female nurses | • “Want a list and do what’s on the list”  
• “Don’t feel sitting and talking to a patient is an intervention”  
• “Have a little bit harder time with the psychological nursing diagnosis”  
• “Tend to focus on tasks”  
• “Males might be more uncomfortable with touch” | • Sally prompted the male students to talk about their patient care experiences.  
• She focused and called on the males students throughout the clinical post conference time. | • Male student’s state  
• “I did this” or “I helped with this”  
• Task oriented |
Table 6

*Gender Stereotypes Persist*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timmy</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Agrees male</td>
<td>• “My friends</td>
<td>• Timmy made it a</td>
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<td></td>
<td>nurses are often</td>
<td>nurses are often mistaken for point to focus on</td>
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<td>mistaken for</td>
<td>becoming a</td>
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<td></td>
<td>doctors</td>
<td>nurse”</td>
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<td></td>
<td>• Neutral about</td>
<td>• His friends often</td>
<td>• He was sensitive</td>
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<td>portrayal of</td>
<td>joked, “you’re</td>
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<td>male nurses is</td>
<td>gay”</td>
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<td>relatively</td>
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<td>to male nursing</td>
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<td>unattractive</td>
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<td>student’s</td>
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<td></td>
<td>• Strongly agrees</td>
<td>• Felt that while in</td>
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<td></td>
<td>males in</td>
<td>nursing school,</td>
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<td></td>
<td>nursing tend to</td>
<td>his instructors</td>
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<td></td>
<td>be viewed as</td>
<td>were “flirtatious</td>
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<td></td>
<td>feminine or gay</td>
<td>as well as biased</td>
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<td>against him”</td>
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<td></td>
<td></td>
<td>• His instructor</td>
<td>• Timmy did not</td>
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<td></td>
<td>stated, “You’re</td>
<td>take gender into</td>
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<td>embarrassed to be</td>
<td>consideration</td>
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<td>around a woman</td>
<td>when assigning</td>
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<td>who just gave</td>
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<td></td>
<td>birth”</td>
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<td></td>
<td>• “Some nurse</td>
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<td></td>
<td>educators</td>
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<td>continue to be</td>
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<td></td>
<td>gender biased</td>
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<td></td>
<td>against males”</td>
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<td></td>
<td>• “I’ve had male</td>
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<td></td>
<td></td>
<td>students come to</td>
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<td></td>
<td>talk to me about</td>
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<td></td>
<td>that” (male bias)</td>
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<tr>
<td></td>
<td></td>
<td>• Empathetic</td>
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<td>• Inquiring</td>
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<td></td>
<td></td>
<td>• Gentle</td>
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</tbody>
</table>
Table 6 (continued)

*Gender Stereotypes Persist*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mimi</td>
<td>• Strongly agrees male nurses are often mistaken for doctors</td>
<td>• While in nursing school, initially thought her male classmates ‘must be gay’</td>
<td>• Mimi Initially stated, “I give a male student a male patient.”</td>
<td>• Needy</td>
</tr>
<tr>
<td></td>
<td>• Agrees males in nursing tend to be viewed as feminine or gay</td>
<td>• “I believe gender stereotypes do exist”</td>
<td>• Three out of three visits, her male student was assigned to a male patient.</td>
<td>• Hesitant</td>
</tr>
<tr>
<td></td>
<td>• Agrees males in nursing are negatively stereotyped</td>
<td>• “I’ve had staff, during clinical, tell me they sometimes wonder why a guy might go into nursing”</td>
<td>• Mimi displayed many nonverbal communication cues such as, eye rolling and head shaking.</td>
<td>• Not as nurturing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “They’re (males) a little out of place”</td>
<td>• However, verbal communication with males was pleasant and calming.</td>
<td>• Looking for a career choice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Sometimes I think they might want to consider oceanography”</td>
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<td></td>
<td></td>
<td>• “I try really hard not to be biased”</td>
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<tr>
<td></td>
<td></td>
<td>• “I want to ask males, ‘Do you view this as a profession or more of an employment opportunity?’”</td>
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</tr>
</tbody>
</table>
Table 6 (continued)

**Gender Stereotypes Persist**

<table>
<thead>
<tr>
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<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate</td>
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<tr>
<td></td>
<td>• Agrees male</td>
<td>• Recalls</td>
<td>• Kate</td>
<td>• Hesitant</td>
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<td></td>
<td>nurses are often</td>
<td>the male</td>
<td>admitted</td>
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<td>mistaken for</td>
<td>student in</td>
<td>taking gender</td>
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<td>doctors</td>
<td>her nursing</td>
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<td>• Strongly</td>
<td>class as</td>
<td>consideration</td>
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<td>agrees males in</td>
<td>being “somewhat”</td>
<td>when assigning</td>
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<td></td>
<td>nursing tend to</td>
<td>feminine”</td>
<td>students to</td>
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<td></td>
<td>be viewed as</td>
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<td>patient care;</td>
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<td>feminine or gay</td>
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<td>typically she</td>
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<td>• Agrees males</td>
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<td>assigns students</td>
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<td>in nursing are</td>
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<td>to same gender</td>
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<td>negatively</td>
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<td>patients.</td>
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<td>stereotyped</td>
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<td>• She Offered</td>
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<td></td>
<td></td>
<td>much patience</td>
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<td>and support</td>
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<td>• She displayed</td>
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<td>calming and</td>
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<td>soothing</td>
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<td></td>
<td>interactions</td>
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<td></td>
<td></td>
<td></td>
<td>• Kate was</td>
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<td></td>
<td></td>
<td></td>
<td>approached</td>
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<td>frequently by</td>
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<td>her male</td>
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<td></td>
<td>students.</td>
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<td></td>
<td>• Generally</td>
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<td>Kate spent</td>
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<td>slightly</td>
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<td>more time</td>
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<td>with males</td>
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<td>(two minutes</td>
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<td>more per hour)</td>
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<td></td>
<td></td>
<td>• Hesitant</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Timid</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Task oriented</td>
<td></td>
</tr>
</tbody>
</table>
Table 6 (continued)

*Gender Stereotypes Persist*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
</table>
| Sally       | • Agrees male nurses are often mistaken for doctors  
• Agrees media portrayal of male nurses is relatively unattractive  
• Agrees males tend to be viewed as feminine or gay  
• Agrees patients prefer female nurses  
• Agrees males in nursing are negatively stereotyped  
• “Male nurses gravitate towards ER, ICU, Cardiac”  
• “I liked having male students in class”  
• Admits tendency to “assign student patients based on similar gender”  
• “Sometimes I intentionally give males more complex patients because I think they want to do tasks”  
• “Sometimes I assign male students to male patients to avoid any potential discomforts”  
• Has seen signs on patient’s doors that read, “Male nurses not to bathe”  
• Has heard peers say, “He’s my bud.” Conversely, had heard peers say arrogance in | • Sally was skeptical of student’s progress in regard to patient care.  
• For two of the three weeks, her male students were assigned to male patients.  
• She was frustrated with her students during clinical post conference.  
• She routinely called on one of the male students for answers or discussion.  
• Task oriented  
• “Nursing is different for them because they are a male” |
reference to male students

• “Male student had a male patient who did not want a male student to catheterize him”

Physical Strength is Exploited

The exploitation of male nurses’ physical strength is not emphasized in much of the literature that focuses on men in nursing. However, although this theme was not part of my original discussions with all four educators, each of them mentioned that ‘using’ males for the physical attributes was something they, themselves, were aware of, and often tried to avoid. During my observations of the nurse educators, I also observed the nursing staff frequently ask males if they can “help out” with the patients. This request for male assistance, from staff, typically occurred twice during each of the observation periods. Only Timmy admitted her makes a conscience effort not to ask his male student to assist others for physical needs such as lifting or transferring patients. Table 7 summarizes the data supporting this theme.

Table 7

*Physical Strength is Exploited*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timmy</td>
<td>• There were no statements to assess regarding the exploitation of physical strength</td>
<td>• “Male students are often used for their physical strength”</td>
<td>• He was reluctant to say no when nurses ask him for physical assistance.</td>
<td>• Empathetic • Eager to help</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Female nurses will often call on males, including students, to move</td>
<td>• Timmy assisted his male student but did not ask his</td>
<td></td>
</tr>
</tbody>
</table>
or transfer, a lot of physical activities”
• “Incidence of back injuries from male nurses doing added physical work”

students to help others in regards to physical help.

*Table continues*

**Table 7 (continued)**

**Physical Strength is Exploited**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Qualtrics Survey</th>
<th>Interviews</th>
<th>Observations</th>
<th>Weekly Emails</th>
</tr>
</thead>
</table>
| Mimi        | • “I think we ask them (males) to help with physical care without giving it any thought”
• “Male students are great for helping to lift and transfer patients.”
• “I guess I’m guilty of using them (males) too.” (for their strength)
|              | Mimi suggested to her male student that he “see if another student needed assistance transferring her patient to a chair.” |
| Kate        | • “I tend to ask my male students to help with more physical aspects of care, like moving or transferring patients”
• “Staff often ask me if any male student can assist them”
|              | Kate instructed her female student to ask the male student to assist in transferring a patient.
• Four times during the three observation periods she directed her male students or offered their assistance to the nursing staff.
• Kate seemed unaware that she asked the males to
• Eager to complete tasks |
help out routinely with physical care.

Sally

- States she “often sees staff ‘use’ male students to do a lot of lifting”
- “I’ll bet we’re all guilty of that” (referring to asking males to help with physical tasks)
- She instructed one of her male students to assist a female colleague attempting to transfer a patient from the bed to a wheelchair.

- Task oriented

This chapter presented four individual case studies followed by a cross case analysis. Data were collected via a Qualtrics Survey, two interviews, three observation periods, and weekly emails. Four themes emerged from the analyses that were presented in table form to allow for ease of comparison for the reader.

The themes that emerged included: nurse educators have preconceived assumptions about male nursing students, the concept of caring differs between males and females, gender stereotypes persist, and physical strength is exploited. In addition, the similarities among responses were compelling and exceeded the differences.

Chapter 5 presents a discussion of the findings, implications for nursing education, limitations, and recommendations for future research.
CHAPTER V
DISCUSSION AND IMPLICATIONS

In many industrialized countries of the world, the gendering of occupations persists with clear divisions of what constitutes “men’s work” and “women’s work.” Thus, it is not surprising that the percentage of men in nursing, a predominantly female-dominated profession, has not substantially increased in the past five decades (U.S. Census Bureau, 2013; Williams, 1993). Moreover, although healthcare is one of the fastest growing industries in the United States and the demand for registered nurses (RNs) has increased, the percentages and numbers of males entering into the nursing profession is small to moderate compared to the rate of growth of the healthcare industry (U.S. Census Bureau, 2013). This chapter presents a discussion of the results of this qualitative multicase study, followed by the implications for the nursing profession and potential limitations inherent in this study. Lastly, implications for future research are discussed.

Discussion

Nurse leaders and educators recognize that a key aspect of nursing education reform is to increase efforts to recruit more males into the nursing profession (Anthony, 2004; Bell-Scriber, 2008; Meadus, 2000; Meadus & Twomey, 2007; O’Lynn, 2004; Porter-O’Grady, 1998; Perkins, Bennett, & Dorman, 1993; Villeneuve, 1994; Xu, 2008). However, a review of the literature and evaluation of current nursing research has revealed that stereotypical perceptions of male nurses and gender barriers to practice continue to permeate within society and the educational realm. In addition, while there is
a plethora of research that supports that stereotypical perceptions linger in society and in
the classroom, I was unable to find research that examines nurse educators’ perceptions
of male nursing students in the clinical setting. This gap in the literature is important
since clinical is an integral and critical component of the nursing curriculum.

Students accepted into this nursing program must maintain a minimum average of
75% in the classroom coupled with satisfactorily completing the clinical component of
each nursing course in order to successfully complete the program. The evaluation of a
student’s performance, by the clinical educator, is based upon interactions and
observations of students within the clinical setting. Additionally, the ratio of nurse
educators to students is typically no greater than 10 students to one educator resulting in
more individual attention for each student. Each clinical rotation typically commences
over 8 to 15 weeks with time spent per clinical day ranging from 6 to 12 hours. Thus,
student and educator are in a clinical area for an average of 90 to 180 hours per semester.
As a result, the interactions between nurse educators and male nursing students is a
prominent feature of the clinical aspect of the nursing curriculum. Hence, we, as nurse
educators, are in a prime position to become instrumental change agents by recognizing
our own biases through self-reflection, self-awareness, and seeking dialogue with male
nursing students to embrace diversity and inclusion within the nursing curriculum.

The four major themes that emerged from this study are, for the most part,
consistent with research pertaining to stereotypical and gender bias related to male
student nurses and males working as registered nurses. It was interesting that much of
what the nurse educators stated, combined with the observation and other data sources, supports what is perpetuated in the literature regarding male nurses.

Particularly intriguing was that Timmy’s responses were more similar than different from the other three female educators in this study. Since educator and student interaction is a critical component of nursing education, and my study focused on the clinical aspect of education, the results of this study are unique and worth noting. The findings indicate that nurse educators do in fact bring with them into the clinical area, preconceived biases and stereotypes that may impact the male students’ evaluation. As a result, nurse educators need to be cognizant of any personal biases or stereotypes about males they bring into the clinical setting.

**Preconceived Assumptions About Male Nursing Students**

The four nurse educator participants in this study have been nurse educators for an average of 10 years. Each admitted to having preconceived assumptions about male nursing students. Although Timmy, Mimi, Kate, and Sally had similar assumptions about males, their assumptions were unique to this study and have not been documented in the literature. The lack of data to support these assumptions could be attributed to the fact that I found no research that addressed nurse educators’ preconceived assumptions of male nursing students in the clinical area. This is an important finding since it indicates that nurse educators enter into the clinical area with preconceived assumptions about male students. Nurse educators need to be aware of any preconceived assumptions that may unfairly bias male students and further perpetuate stereotypes.
All four nurse educators described their male students as “timid” and “task oriented.” In addition, although each of the nurse educators described the male students as less confident, Mimi and Sally’s emails suggest that the students, themselves, exhibited “overconfidence.” This disparity between what the educator perceived and what the male student verbalized is supported by observations that suggested that nurse educators spent, on average, two minutes more per hour with their male students although their interactions differed. For example, although Timmy spent additional time with his male student, the majority of the extra time was spent “chatting.” However, it was interesting that despite Timmy chatting with his male student, he stated that generally “males are more side tracked.”

In contrast, Mimi and Kate’s additional time with their male student(s) was due to the student’s request for additional help or guidance. Mimi explained this added time spent with her male student as his “constant need for redirection.” Similarly Kate noted the males in her clinical group “need more guidance and direction.” Although Sally spent equal time with all her students, she admitted, the male students “are a bit lacking” and typically “fly under the radar.” When I asked Sally to clarify these statements she stated, “Sometimes I wonder what they’ve been doing all morning.” She continued, “I think really the guys are just looking for a stable career.” Mimi, frequently rolling her eyes, stated, “Males are a little out of place.” Mimi further reinforced this statement when one week later, after redirecting her male student, turned to me, and stated, “Perhaps he should have considered oceanography.”
Although all the nurse educators in this study admitted to having preconceived assumptions about male nursing students, none of them acknowledged that these biases may have an impact on the interactions with the male students. In fact, based on their comments, they essentially reinforced the stereotypes and contributed to further bias. Rather than embracing differences and citing positive attributes about the male student(s), the educators focused on more negative characteristics.

**Concept of Caring**

The definition of caring can be somewhat broad and complex. The concept of caring has pervasively been associated with women and femininity (Scotto, 2003). Noddings (2005) contended that dialogue goes beyond just discussion by providing students and educators an opportunity to reflect upon, critique practices, and entertain questions. Students frequently have their own interpretations of caring, and dialogue enables them to “search for understanding, empathy, or appreciation” (p. 23). Additionally, the association between caring and women is strengthened by the sociological and psychological definitions of caring that historically relate females with the task of caring for the sick and the family (As cited in O’Lynn & Tranbarger, 2007). The four nurse educators relayed that the concept of caring is different for males and females. For instance, all four of the nurse educators concluded that male nursing students’ concept of care is directed toward completing tasks. Each contends that males focus more on physical care, or tend to focus on tasks or the physical well-being of the patient while overlooking the psychological aspects of patient care. Timmy compared his male students to “mechanics,” stating a male nurse’s goal might be, “Let’s fix this.”
Sally stated her male students typically “want a list and do what’s on the list; likely to do things step by step.” Thompson (2002) supported this view suggesting that “men provide care from an emotionally safe distance, focusing on instrumental tasks rather than affective tasks” (O’Lynn & Tranbarger, 2007, p. 133). In addition, Thompson (2002) noted that males typically approach caregiving by focusing on task completion, problem solving, and meeting the physical needs of the patient.

The nurse educators in this study consistently noted that male student nurses tended to focus on the physical care of the patient while spending less time meeting the psychological needs of the patient. Timmy went so far as to state, “Males miss out on the heart of nursing;” similarly Mimi admitted, “Males often overlook the psychological aspects of care, while Kate noted, “Psychological aspects of care are often missing and/or overlooked.” The participants all conceded that the concept of care is different for males and females. Paterson and colleagues (1996) acknowledged that the concept of care among genders may exist. They interviewed 20 male nursing students and noted that beginning students did not identify gender differences in caring. However, by the time these students were seniors, they (males) perceived that gender differences in caring exist and developed their own styles of care. For example, according to Paterson et al., the students described their caring styles as developing more friendly relationships with their patients and being less apt to touch. Conversely, the male students in the study described the female nurse interactions with patients as more maternal. The male students in Paterson and colleagues’ study reported that nursing faculty never discussed the concept of caring and expected them (males) to provide care for patients as the females would
care for patients. This idea was apparent when Sally often prompted her male students to talk about their patient care experiences hoping they would discuss more than just the physical care they provided the patient. Nurse educators were unaware of the conflicts that might result related to the students’ attempt to care for patients similar to females; thus, marginalizing male students as they attempt to adhere to feminine expressions of caring (Grady, Stewardson, & Hall, 2008), which emphasize more emotive and maternal characteristics of care (O’Lynn, 2007).

Milligan’s (2001) interview of eight male nurses concluded that their (males’) concept of care was difficult to define and explain. The study noted that male nurses were aware of societal expectations related to male caregiving rather than focusing on wanting to “get the job done” (p. 15). O’Lynn and Tranbarger (2007) conceded that men and women care differently; however, masculine care “has scarcely been mentioned in the literature” (p. 129). Perhaps this is one reason that all four nurse educators agreed that males’ concept of care was focused on physical tasks and rarely addressed the psychosocial aspects of caring. This study helped illuminate the need for addressing the concept of care within the nursing curriculum.

All four nurse educators also acknowledged that male nursing students communicate differently with their patients. Mimi noted her male student’s conversations with patients tended to be “staccato” in nature, whereas Timmy and Mimi described their male students’ conversations as more “male-oriented,” focusing more on topics such as sports. In addition, all the participants noted that male students tended to talk to patients with a purpose related to the physical care they were giving the patient
rather than engaging in social conversation. Yoshimura and Hayden (2007) supported and acknowledged that men’s speech is often task related; whereas, women’s speech is typically relationship oriented. Ellis et al. (2006) noted that “men get to the point more quickly” (p. 524), whereas women take longer to discuss a topic.

According to O’Lynn (2007), “Despite all the activity attempting to understand and explain caring, little research has been completed in the area of how male nurses, as men, care for others” (p. 121). Nurse educators need to recognize that male caring is exhibited in various forms within our social worlds. For example, one nurse may define helping a patient with a meal tray an act of caring whereas another nurse may define caring as offering comfort. It is apparent that until nurse educators’ address and dialogue about other ways of caring they may continue to view caring from the feminine perspective while failing to acknowledge and embrace the ways in which male nursing students care and communicate.

**Gender Stereotypes Persist**

All four nurse educators agreed that gender stereotypes persist in the nursing profession. Additionally, all agreed or strongly agreed that male nurses are often mistaken for doctors and frequently stereotyped as being feminine or gay. These findings are consistent with numerous perceptions of males in nursing documented in the literature. Ierardi, Fitzgerald, and Holland (2010) noted, “Nursing is a profession strongly influenced by stereotypes and gender bias” (p. 215). Thus, one of the themes that emerged from their study focused on male nursing students being mistaken for physicians while wearing white in the clinical setting. Similarly, Genua’s (2005) random
survey of six male nursing students found that patients mistook all of them as doctors, assuming since they were male, they must be doctors.

Kate admitted her male student was mistaken for a doctor. When the educator corrected the patient, the patient requested the “girl” nurse. Although Timmy, Mimi, and Sally did not directly experience a similar situation, during this study period, they verbalized they have overheard female patients asking male students if they were doctors or preferred a female rather than a male nurse to assist with their care. Chiduku (2015) noted that there are times in the workplace when patients request a nurse of the same gender. Thus, Mimi, Kate, and Sally admitted they do take the patient’s gender into consideration when assigning patient care. For example, Mimi stated, “Initially I give a male student a male patient.” Similarly, Kate admitted to taking gender into consideration when assigning patient care. She stated, “I think male patients prefer a male nurse, especially if the patient is alert and oriented.” Each week Kate’s male students were assigned a male patient. Sally stated, “Sometimes I assign male students to male patients to avoid any potential discomforts.”

As a result, for at least two of the three observation weeks, the male students in each group were assigned a male patient. Although, Timmy denied considering gender when assigning patient care, two of the three weeks his male student was assigned a male patient. When I brought this to Timmy’s attention, he responded, “It just happened that way.” Mimi, Kate, and Sally each admitted to consciously assigning their male student to a male patient; however, they did not view this as a bias, but rather, saw their decision as “more comfortable” for both the patient and the student. This creates an opportunity
for nurse educators to reflect upon their own gender bias and how this may affect how
they assign students patient care.

The nurse educators in this study also agreed or strongly agreed with the
stereotypical view that male nurses tend to be viewed as feminine or gay. Timmy
recalled being teased while in nursing school as well as feeling bias from his college
instructors. He also admitted that other male students have approached him about faculty
bias. He stated, “I’ve had male students come talk to me about that (male bias).”
Timmy’s comment was reinforced by Kate and Sally who both admitted, “I have heard
other faculty members comment about male gender bias.” Additionally, Mimi, Kate, and
Sally admit their own gender bias by questioning why males choose nursing, or assigning
more complex patients to the male student. For example, while in nursing school, Mimi
and Kate had a male student in their nursing class and both admitted to wondering, “Why
is he here?”

This commonly held stereotype that men in nursing are effeminate or gay is
pervasive in nursing literature (Bartfay et al., 2010; Lo & Brown, 1999; Meadus, 2000;
O’Brien et al., 2008; Williams, 1995). This stereotype is based on the falsehood that
nursing requires individuals to be nurturing, empathetic, and compassionate;
characteristics that are often viewed as predominately female (Meadus, 2000). Genua
(2005) conducted a mini study and conceded that a physician once described a male nurse
as “gay” because he was a male nurse wearing an earring.

Negative media portrayal of male nurses also reinforces inaccurate and
unprofessional depictions of male nurses that further perpetuates negative stereotypes
(Burton & Misener, 2007; Cabaniss, 2011; Kelly et al., 1996; Stanley, 2012; Weaver, Ferguson, Wilbourn, & Salamonson, 2013). Although Timmy did not agree nor disagree that media portrays males negatively, Mimi, Kate, and Sally all agreed that male nurses are negatively portrayed in the media and this does affect how society perceives males in nursing. Thus, media portrayal of male nurses as gay or effeminate in movies such as, “Meet the Parents,” only serves to further cultivate this unfair portrayal of male nurses.

**Physical Strength is Exploited**

The exploitation of physical strength materialized in discussions with nurse educators emerged as a common theme. All four educators acknowledged they have witnessed male nurses frequently asked to help move, transfer, or assist patients, particularly heavy patients. Each admitted that often nursing staff would seek out male nursing students to assist with moving or repositioning patients. Timmy currently works as a staff nurse and is sensitive to being asked to help; thus, he avoids directing or asking his male students to do “extra lifting.” He admits he is reluctant to say “no” when asked to assist with heavy patients; however, he usually relents but worries about the added strain on his back. Mimi, Kate, and Sally recognized males are often asked to assist, unfairly, with heavy lifting but seemed unaware that during the clinical observation periods they each routinely “volunteered” the male student to assist the staff on at least three occasions. During the second observation period, Mimi “volunteered” her male student three times in three hours to assist with transferring a patient from the bed to the chair. When I brought this up to Mimi’s attention, she replied, “I think we ask them (male students) to help with physical care without giving it any thought.” Similarly, Kate
instructed her male students twice in the first two observation periods to assist the staff with moving a patient from the bed to the cart. I asked her if this is common and she stated, “Yes, this happens all the time and it’s probably unfair.”

This “use” of male nurses to assist with physical activities such as moving or transferring patients has been described as “he-man” activities related to a man’s masculinity, particularly focusing on physical strength (Meadus & Twomey, 2011, p. 276). In addition, Kelly et al. (1996) reported that male nursing students felt their clinical educators expected them to take on physical tasks such as lifting a patient. Rajacich, Kane, Williston, and Cameron (2013) noted that in many instances, male nurses feel they are “expected to engage in physically demanding work” (p. 76). Further, Chiduku (2015) conceded that having male nurses as part of a team can be viewed as a “benefit” (p. 55) since males are physically stronger and more capable of heavy lifting. Milligan (2001) noted that male nurses often felt that physical strength and helping with physical tasks was a male expectation. This study confirmed that males are often called upon to assist with lifting, transferring, and moving patients because of their assumed physical strength. Nurse educators need to be aware that the expectation males should be called upon for these types of physical tasks may be contributing to barriers impeding males from entering into the nursing profession.

The themes that emerged during this data collection period are consistent with the nursing literature from the past several decades. These themes reinforce the stereotypes that have permeated and continue to perpetuate. No studies focused on nurse educators’ perceptions of male nursing students in the clinical setting. Thus, this study provides
insight that perhaps nurse educators aid in the continuation of gender barriers and stereotypes that may be hindering males’ decisions to enter into nursing. Strategies need to be implemented in the classroom, as well as the clinical setting, that empower males and illuminate the contributions they can make to the profession. Nurse educators need to promote gender neutrality by reflecting upon and confronting their own inherent biases they may bring into the educational realm that overemphasizes the feminization of the nursing profession.

**Implications for Nursing Education**

Although healthcare is one of the fastest growing industries in the United States, and the demand for registered nurses has increased, the percentage of males entering into the female dominated profession of nursing has only steadily increased since 2011. There are a number of implications suggesting ways in which nurse educators can become proactive to create an inviting and positive atmosphere for male students.

This study concluded that many of the stereotypes and biases male nurses faced 30 years ago seem to be culturally embedded into our ways of thinking and responding to males in nursing. Thus, it is imperative that nurse educators foster an educational environment that responds to and understands the unique qualities that males contribute to the nursing profession. In addition, nurse educators need to “search for the threads of social justice and human rights in curricula” (Fitzpatrick, 2003, p. 65) that ensures fairness, equal respect, and equal opportunities for those underrepresented in the female dominated nursing profession.
Henderson (2015) advocated engaging students in reflective, caring, and interactive dialogue that appreciate the contributions of each student. This dialogue includes an openness between an educator and a student that allows for both parties to explore ideas and raise questions in search of a shared understanding (Noddings, 1992). Through reciprocal conversations, all parties involved “open themselves” to the possibility for new possibilities (Castner, 2015, p. 41). Inviting male students to dialogue in critical conversations with nurse educators may result in a collaboration of new ideas and insight that creates a less gender focused learning environment.

Nursing tends to be labeled as a “female profession” that further perpetuates the notion that there are certain “characteristics” of males that tend to preclude them from considering nursing as a career. For example, discussions about the concept of caring often exclude males based on the assumption that men lack caring qualities due primarily to their drive for status and power (O’Lynn, 2007). This association between the notion of caring in males is further strengthened in sociology and psychology literature that ascertained males worked to feed the family, whereas females were charged with caring and nurturing the family (O’Lynn & Tranbarger, 2007). As a result, nurse educators have the opportunity to be advocates and educate others about the differences in caring between genders. The aim is for all nursing students, regardless of gender, to have the same learning opportunities in all clinical areas.

Sherrod (2003) reported that nurse educators are often unaware of the gender stereotypes and perception existing within schools of nursing. As a result, nurse educators may need to reevaluate their behaviors and admit, and be aware that sexism
and bias exists in both the classroom and clinical setting. One strategy may be to increase nurse educators’ awareness that lingering misconceptions and stereotypes continue. Bell-Scriber (2008) suggested including “outsiders” (p. 140) to the clinical or classroom for observations that may provide feedback for educators unaware of the subtle, unintentional bias that may be unknowingly conveyed to male students in the clinical area. Bell-Scriber also suggested formulating ongoing plans and perhaps a checklist to assess bias related to gender, where it would help in assessing and ensuring that an equitable learning environment is being promoted. Henderson and Kesson (2004) advocated educators document their reflections in journals to gather information that addresses social relationships between student and educator, and allows for a better understanding of the interactions and dialogue that are taking place. Reflecting on the interactions and dialogue that occurred between educator and student in the clinical setting may increase awareness of the gender bias that educators perpetuate but seem to be unaware of.

Eagly (1987) explained that Social Role Theory further symbolizes how stereotypes help reinforce and permeate gender differences. Lips (2014) noted these deep-rooted gender stereotypes can lead to bias evaluations that ultimately reinforce barriers and dictate what constitutes male and female behaviors, particularly in gender-dominated professions such as nursing. As a result, men entering distinctly female-dominated professions often face challenges and barriers that may contribute to the forces that instigate and create delusion among gendered professions. Perhaps if
nurse educators were familiar with this theory and reflected on the impact it may have on men contemplating nursing as a career, this cycle of disharmony may cease.

Colleges, universities, and schools of nursing need to reevaluate and assess the curriculum with “respect to a feminine lens” (Meadus & Twomey, 2011, p. 277) and the impact this may have on male nursing students. This includes being aware of communication styles of males and females both in the classroom and clinical settings. This idea might be aided by hiring more male faculty that could serve as role models for male nursing students to decrease potential feelings of loneliness and provide a supportive learning environment.

Henderson (2015) promoted emboldening and empowering educators in order to “liberate human potential in education” (p. XVII). This requires that nurse educators be aware of existing stereotypes and gender biases that persist for men in nursing. As a result, nurse educators need to confront their biases and embrace the uniqueness of males entering nursing while promoting and capitalizing on male nursing students’ potential contributions to the profession.

**Limitations**

The results of this multicase research study concluded that nurse educators’ perceptions of male nursing students parallels those of society and may be contributing to the stereotypes and gender biases that continue to perpetuate. Perhaps these lingering stereotypes contribute to the relatively slow growth in the percentage of males entering into the nursing profession. However, there were limitations to this study that need to be addressed.
First, although the sample size and study design was consistent with a multicase study, it would have been intriguing to widen the sample size and include nurse educators from other college or university nursing programs to ascertain whether the size or location of the program influences the results. For example, analyzing data collected from clinical educators on a smaller campus located in a rural area may differ from data gathered from a large, urban campus.

Second, all four nurse educators in this study have been involved in clinical education for a combined average of 10 years. Thus, responses among nurse educators who are new to clinical nursing education may have limited experience in the clinical realm. Similarly, responses may differ for educators, like myself, who have more than 10 years of experience in nursing education and have had male students in both the classroom and clinical setting.

Third, the use of observation as a data collection method can also contribute to study limitations. Although I spent nine hours observing, the nurse educators may have behaved in an atypical or unnatural fashion when they knew they were being observed, particularly when they were cognizant of the focus of my study. The selective perception of myself as the observer may narrow and/or distort the observations since my analysis may be based on personal interpretations of what I observed. Additionally, Patton (1990) pointed out as the observer, I was limited to the external behaviors of the educators and not able to assess what was happening inside the individuals.

Fourth, two of the four nurse educators had clinical groups consisting of only one male registered for that particular clinical section. As a result, all observational data
obtained for those instructors were based on the interactions between the nurse educator and only one male student. Hence, observations and data collected on multiple male students in each clinical may have offered different insight.

Last, although one nurse educator participant was a male, it would provide a stronger case in assessing the responses of additional male nurse educators. The responses from multiple male nurse educators could then be compared and contrasted. This may provide insight as to whether gender bias and stereotyping is more pervasive among female educators.

Implications for Future Research

The findings of this study are consistent with literature contending that gender stereotypes and gender bias continues to persist, perhaps impacting the number of males entering into the nursing profession. These are important findings because nurse educators need to realize and admit how these biases and stereotypes may influence the clinical evaluations of the male students. Time spent in clinical is significant within a nursing program and the evaluation of students is a major component of the students’ ability to pass a course. As a result, educators need to confront any bias they may bring into the evaluation process. This study also suggests possible avenues for future research that may warm the climate for male students and those considering a nursing career.

Rappleye (2015) noted that whereas females continue to outnumber men in nursing nationwide, there are discrepancies in the ratio of female to male nurses across all 50 states. For example, in Iowa, where the largest disparity occurs, the ratio of female to male nurses is 16.5 to 1. Conversely, Nebraska’s ratio of female to male nurses is the
lowest in the nation at 3.9 to 1. The ratio of female to male nurses in Ohio is 11.3 to 1; slightly higher than the national average ratio of 9.5 to 1. Additionally, Rappleye concluded that nationally states have an equal distribution of gender in the nursing profession. As a result, replicating this study where males are largely underrepresented may be noteworthy and offer further insight regarding the relatively low percentage of males in the nursing profession.

All four nurse educators in this study agreed that gender stereotypes persist and the concept of caring is defined differently based on gender. Thus, further research should be conducted to explore male nursing students’ perceptions regarding the existence of gender stereotypes and the impact these stereotypes may, or may not, have on the student’s educational experience. In addition, more research should be focused on understanding male students’ concept of caring and caring styles to help delineate gendered differences in the clinical setting. After all, “as nursing does not belong to one gender, neither does caring” (Rajacich et al., 2013, p. 79).

Additionally, although the sample size for this qualitative study was adequate, there was only one male nurse educator as participant. Bell-Scriber (2008) noted that the climate of the classroom, and perhaps the clinical setting, may be affected by the gender of the educator. Hence, although male educators are a relative minority in nursing education, future research regarding perceptions of gender should aim to include a greater sampling of the perceptions of male nurse educators. Paterson et al. (1996) noted that male nursing students felt they learned more from the male nurses on how to deal with gender issues of communication and care. The students also conceded they hesitated to
discuss issues with the female educators because they believed female faculty could not relate to or understand a male’s perspective. Perhaps if there were more male educators as role models the overall feminine imagery of the nursing profession might be lessened.

Finally, further research should be aimed at improving the negative portrayal of male nurses in the media. Perhaps a qualitative study with patients as participants may help to explain any unfavorable portrayals and offer feedback about reversing these uncomplimentary characterizations.

**Conclusion**

It is well documented that men, as well as women, have an equally valid historical role within the nursing profession (Mackintosh, 1997). However, the historical culture of the profession has been highly gendered and influenced by the work and writings of Florence Nightingale who described the male caring role as unnatural since caring was seen as an extension of women’s domestic roles (Anthony, 2006; Mackintosh, 1997; O’Lynn, 2004). As a result, the number of males in the nursing profession began to decline as men were ostracized and women were then given the nursing jobs.

This multicase research study examined nurse educators’ perceptions of male nursing students in the clinical setting and concluded that many of the stereotypes and gender bias that were prevalent in the literature continues. The four nurse educator participants all agreed that gender stereotypes persist and that the concept of caring is defined differently based on gender. In addition, all the nurse educators in this study admitted to having preconceived assumptions about male nursing students. These results are supported by O’Lynn (2004) who acknowledged that many of the barriers,
challenges, and stereotypes that men confronted within the nursing profession continue today. For example, the stereotype that reinforces the myth that men entering into the nursing profession are gay or effeminate currently persists. This negative characterization is further perpetuated in the media that often portray men in narrow and stereotypical ways Weaver et al., 2013). In addition, the assumption that men are not caring continues to be a barrier to men considering nursing as a career. Tranbarger (2007) stated, “Men entering nursing today face many of the same problems, attitudes, and discrimination as in the past” (p. 283).

However, with the increasing complexity of healthcare, the average age of nurses increasing, and the aging of our population, it is imperative that nurse educators and educational institutions invite males into the profession. By embracing the unique qualities males can contribute, creating a warm environment where social justice is exemplified, and dialogue is the norm, we, as nurse educators, can offer male students an opportunity to experience and participate in all aspects of a neutral gendered nursing profession. Tranbarger (2007) summed it up nicely stating, “Men and women in nursing have a rich history and a vibrant future together” (p. 283).
APPENDIX A

STUDY INVITATION
Appendix A

Study Invitation

November 23, 2015

Dear Nurse Educator:

My name is Kathleen Dwinnells, and I am a nurse educator conducting a study entitled, *Nurse Educators’ Perceptions of Male Nursing Students in the Clinical Setting*, to meet the requirements for my Ph.D. at the College of Education, Health and Human Services, at Kent State University. I am hoping to understand how nurse educators perceive male students in this female dominated profession.

I am interested in interviewing nurse educators who have taught clinical in an Associate or Bachelor Degree nursing program for at least two (2) years. If you are interested, you and I can meet at an agreed-upon location for two 45-60 minute interviews, focusing on your perceptions of male students in the clinical setting.

Prior to the initial interview, I am requesting participants complete an eight-statement Likert Scale survey, evaluating the statements relative to males in nursing. In addition, I would like to make three (3) observational visits on your clinical unit for approximately three (3) hours per each visit. The second interview can be done via telephone or Skype. Additional interviews may be needed for clarification purposes. Lastly, I am asking each participant to respond to two (2) email questions each week regarding their clinical experiences with males for that particular clinical. These email responses can be answered in one-to-three sentences.

Your participation in this study is voluntary; it is not part of the program, and participating in this study will not affect your status as a nurse educator.

If you are interested or have any questions, please contact me at the phone number or email address listed below. In addition, if you are aware of any faculty members that may be interested in participating in my study, please forward this letter to them.

Thank you for considering this request, and I look forward to hearing from you.

Sincerely,

Kathleen Dwinnells, MSN, CNS, CNE
mdwinnel@kent.edu
(330) 675-8906 - work
(330) 717-9004 - cell

KStH

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Phone: 330-847-0571 (Warren) • Fax: 330-675-8888 • http://www.trumbull.kent.edu
Appendix B

Data Collection Summary

**Title:** Nurse Educators’ Perceptions of Male Nursing Students in the Clinical Setting

**Overreaching Research Questions:**
1. What are nurse educators’ perceptions of male nursing students?
2. How do nurse educators’ perceptions effect their interactions with male nursing students?

**Data Collection Methods:**
A. Likert Scale Survey
B. Interviews
C. Observations
D. Weekly Email Communication

**A. Likert Scale Survey:**
- Send Likert Scale Survey to 4 nurse educators within the Kent State University system (full or part-time with at least two semesters teaching in the clinical unit). The Likert survey will be 10 statements based on common stereotypes of male nurses (as noted in the literature regarding male nurses). Participants will be asked whether they “definitely agree” “somewhat agree” “somewhat disagree”, or “definitely disagree”.
- Example statements may include: “Male nurses tend to be feminine”; Male nurses are not overly nurturing”.

**B. Interviews:**
- Participants will be interviewed twice within the 10 week period utilizing a semi-structured format. I will let the participants know the interviews may last 45-60 minutes.
- There will be an initial interview weeks 1 or 2 (2 participants week 1; 2 participants week 2) and a follow-up interview weeks 9 and 10.
- Interviews will take place when Kent faculty have office hours.

**C. Observations:**
- I will observe participants in the clinical setting three times throughout the ten-week period.
  Since early mornings and late afternoons are very hectic during the clinical day, I will observe each participant from 9am to 12pm one week and 1pm to 4pm the consecutive week. This ensures that each participant is observed in the morning as well as the afternoon.
- I will keep field notes during my observations.

**D. Weekly Email Communication:**
- Each week I will email each of the 4 participants 2 questions pertaining to their clinical interactions with male students that week. For example, I may ask, “describe ‘John’s clinical performance this week in 3 words’; Have you noticed any difference in ‘John’s’ clinical
performance this week compared to last week”? Questions may vary depending on the clinical makeup of each group. For instance, some educators may have more than one male in the clinical group.

- I will email these questions to each participant weekly (on their clinical day). This way much of the experiences and interactions will be “fresh” in their minds allowing for potentially easier recall.

<table>
<thead>
<tr>
<th>NURSE EDUCATOR*</th>
<th>WEEK 1** (MONDAY)***</th>
<th>WEEK 2 (MONDAY)</th>
<th>WEEK 3 (THURSDAY)</th>
<th>WEEK 4 (FRIDAY)</th>
<th>WEEK 5 (THURSDAY)</th>
<th>WEEK 6 (FRIDAY)</th>
<th>WEEK 7 (THURSDAY)</th>
<th>WEEK 8 (FRIDAY)</th>
<th>WEEK 9 (MONDAY)</th>
<th>WEEK 10 (MONDAY)</th>
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<tbody>
<tr>
<td>NURSE EDUCATOR “A”</td>
<td>Initial Face to Face Interview</td>
<td>3-hour Observation (#1) 9:00 AM-12:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>3-hour Observation (#2) 1:00 PM-4:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>3-hour Observation (#3) 9:00 AM-12:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>Email follow-up</td>
<td>• Second Interview **</td>
<td></td>
</tr>
<tr>
<td>NURSE EDUCATOR “B”</td>
<td>Initial Face to Face Interview</td>
<td>3-hour Observation (#1) 1:00 PM-4:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>3-hour Observation (#2) 9:00 AM-12:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>3-hour Observation (#3) 1:00 PM-4:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>Email follow-up</td>
<td>• Second Interview **</td>
<td></td>
</tr>
<tr>
<td>NURSE EDUCATOR “C”</td>
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<td>3-hour Observation (#1) 9:00 AM-12:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>3-hour Observation (#2) 1:00 PM-4:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>3-hour Observation (#3) 9:00 AM-12:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>Email follow-up</td>
<td>• Second Interview **</td>
<td></td>
</tr>
<tr>
<td>NURSE EDUCATOR “D”</td>
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<td>3-hour Observation (#1) 1:00 PM-4:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>3-hour Observation (#2) 9:00 AM-12:00 PM Email follow-up</td>
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<td>3-hour Observation (#3) 1:00 PM-4:00 PM Email follow-up</td>
<td>Email follow-up</td>
<td>Email follow-up</td>
<td>• Second Interview **</td>
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*Following completion of Likert Scale Survey **Specific dates will depend on IRB approval ***Clinical days are Thursdays and Fridays; office days are Mondays **** Email follow-ups (2 questions) relevant to that particular clinical
APPENDIX C

RESEARCH AND INTERVIEW QUESTIONS
Appendix C

Research and Interview Questions

<table>
<thead>
<tr>
<th>Overarching Research Questions</th>
<th>Related Semi-Structured Interview Questions</th>
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<tbody>
<tr>
<td>1. What are clinical nurse educator(s) perceptions of male nursing students?</td>
<td>a. How long have you been in nursing?</td>
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<td></td>
<td>b. What comes to mind when you think of males in the nursing profession?</td>
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<td></td>
<td>c. Describe your experiences teaching undergraduate nursing students?</td>
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<tr>
<td></td>
<td>d. What advice would you give male high school students who are interested in a nursing career?</td>
</tr>
<tr>
<td>2. How do nurse educators’ experiences with male nursing students inform their perceptions?</td>
<td>a. Have you ever worked with male nurses?</td>
</tr>
<tr>
<td></td>
<td>b. Describe your clinical experiences with male students.</td>
</tr>
<tr>
<td></td>
<td>c. What are the challenges in preparing male vs. female nursing students in clinical?</td>
</tr>
<tr>
<td></td>
<td>d. How do you determine patient assignments for your clinical group?</td>
</tr>
<tr>
<td></td>
<td>e. How would you describe one of your male students and how would you describe one of your female students?</td>
</tr>
<tr>
<td></td>
<td>f. Do males and females differ in the way they respond to professionalism and caring? If yes, can you elaborate?</td>
</tr>
</tbody>
</table>
APPENDIX D

AUDIOTAPE CONSENT FORM
Appendix D

Audiotape Consent Form

Nurse Educators’ Perceptions of Male Nursing Students in the Clinical Setting

M. Kathleen Dwinnells

I agree to participate in audio-taped interviews about nurse educators’ perceptions of male nursing students in the clinical setting, as part of this project and for the purposes of data analysis. I agree that M. Kathleen Dwinnells may audio-tape these interviews. The date and time of the interviews will be mutually agreed upon.

________________________________________  __________________________
Signature                                      Date

I have been told that I have the right to listen to the recording of the interview before it is used. I have decided that I:

____ want to listen to the recordings  ______ do not want to listen to the recordings

Sign below if you do not want to listen to the recordings. If you want to listen to the recording, you will be asked to sign after you have listened to them.

Kathleen Dwinnells may use the audio-tape made of me. The original tapes or copies may be used for this research project, publications, and/or presentation at professional meetings.

________________________________________  __________________________
Signature                                      Date

Address:
Appendix E

Consent Form

Study Title: Nurse Educators' Perceptions of Male Nursing Students in the Clinical Setting

Principal Investigator: M. Kathleen Dwinnells, Dr. James Henderson

You are being invited to participate in a research study. This consent form will provide you with information on the research project, what you will be asked to do, and the associated risks and benefits of participating. Your participation is voluntary and you may choose to stop participating at any time. Please read this form carefully. It is important that you ask questions and fully understand the research to make an informed decision about participating. You will receive a copy of this document to take with you.

Purpose
This is a qualitative research study that seeks to explore faculty perceptions of male nursing students in the clinical setting.

Procedures and Audio Recording
In this study, you will be asked to participate in two semi-structured interviews that will last approximately 45 to 60 minutes. These interviews will be audio-recorded and transcribed to a text file. In addition,

- Following the initial interview, the assistant researcher will email the participants eight Likert Scale questions asking them to evaluate these statements relative to males in nursing obtained from the literature review. This particular Likert Scale will enable the participants to choose one of five options including, “strongly agree”, “agree”, “neutral”, “disagree”, and “strongly disagree”.

- Participants will then be observed three times at varying times throughout the ten week data collection period. Each observation session will last approximately three hours.

- Concurrently, the assistant researcher will email each of the participant’s two questions pertaining to their clinical interactions with male students that week. The asynchronous idea of online data collection may have the benefit of adding reflection time that may be unavailable in a face to face interview. Further, weekly email questions may allow the participant to respond in a more thoughtful way without extraneous noises and feeling “put on the spot”. These questions can be answered in one to three sentences.

- A second interview will be scheduled near the end of the data collection period. Additional interviews may be needed for clarification purposes.

Participants will have the opportunity to choose a pseudonym for themselves.

All data (audio files, transcriptions, and copies of reflections) will be kept in a locked file cabinet or in a password protected electronic file in the possession of the researcher. The researcher may contact you once the audio file is transcribed and the data is analyzed to clarify or collect further data. The audio file of the interview may be used in the final written dissertation, in conference presentations, and for scholarly activity, such as publications. You can choose to allow this or not.
Risks and Discomforts
There are no anticipated risks beyond those encountered in everyday life.

Privacy and Confidentiality
The researcher will keep your identity confidential within the limits of the law. Your signed consent form will be kept separate from your study data and your interview transcripts, email responses and any observation notes will not be linked to you. You will be given the opportunity to use a pseudonym that will be used in recording of data and research reports. Your real name will not be used.

Any identifying information will be kept in a secure location and only the researchers will have access to the data. Research participants will not be identified in any publication or presentation of research results.

Voluntary Participation
Taking part in this research study is entirely up to you. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. Participating or not participating will not affect your academic progress in any way.

Contact Information
If you have any questions or concerns about this research, you may contact Kathleen Dwinnells, at (330) 717-9004, or mdwinnel@kent.edu. Or, you may contact James Henderson, Ph.D., my faculty advisor, at (330) 672-0631, or jhenders@kent.edu. This project has been approved by the Kent State University Institutional Review Board. If you have any questions about your rights as a research participant or complaints about the research, you may call the IRB at (330) 672-2704.

Consent Statement and Signature
I have read this consent form and have had the opportunity to have my questions answered to my satisfaction. I voluntarily agree to participate in this study. I understand that a copy of this consent will be provided to me for future reference.

Participant Signature
Date

Participant’s Printed Name
APPENDIX F

NURSE EDUCATORS’ PERCEPTIONS OF MALE NURSES
Appendix F

Nurse Educators’ Perceptions of Male Nurses

1. Male nurses are often mistaken for doctors
   ❑ Strongly disagree
   ❑ Disagree
   ❑ Neither disagree nor agree
   ❑ Agree
   ❑ Strongly agree

2. Media portrayal of male nurses is relatively unattractive.
   ❑ Strongly disagree
   ❑ Disagree
   ❑ Neither disagree nor agree
   ❑ Agree
   ❑ Strongly agree

3. Males in nursing tend to be viewed as feminine or gay.
   ❑ Strongly disagree
   ❑ Disagree
   ❑ Neither disagree nor agree
   ❑ Agree
   ❑ Strongly agree

4. Male nurses are not overly nurturing.
   ❑ Strongly disagree
   ❑ Disagree
   ❑ Neither disagree nor agree
   ❑ Agree
   ❑ Strongly agree

5. Male nurses communicate differently than female nurses.
   ❑ Strongly disagree
   ❑ Disagree
   ❑ Neither disagree nor agree
   ❑ Agree
   ❑ Strongly agree

6. Gender bias exists in nursing.
   ❑ Strongly disagree
   ❑ Disagree
   ❑ Neither disagree nor agree
   ❑ Agree
   ❑ Strongly agree

7. Patients prefer female nurses.
   ❑ Strongly disagree
   ❑ Disagree
   ❑ Neither disagree nor agree
   ❑ Agree
   ❑ Strongly agree
8. Males in nursing are negatively stereotyped.
   - Strongly disagree
   - Disagree
   - Neither disagree nor agree
   - Agree
   - Strongly agree
APPENDIX G

WEEKLY OBSERVATION OF NURSE EDUCATORS INTERACTIONS
WITH MALE NURSING STUDENTS IN THE CLINICAL SETTING
Appendix G

Weekly Observation of Nurse Educators Interactions

With Male Nursing Students in the Clinical Setting

1. Patient Assignment:
   - Female to Female □ yes □ no
   - Female to Male □ yes □ no
   - Male to Female □ yes □ no
   - Male to Male □ yes □ no

   Comments:

2. Verbal interactions between female students – primarily positive: □ yes □ no
   Verbal interactions between male students – primarily positive: □ yes □ no

   Comments:

3. Positive non-verbal interactions (smiling, etc.):
   - Males □ yes □ no

   Comments:

   Females □ yes □ no

   Comments:

   Negative non-verbal interactions (rolling eyes, shaking head, etc.):
   - Males □ yes □ no

   Comments:

   Females □ yes □ no

   Comments:

4. Does the Nurse Educator comment on caring attitudes?
   - Males □ yes □ no
   - Females □ yes □ no

   Comments:

5. Does the Nurse Educator ask more questions to:
   - Males □ yes □ no
Females □ yes □ no

Comments:

Average time spent with students per patient interaction:

Males
Females

Comments:

Additional Comments:
REFERENCES
REFERENCES


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